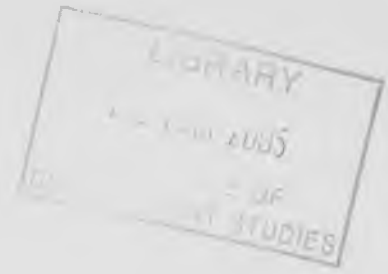


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Research
Review



**SOCIOCULTURAL DIMENSIONS OF
REPRODUCTIVE HEALTH AND HUMAN
DEVELOPMENT (2)**

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LEGON**

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RESEARCH REVIEW

New Series Vol. 19 No. 1

2003

**SOCIOCULTURAL DIMENSIONS OF REPRODUCTIVE
HEALTH AND HUMAN DEVELOPMENT (2)**

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EDITOR'S PREFACE

This issue of the *Research Review* contains papers from the seminar on Socio-Cultural Dimensions of Reproductive Health and Human Development held in Legon in 2002. These papers centre on the theme of Sexual Behaviour and its Consequences for Health and Reproduction. Another set was published as Vol.18 No.1. Additional papers will be published as Supplements to the *Research Review*.

Delali Badasu's paper examines the policy implications of the variations in the fertility transition in Ghana. It discusses the determinants of the disparities observed and the socio-economic development policy implications. It also considers the implications of the disparities in the patterns and trends of fertility change for research /studies on the subject and for family planning /reproductive health programmes. It recommends adoption of more equitable socio-economic development policies in the country as a major strategy to remove the disparities in socio-economic development which underlie the observed variations in this demographic process.

In his paper, Chuks Mba reviews available literature and studies on sexual behaviour and the risks of HIV/AIDS and other STDs among young people in some Sub-Saharan African countries. The paper discusses the evidence of premarital sex and other sources of vulnerability and risk-taking among young people. It stresses the greater risk of girls. It suggests that governments should play a leading role in addressing the problem, by putting the reality of youth sexuality on the political agenda.

John K. Anarfi discusses the obstacles and resistance to sexual behavioural change among the youth in Ghana in the era of the HIV/AIDS epidemic. He considers the cultural inhibitions, high illiteracy levels, poverty, misconceptions about sex and HIV/AIDS, Western influences, among others. The study is based on field work conducted in five administrative regions of Ghana, representing each of the three ecological zones in the country. It recommends that government must step up its efforts at controlling the disease, which is affecting mostly the youth, by expanding both content and scope of programmes addressing the problem.

The subject of Clara Opare-Obisaw's paper is the relationship between nutrition and health. It discusses the role of nutrition in human development from conception to reproductive age. Focusing on the importance of maternal nutrition for development, she recommends measures that could be taken to meet dietary requirements of women so that the cycle of poor health and nutrition that passes on from one generation to another could be broken. She discusses some findings on the nutritional status of mothers and children in Ghana and other countries.

Kodjo Senah examines the "non-medical" issues that affect maternal mortality in Ghana. These are the socio-cultural factors such as taboos about eating during pregnancy, delays in arriving at health facilities for delivery due to transportation problems, delays on the part of medical staff in attending to women in labour, among others. The paper also examines the contribution of abortion to maternal deaths. He points out that though the socio-cultural components of maternal mortality are not ignored by governments, the tragedy of maternal mortality is gendered because of the political voicelessness and financial powerlessness of women.

In their paper, Richard Yeboah and Monica Kom examine some aspects of abortion cases admitted to the Chenard Ward of the Korle Bu Teaching Hospital during the years 2000 and 2001. They consider the reasons given by the patients for aborting their pregnancies and the social effects of the abortions. They also make policy recommendations that can be adopted to address the problems of abortion – health, social, and psychological – experienced by the patients.

In her paper Laetitia Hevi-Yiboe examines how *Tugbewowo*, the puberty rites of the people of Dodome in the Ho District, could be repackaged and used as a family resource to address problems of early childbearing in that area. She suggests that families must be empowered financially to be able to use this resource and also stresses the need to research into the practice to understand it so that it could be modernized.

Delali Badasu

POLICY IMPLICATIONS OF THE VARIATIONS IN GHANA'S FERTILITY TRANSITION

Delali Badasu

Abstract

The results of three consecutive Demographic and Health Surveys (GDHS), carried out in 1986, 1993, 1998, show that Ghana's population has been experiencing a fertility transition. An analysis of the data, however, indicates that there are wide and increasing differentials in both the timing and trends in the process among geographic and socioeconomic subgroups of the population. Current Total Fertility Rate (TFR), for example, varies from around 3 to 7.

This paper examines the policy implications of the variations in the fertility transition. The transition is associated mainly with urbanization and education (particularly of mothers). The differentials are therefore explained by increasing economic inequalities among the socioeconomic subgroups of the population and the administrative regions. Policies that seek to remove the disparities in the fertility transition in the country must therefore address this underlying factor. While implementation of reproductive health/family planning programmes will have to be continued, even as the level of unmet need for contraception is still high in the population, socioeconomic development goals that seek to address such population problems must be a first priority and also be at the centre of population programmes in the country. Another policy approach will be the documentation of the details of the process at regional, district and other levels because the national averages obscure the peculiar patterns and trends presents at such levels. The quantitative data so far gathered on the various issues in reproduction in the country will also have to be supplemented by micro studies that adopt qualitative approaches to discover issues that are not captured by quantitative approaches.

Introduction

Three Demographic and Health Surveys (GDHS I, II and III) conducted in 1988, 1993 and 1998 respectively show that Ghana has achieved significant reduction in her fertility rate. Over a ten-year period, the Total Fertility Rate (TFR) dropped from 6.4 at the 1988 GDHS to 4.6 at the 1998 survey. This shows a two-child drop in the average number of children ever born alive to women in their reproductive period.

The results of the surveys however indicate significant differentials in the fertility change among geographical entities as well as socioeconomic subgroups of the population. The disparities are obscured by the national averages.

This paper discusses the patterns and trends in the variation of the fertility change and the associated factors. The main objective is to examine the emerging patterns and trends in this important demographic process in the population. Assessing how the observed variations are accounted for by disparities in socio-economic development and health indicators, the paper then shows how these pose challenges to Ghana's socio-economic development policy and the family planning/reproductive health policies and programmes that have been implemented in the country so far. It recommends equitable principles in development policy formulation and implementation to manage the challenges of the disparities observed. It also stresses that better understanding of the differentials in the fertility transition requires data on smaller geographical units and more socio-economic subgroups (apart from the educational and residential categories)

of the population as well as qualitative approaches to data collection on fertility and related demographic and related issues.

Data Sources

The main sources of data for the study are the GDHS of 1988, 1993 and 1998 and the report on the Ghana Fertility Survey (GFS) conducted in 1979/80. Data from the Ghana Living Standards Surveys (GLSS) of 1985, 1990, 1995 and 2000 have also been used. The reports of the various censuses conducted in 1960, 1970, 1984 and the 2000 (population and housing) provided some information for the study (Ghana Statistical Service 2000a).

The GFS is part of a worldwide fertility survey which was conducted in the 1970s. The GDHS is also part of an international effort coordinated by Macro International Inc. (U.S.A.) and funded by the USAID). It began in 1984 in some forty-six countries (The Allan Guttmacher Institute 1998, Ghana Statistical Service 1994: 2). In Ghana, the three surveys GDHS I, II, and III were carried out in 1988, 1993 and 1998 respectively.

The various GLSS are nation-wide surveys which collected data on a variety of socioeconomic issues – demographic characteristics of the population, education, health, employment and time use, migration, housing conditions, household agriculture and non-farm business (Ghana Statistical Service 2000b: v). The main purpose of these surveys was to provide needed information to policy makers and others to evaluate living standards and information on labour force systems in the country as well as enable monitoring and evaluation of the welfare of the population following the introduction of the Structural Adjustment Programmes with poverty reduction components.

Theoretical Perspectives

Evidence from research and historical records on fertility transitions shows that the process hardly occurred in uniform patterns over geographical entities or even within socioeconomic subgroups of a population. This is because the process itself is determined by several factors which may vary within any given population and also bring about the onset or precipitation of the process at widely varying levels of their presence (Bongaarts and Watkins 1996: 640).

The European experience is often cited in the literature. France was the forerunner and experienced fertility decline between 1780 and 1950 and was followed by the majority of the countries who had recorded fertility change in their populations during the second half of the Nineteenth Century. The few who were the stragglers experienced their transition at the beginning of the Twentieth Century (Livi Bacci 1992 cited by Agyei—Mensah 1997:15, Knodel and van de Walle 1986: 412). Differentials in fertility transition within the various countries have also been noted.

The earliest demographic explanation on fertility decline which is embodied in the Demographic Transition Theory is based on the European experience (Notestein 1953). According to the Demographic Transition Theory, fertility decline occurs in a population when socioeconomic changes (termed “modernization” in the theory) brings about new lifestyles which discourage large family size. The modernization process which occurs as a result of urbanization and industrialization comes with rising cost of raising children due mainly to the cost of their education and their declining economic value. These two forces considered the central forces driving fertility decline (Bongaarts and Watkins 1996) weaken the motivation for having large number of children. An associated increased child survival rate in the modernization process (due to improved living conditions and subsequent drop in mortality levels) also encourages adoption of fertility control measures to limit the size of the family. By implication, the Demographic Transition Theory provides explanation on how variations in socio-economic

development within any population can result in disparities in the patterns and trends in its fertility change (Bongaarts and Watkins 1996: 40-41).

Even though empirical evidence suggests that no society¹ has gone through significant socioeconomic transformation without experiencing some level of fertility decline, the role of socioeconomic development in accounting for the process has been challenged not only by new or recent findings on earlier transitions such as Europe's but even some recent ones.

In the European region, the forerunner, France experienced fertility transition when rural and agrarian conditions were characteristic of the population. In addition, infant mortality level was high in France when fertility level begun to fall, though drop in infant mortality is considered critical in fertility change. Britain, on the other hand, achieved high levels of socioeconomic development and technology before the onset of fertility transition in her population (Guinnane et al. 1994). Recently, Bangladesh has made some progress in fertility decline even though socioeconomic development in that country has not advanced much and there is "little apparent change in traditional values" (Mason 1997: 444). Bongaarts and Watkins (1996) in their study on contemporary fertility transitions have also found out that a number of developing countries apart from Bangladesh, have experienced the onset of fertility decline under low levels of socioeconomic development. They have also referred to Kirk's (1971) observation that the pace of development in the developing world as a whole has been substantially more rapid than that observed in Europe around the turn of the Twentieth Century. One major finding of Bongaart and Watkins (1996) and other works such as Cleland and Wilson's (1987) which also found similar relationship, is noted in the diffusionist explanation of fertility decline. The diffusionist approach states that family practices may be adopted apparently independently of social and economic circumstances.

Demographers have had to explain fertility transition as resulting from two contrasting underlining view points. The earlier adaptation explanation argues that fertility control reflects couple's response to changes in economic and social circumstances. The innovation hypothesis links fertility transition with behavioural change – a new behaviour whose origins may be new knowledge most likely about contraception. Such new knowledge may also result from changes in cultural conditions that makes family limitation practices "acceptable for the first time on moral grounds" (Guinnane et al. 1994: 1-2).

However, the diffusionist explanation and the narrow view that the spread of information on modern contraception from western countries to developing countries can bring about fertility change has been challenged by the wide gap between knowledge attitude and practice (KAP – gap) in many of these populations. In other words, the presence of the family planning programmes does not necessarily lead to the practice of family limitation.

The distinction between the diffusion of the information regarding fertility regulation and the diffusion of preferences regarding family size/limitation (Pollak and Watkins 1993) explains this paradox. While the presence of family planning facilities and services creates awareness about contraception, diffusion and subsequent adoption of preferences for family limitation innovation is what actually results in fertility change. This distinction is important but it must be accepted that the presence of the facilities and services do sometimes serve both purposes, and bring about increases in Contraceptive Prevalence Rate (CPR) and subsequent fall in fertility change. Recent fertility changes in Bangladesh and Kenya are associated with family planning programmes implemented in those countries (Piotrow et al 1997).

¹ The case of the Arab nations which continue to have relatively high levels of fertility despite significant socioeconomic transformations may be an exception. Adherence to socio-cultural and some religious practices account largely for this situation.

In Ghana, the recent fertility change is associated with socioeconomic factors. Thus the variations in Ghana's fertility transition are explained by differentials in socio-economic processes or fit the adaptation explanation. As we will see in the next section, disparities in development levels within geographical and socio-economic subgroups of the population underlie the variations in fertility transition among them. The implications of the variations in the fertility transition are challenges to the socio-economic policies that have been inequitable.

The Fertility Change – Patterns And Trends

Even though the earliest fertility decline in Ghana was observed at the 1979/80 GFS, it was the results of three consecutive surveys – GDHS I, II, III, conducted in 1988, 1993 and 1998 respectively which indicated that the population has begun to experience fertility transition. Thus from a high fertility level which was in excess of 6 in the 1980s, the onset of fertility transition was observed by the early 1990s and has since been sustained by further significant drop in the TFR.

National

Before the mid-1970s the TFR in Ghana was estimated to be between 7 and 8 (National Population Council 1994). The 1979/80 GFS results show that five years before the survey the TFR had declined to 6.5, that is by the mid-1970s. Thus the earliest decline in fertility levels in Ghana was observed at the 1979/8 GFS. See Table 1. The decline was however not sustained as revealed by the 1988 GDHS results, The TFR dropped insignificantly between the two surveys from a TFR of 6.5 at the 1979/80 GFS to 6.4 at the 1998 GDHS.

Table 1: Trends in Total Fertility Rate, 1979/80 to 1998

Year	TFR
1979/80	6.5
1988	6.4
1993	5.5
1998	4.6

Source: Ghana Statistical Service 1989 and 1999

The temporary decline in fertility level during the mid-70s was attributed to large scale emigration from the country especially of males due to intensified economic hardship in the country (Adjei-Mensah 1997). Their partners who were left behind therefore postponed their next child birth.

Fertility decline begun to be significant from early 1990s. Between the GDHS of 1988 and 1993 the TFR dropped by 14% from 6.4 to 5.5. A higher rate of decline, 16 %, was recorded between the 1993 and 1998 surveys, bringing the TFR to 4.6 in 1998. Table 1. Between the ten-year period from 1988 to 1998 the TFR dropped by 28% from 6.4 to 4.6 showing a two-child drop in the average number of children ever born alive to women in their reproductive ages. Thus from a pretransition fertility level which was in the excess of 6 in the 1980s, an onset of decline was observed in the early 1990s and is being sustained.

The national averages of the fertility changes have however obscured differentials in the transition among various geographical entities and socioeconomic subgroups of the population.

Regional Disparities

The most noticeable differences in fertility patterns and trends are between the northern and southern parts of the country. In the southern parts of the country fertility decline has been

experienced in all the regions. Generally, the rate of change is faster here than in the northern regions except in the case of the Upper East Region where significant fertility change was recorded between 1993 and 1998. See Figure 1. Differences are observable among the individual regions too. Refer to Table 2.

Table 2: Total Fertility Rate (TFR) by Region, 1988 – 1998

Region	Total Fertility Rate (TFR)			% Change in TFR		
	1988	1993	1998	1988-93	1993-98	1988-98
Western	6.1	5.5	4.7	-09.8	-14.5	-23.0
Central	6.6	5.6	4.7	-15.2	-14.3	-27.3
Greater-Accra	4.6	3.6	2.7	-21.7	-25.0	-41.3
Volta	6.6	5.4	4.4	-18.2	-18.5	-33.3
Eastern	5.7	5.1	4.4	-10.5	-13.7	-22.8
Ashanti	5.9	5.6	4.8	-05.1	-14.3	-18.6
Brong-Ahafo	6.9	5.5	5.4	-20.3	-01.8	-21.7
Northern	6.8	7.4	7.0	+8.8	-05.4	+02.9
Upper West	6.8	6.0	6.1	-11.8	-01.7	-10.3
Upper East	6.8	6.4	5.0	-05.9	-21.9	-26.5
All Region	6.4	5.5	4.6	-14.1	-16.4	-28.1

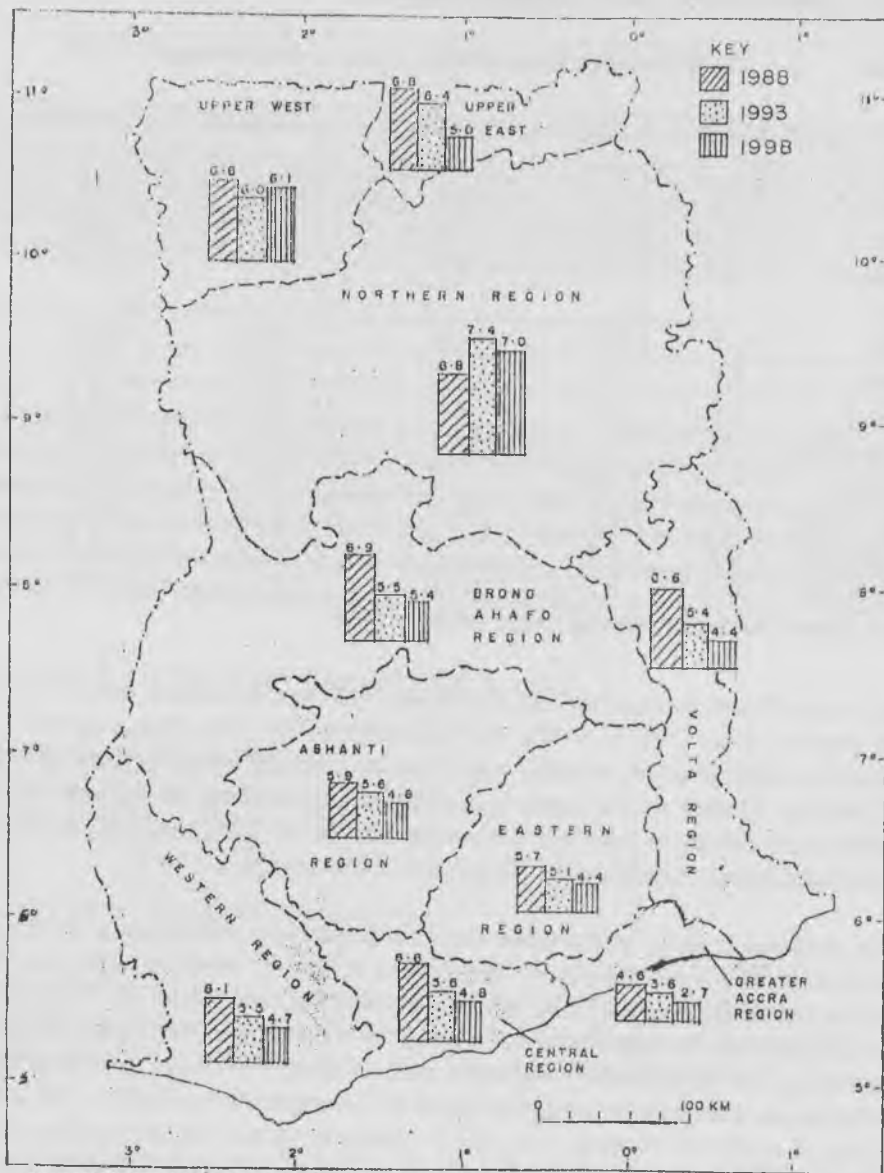
Source: Ghana Statistical Service 1989: 1993: 1998:

The Greater Accra Region has had the lowest TFR and the fastest rate of decline. During the ten-year period (from 1988 to 1998), its TFR dropped by 41%, from 4.6 to 2.7. All the other regions in the south, (except Ashanti), also recorded over 20% drop in their TFR during the same period. Another feature of the trend in fertility change among the regions in the south is the increased rate of change in fertility from the period 1988 to 1993 and 1993 to 1998. Two regions, the Central and Brong Ahafo are the exceptions in this regard.

In the northern regions on the other hand, both increase and decrease in TFR were recorded. The increase in TFR was observed in the Northern Region between 1988 and 1993, which was followed by an insignificant decline of 5% between the 1993 and 1998 surveys. The other two regions had decline both significant and negligible between the 1993 and 1998 surveys, 21.9%, is worth nothing. The exceptionally high rate of decline between 1993 and 1998 in the Upper East Region where socioeconomic conditions have not changed just as in the other northern regions is interesting. A study by (Appiah et al. 2001) observed that a temporary drop in birth rates was recorded in one of the districts in the Upper East Region, Kasena-Nankana. This was attributed to agricultural adversity or drought and famine. Other parts of the region might have had the same experience. It may however be important to investigate if the process has become permanent or not, and if it is not due to other factors.

Sudden decline in fertility has been observed in some developing countries too. Bongaarts and Watkins' (1996: 653) study on contemporary transitions observed that "the most striking feature of these transitions is the suddenness with which the fertility levels changed". They found out that in some populations (Chile, China, Colombia, Mauritius, Singapore, Thailand etc.) fertility declined by more than 30% per decade. The lower rate, 21.9% observed between 1993 and 1998 for Upper East may be another example and is worth investigating because of its uniqueness in that part of the region. Moreover, famine has been characteristic of the whole northern section of Ghana even in the past. We need to know why it is contributing to fertility change temporarily or may be permanently.

FIG. 1 TOTAL FERTILITY RATE (TFR) BY REGION 1988-1998



Source: Ghana Statistical Service 1989, 1994, 1999. RATE OF URBANIZATION: STATISTICAL SERVICE, 1987.

Another important feature of the patterns and trends among the regions is the increase in the range of TFR since the onset of the transition. In 1988, TFR ranged from 4.6 in the Greater-Accra Region, to 6.8 in the Northern Region. By 1998, the Greater Accra Region, still recording the lowest TFR had 2.7 while the highest was 7 in the Northern Region, which also had the highest rate. Considered in numerical terms as “long-term decline in the number of children from four or more per woman to two or fewer” (Mason 1997: 443), we can conclude that fertility transition in Ghana’s population is a selective process among the geographical regions. Some regions cannot be said to have even experienced the onset of decline while others have had sustained and significant drop in their fertility levels.

The disparities in the regional trends are attributable to variations in the main factors associated with the fertility decline: urbanization, education (especially female education) and health status of the population measured in terms of mortality rates (particularly of infants and children). We defer discussion on this to another section to avoid repetition.

Variations in Fertility Change among Socioeconomic Sub-Groups of the Population

Disparities in fertility change exist among socioeconomic subgroups of the population too. Rural – urban differentials and variations by educational status (of mother) can be observed on Table 3.

Table 3: Total Fertility Rate By Background Characteristics

Background	1988	1993	1998
Residence			
Rural	6.6	6.4	5.4
Urban	5.1	4.0	3.0
Education			
No Education	6.7	6.7	5.8
Primary	6.1	6.1	4.9
Middle / JSS*	5.9	4.7	3.8
Secondary+	3.6	2.9	2.8
Total	6.4	5.5	4.6

* JSS: Junior Secondary School

Source: Ghana Statistical Service, 1994, 1999

While TFR dropped significantly (25%) in urban areas between the 1988 and 1993 there was negligible change (3%) in rural areas. The pace of fertility decline has since then remained higher in the urban population than in the rural. This has resulted in the increase in the difference between rural and urban fertility levels. See Table 3. Between 1988 and 1998, there was a two-child drop in the TFR of urban women compared with one among rural women. The difference in TFR between urban and rural areas which was less than one (6.6 and 5.1) in 1988 therefore increased to almost two (5.4 and 3.0) by 1998.

With regard to educational subgroups, the surveys show an inverse relationship between education and fertility as is normally so in many populations. The pace of fertility decline was higher among women with primary or higher levels of education than those with none. This may imply that the level of fertility among women with secondary or more education has reached a level. Women with Middle / JSS level of education experienced the fastest pace of decline over the ten-year period from 1988 to 1998, registering a two-child-drop in their TFR. This is even higher than the decline among women with secondary or more education. They had a little below one-child drop. Even though fertility levels are significantly lower at higher levels of education

(secondary and over) the data from the survey shows that there may be significant drop in fertility when Ghanaian women are educated just up to the Middle/JSS level.

Based on the patterns and trends in fertility among the socioeconomic subgroups and those of among the regions, we can agree with Agyei-Mensah and Aase (1998: 203) who studied the process at its early stages that “Ghana’s fertility change is occurring in a socioeconomic and geographically distinct manner”.

Policy Implications of the Patterns and Trends

There may be several policy implications of the patterns and trends in fertility decline in the country that have been observed thus far. We will however focus on (1) data needs, (2) socioeconomic development policy and (3) implementation of population and family planning/reproductive health programmes.

Data Needs

Our analysis indicates that the aggregate data or national averages obscure marked differences in the levels and trends of fertility decline among the regions and other subgroups of the population. We concluded that some regions cannot be said to have even experienced the onset of fertility decline yet while the process has so far been sustained in others.

Obviously, surveys or studies carried out at regional or within smaller geographical entities are needed to understand further the marked differences observed. Such studies can also aim at analysing intraregional disparities or differences among smaller or more socioeconomic subgroups of the population. The Ghana Statistical Service (who conducted all the surveys) can also consider disaggregating the data such that some aspects needed for planning and other uses at levels other than those so far available can be published .

The reports on the GDHS I, II, and III indicate that urbanization, education (of women) and improved health status (reduced infant and child mortality in particular) are the factors associated with Ghana’s fertility transition. These are broad categorization of the determinants of the process. Urbanisation, for example, is a very broad terminology that comprises a number of social and economic characteristics. The degree to which these factors and their constituents influence fertility levels and trends can be determined when appropriate data is generated. Such analysis will then help policy makers to adopt informed policies to reinforce those factors that contribute significantly to the process within defined units or areas. Our analysis has shown that education to at least Middle/JSS level is required to influence fertility among Ghanaian women. Urbanization, education and health are interrelated and influence each other. The degree of influence may however vary within different socioeconomic and cultural contexts. Particular types of data will have to be generated for such observations to be made.

Finally, both quantitative and qualitative approaches to data collection and any type of study on the fertility transition will have to be encouraged. The study by Appiah et al. (2001) referred to in the previous section, suggests that we can discover more about the trends when we investigate the patterns observed to understand them by adopting micro study approaches too. We will thereby avoid making any generalizations or conclusions without any proofs. The qualitative studies will also capture those socio-cultural factors that may not be observed by quantitative research techniques.

Socioeconomic Development

The literature on Ghana’s socioeconomic development has reiterated that urban bias and export-oriented policies of the country have resulted in regional inequalities in development in

the country. (See, for example, Songsore 2002; Deh 1986; Yankson 1985). The greatest evidence of this is the striking disparities in development between the southern and northern parts of the country; and rural-urban differences in access to basic needs such as drinking water, health and educational facilities and services. (Some deviations from the general patterns do exist within these broad regions though. They reflect in the patterns and trends in fertility observed as noted earlier).

Ghana's fertility transition which has been one of adaptation and associated with urbanization, education and improved health status of infants and children has consequently varied among the regions and socioeconomic subgroups of the population. The relationship between the factors associated with the process and the patterns and trends in fertility can be observed from Table 4. It shows that generally where smaller proportions of infants and children are dying, higher proportions of females aged 15 years and over have been to school, and the proportion living in urban areas are highest fertility decline is highest.

This general picture shows that the demographic process has been and in future will have to be influenced by socioeconomic policies. The revised 1994 Ghana Population Policy has stressed the need for population issues to be addressed in socioeconomic planning. This obligation for government to consider population issues in socio-economic planning is spelt out in Article 37, Clause 4 of the Fourth Republic Constitution of 1992 National Population Council 1994). It demonstrates the expectation that population processes can be influenced by socio-economic policy.

Such policies required must include more equitable provision of health and educational facilities and services to the population. While the northern regions automatically may receive more attention than any other regions with respect to these and other social services the Western, Central and Brong-Ahafo regions need to be included in any health programmes aimed at reducing infant and child deaths. If data becomes available at district and other lower levels, peculiar conditions within some areas within some regions can receive more attention. Examples include northern parts of Volta and Western regions who problems of transportation and unattractiveness to teachers and health workers cannot be overlooked.

The implementation of the Free Compulsory Universal Basic Education (FCUBE) programme introduced since the early 1990s will also have to be considered as a very important component of population programmes that aim at reducing childbirth and mortality among infants and children. Table 4 shows that mothers with no education have 131 of their children under five years dying per 1000 live births compared with 91 among mothers with Middle /JSS level of education. Thus mother with no education on the average have 6 children compared with 4 among these with Middle /JSS education. The FCUBE programme can equally bring about decline in fertility as family planning/reproductive health programme.

Table 4: Socioeconomic Characteristics and Change in Fertility by Background

Background Characteristics	Infant Mortality Rate	Under-Five Mortality Rate	Females Aged Who Have Been to Urban 15years+ Ever School Rural		Proportion of Population Living in Urban Areas (%), 2000	Percentage change in TFR, 1988-1998	TFR 1998
			Urban	Rural			
Region							
Western	6.0	109.7	79.4	58.2	34.9	-23.0	4.7
Central	83.8	142.1	64.6	54.5	37.1	-27.3	4.8
Greater Accra	41.4	62.0	80.4	61.9	87.4	-41.3	2.7
Volta	53.8	98.0	70.4	55.0	26.6	-33.3	4.4
Eastern	50.2	89.0	74.6	62.3	34.7	-22.8	4.4
Ashanti	41.9	78.2	82.6	64.8	53.2	-18.6	4.8
Brong Ahafo	77.3	128.7	69.1	58.4	37.4	-21.7	5.4
Northern	70.1	171.3	20.1	23.0	27.0	+2.9	7.0
Upper West	70.6	155.6	56.2	23.8	17.5	-10.3	6.1
Upper East	81.5	155.3	50.0	12.3	15.1	-26.5	5.0
Residence							
Rural	67.5	122.0	N/A	N/A	N/A	-18.2	3.0
Urban	42.6	76.8	N/A	N/A	N/A	-41.2	5.4
Education (of Mother)							
No Education	66.1	130.8	N/A	N/A	N/A	-13.4	5.8
Primary	70.3	112.5	N/A		N/A	-19.7	4.9
Middle JSS	53.5	91.3	N/A	N/A	N/A	-35.6	3.8
Secondary+	36.8	59.8	N/A	N/A	N/A	-22.2	2.8
All	61.2	110.4	73.8	51.5	N/A	-28.1	4.6

Source: Ghana Statistical Service 1999: 85, 2000D:10. N/A: Not Applicable or Not Available

Another policy consideration that needs examination is the export-oriented production policies of government which has favoured some regions more than others. Those regions in the south which are endowed with resources and favourable climate for production of export commodities (coca, timber, minerals etc.) have made more progress in socioeconomic development than others in the north. Diversifying export commodities to include the products of other regions among the non-traditional export commodities will have to become not just an economic policy but one that can influence living conditions in hitherto deprived areas and indirectly affect fertility levels as well. Care must however be taken not to commercialize agriculture in any part of the country without some level of mechanization. This will ensure that child labour is not required on farms thereby adversely affecting education of children. The absence of some mechanization may encourage the keeping of large families to provide family labour for farm work.

Family Planning/Reproductive Health Programmes

A year after adopting a national population policy in 1969, Ghana launched a family planning programme with a main purpose of providing Ghanaians information about family limitation and modern contraceptives. The programme was relaunched in 1992 to raise the image of the service providers and in 2001 to introduce strategic communication approaches into the delivery of the service (Ministry of Health and Johns Hopkins University 1992). Ghana has also adopted the reproductive health paradigm recommended by the 1994 International Conference on Population and Development (ICPD) held in Cairo (Hardee 1999).²

The major achievement of the family planning programme is the creation of awareness about contraception. Over 90% of both men and women know about some family planning method, according to the 1998 GDHS. The survey shows that only 22% of married women were currently using any family planning method (13% modern and 9% traditional) after almost three decades of family planning implementation in the population from 1970-1998.

The low contraceptive prevalence rate in the population suggests that the family planning programme has not contributed much to fertility decline in the country. The Ghana Statistical Service (1998: iii) has suggested that abortion is probably responsible for reduced births in the population and needs investigation.

The analysis in the previous section also demonstrates the crucial role that socioeconomic policy and development have played in determining the patterns and trends in fertility in the country. As the heydays of demographic targeting in family planning are over and ICPD recommendations are accepted by Ghana, policies that aimed at reducing the growth rate of the population must not just be shelved. Reduction in infant and child mortality rate, adoption of more equitable principles in socioeconomic development, successful implementation of educational policies such as the FCUBE, and the like which directly or indirectly influence reproductive behaviour will have to support the family planning programme in Ghana. The findings of the Ghana Living Standards Survey (GLSS4) of 1998/1999 stress the same issues. It shows a 12.2% reduction in poverty levels at the national level from the 1991/1992 levels and long-term progress in access to safe drinking water and higher rates of school enrolment. However, incidence of poverty has increased or declined marginally in the northern parts of the country and some other areas including rural communities. To remove inequalities in socioeconomic progress and reduce poverty in areas most afflicted are components of strategies that can influence fertility levels in those areas.

² The essential focus is on providing integrated reproductive health services / interventions within cultural, social and economic contexts, rather than the previously limited programs that focused on demographic targets and issues.

The socio-cultural context within which high fertility is prevailing in some parts of Ghana must be given the due attention. Caldwell and Caldwell (1987) have discussed this for sub-Saharan Africa and identify pronatalist and cultural practices in marriage and sexual practices that influence reproductive decision-making. The conference on which this paper and others in this volume have first been presented (see forward) have stressed the need to investigate this area to understand better reproductive behaviour today. Such areas are rarely covered in surveys such as the GDHS. Qualitative approaches with indepth interviews capture such issues more easily. This need is again emphasized and hereby considered indispensable for the effective implementation of the family planning programme. We need to uncover people's values today and continuity of traditional one about childbirth under the rapidly transforming socio-cultural and economic contexts. Surveys and studies done by Opong (1987) and Bleek (1987) provide methodologies that can be replicated for the micro studies that are needed on fertility now to inform the family planning programme.

Conclusion

Evidence from the three GDHS conducted in 1988, 1993 and 1998 shows that fertility transition has been sustained in some geographical areas and within some population sub-groups of the country. The aggregate data obscures the patterns and trends within smaller entities of the population. Data required to understand the process at such levels will help to adopt policies for distinct areas or subgroups of the population.

The analysis of the data further indicate that it is a process of adaptation to socioeconomic transformations that have taken place in the country over the past few decades. Since principles of equity have not been followed in the sharing of the benefits of socioeconomic progress disparities in the demographic process also have emerged. These are challenges to the socioeconomic policy of the country. It must now be seen as a tool that can be used to effect the patterns and trends of fertility observed. Socioeconomic policy must be regarded as an indispensable component of population programmes even as stated in the population policy and the 1992 constitution of Ghana.

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SEXUAL BEHAVIOUR AND THE RISKS OF HIV/AIDS AND OTHER STDs AMONG YOUNG PEOPLE IN SUB-SAHARAN AFRICA: A REVIEW

Chuks J. Mba

Abstract

Reproductive health problems present one of the greatest threats facing youth in sub-Saharan Africa today, in addition to political and economic insecurity. Although pre-marital sex is condemned in many African societies, and young, unmarried people, especially young women, are not expected to be sexually active, the gap between expected and actual behaviour is enormous. In particular, there is almost a universal gap between age at first sexual intercourse and age at first marriage across sub-Saharan Africa. A substantial proportion of young girls are sexually active, sometimes with multiple partners. Available evidence indicates more than 50 percent of all mothers in sub-Saharan Africa are in the age group 15-19 years, and in some settings, the youth are initiated into sexual activity as early as age 12 (girls) and 13 (boys). All these have a direct correlation with reproductive health problems, including HIV infection and other sexually transmitted diseases. Governments in the region should play a leading role in putting the reality of youth sexuality into public consciousness and political agenda.

Key Words: Sexual behaviour, activity, sex, HIV, AIDS, young people, sub-Saharan Africa.

Introduction

The stage of life during which individuals reach sexual maturity is known as adolescence. It is the period of transition from childhood to adulthood. Although the change is biological, the duration and nature of adolescence are primarily a social construct and thus vary greatly from culture to culture (Abraham and Kumah 1999; Senderowitz 1995; Bledsoe and Cohen 1993; Wulf and Lincoln 1985). In some cultures, adolescence may not exist at all: the child moves directly into what is considered adulthood. World Health Organization (WHO) identifies the age range 10-19 years as the period of adolescence, while the term "youth" denotes the age group 15-24 (WHO, 1986). The WHO definitions have been widely adopted, while in some studies, the terms "adolescence" and "youth" are used interchangeably (Bradner et al., 2000; Santow and Bracher, 1999; Darroch and Singh, 1999). This paper refers to the combined age range 10-24 years, which WHO refers to as encompassing "young people", but focuses mostly on the age group 15-24 because this age span incorporates much of the variation seen between countries and population sub-groups in the events that define the beginning of sexual and reproductive life.

Among demographers and other social scientists, there is growing attention towards young people because this period of development is increasingly recognized both as an important determinant of future health, and as a specially vulnerable period of life. In particular, increasing concern has been expressed about sexual risk-taking among young people, and the consequences of such behaviour, including teenage pregnancy (Senderowitz 1995; Gage and Meekers 1994). This concern, as well as the fact that young people aged 15-24 years constitute about 20 percent of sub-Saharan Africa's population and will, therefore, have a substantial impact on future population growth, make an understanding of the patterns of sexual behaviour of young men and women a significant issue for research and policy (United Nations 2001).

However, relatively little is known about young people in sub-Saharan Africa, especially about male adolescents and the unmarried ones (McDevitt 1996; United Nations 1995a).

The present article offers an overview of sexual behaviour and the risks of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) among young people in some parts of sub-Saharan Africa. It utilises some quantitative and qualitative information on young people's sexual behaviour, emanating from national and international organizations, as well as individuals.

Sexual Behaviour

Initiation of sexual and reproductive capability generally occurs in the second decade of life. The events that define entry into sexual and reproductive life among sub-Saharan youth, and their timing, are important determinants of sexual and reproductive health and have important implications for the future life course of these young men and women. At the same time, the factors that motivate young people to initiate and continue sexual activities are not well understood (Mba 2001).

The timing and circumstances of first sexual intercourse before marriage are of interest for a number of reasons. The timing marks the onset of the risk of childbearing and exposure to health hazards, while the circumstances may have implications for future sexual behaviour. The growing body of survey data reveals that sexual behaviour among young people varies widely (Pillai and Benefo 1995; Gage and Meekers 1994; Youri 1994; Zabin 1994). In some areas of the world intercourse begins early and is frequently premarital, while in others it is dictated by strong social sanctions and commonly coincides with marriage, although marriage may occur at a very early age.

Defined as any sexual activity before legally or traditionally sanctioned marriage, premarital sex is frowned at in many traditional African societies. However, several studies indicate a discrepancy between a persistent ideal of virginity before marriage and actual levels of premarital activity. In his study of sexuality, migration and AIDS in Ghana, Anarfi (1993) found that three-quarters of both men and women said that they believed women should be virgins at marriage, but barely 1 in 10 of either sex maintained that he or she was a virgin. He further found that two-thirds of ever-married men and one-half of ever-married women reported having had two or more premarital partners. Similarly, Ogbuagu and Charles (1993) in their study found that 40 percent of the respondents in Calabar city, Nigeria, said that they hold virginity at marriage as an ideal, but fewer than half that proportion could report that they had no sexual activity before marriage. Also, Meekers (1994), using several demographic and health survey data shows that Botswana and Kenya display strong evidence of a rise in premarital sex. Furthermore, Cleland and Ferry (1995) found that between 45 and 60 percent of both sexes are sexually active by the age of 15 in Cote d'Ivoire and the Central African Republic. Crael (1995) reports that in Kenya and Guinea-Bissau, over one-half of all those aged 15-19 years are already sexually experienced. Anarfi and Awusabo-Asare (1993) also found that in Ghana some young people recall that they first had sex when as young as 8 or 10. This young age at first sexual intercourse is important when targeting populations for interventions, particularly in light of the work by Konings et al. (1994) which shows a correlation between early sexual debut and large number of partners.

A vital source of empirical information on young people's sexual behaviour in sub-Saharan Africa is the series of national surveys conducted by ORC Macro (formerly Macro International), the Demographic and Health Surveys (DHS). Fieldwork for this series began in 1985 and continues to the present time. The current DHS evidence reveals that in Ethiopia, interestingly, the median age at first sexual intercourse for women (16.0 years) is the same as the median age at first marriage (Central Statistical Authority and ORC Macro, 2001). The

findings further show that although the median age at first sexual intercourse for men is about four years later than for women, men become sexually active well before first marriage. In Zimbabwe, the median age at first sexual intercourse is 18.7 years for women and 19.7 years for men (Central Statistical Office and Macro International Inc., 2000). Unlike in Ethiopia, although men marry on average five years later than women in the country, both women and men become sexually active before entering marital relationships.

The findings of the latest nationally representative survey in Ghana, the 1998 Ghana Demographic and Health Survey, indicate that the likelihood of the commencement of sexual activity among young people residing in urban areas is quite high, while their counterparts who are rural dwellers tend to delay their sexual debut (Ghana Statistical Service and Macro International Inc., 1999). The results further show that whereas 40 percent of women were sexually active in the four weeks preceding the survey, the corresponding values for Cameroon, Niger, and Senegal, were 58 percent, 57 percent, and 63 percent, respectively. This is noteworthy because teenagers who have an early sexual debut are more likely to have sex with high-risk partners or multiple partners and are less likely to use barrier methods of contraception. Indeed, as a result of early and unbridled sexual behaviour among young people, the countries of sub-Saharan Africa have the highest levels of adolescent childbearing in the developing world. United Nations (1995b) evidence suggests that the proportion of births to unmarried women is on the increase in some sub-Saharan African countries. In contrast, though, in Africa's most populous country, Nigeria, the level of teenage childbearing seems to have declined somewhat. The proportion of girls aged 15-19 who have either given birth or are pregnant with their first child dropped slightly from 28 percent in 1990 to 22 percent in 1999 (National Population Commission and ORC Macro, 2000). However, teenage childbearing is higher in rural than urban areas and for those with no education than those with some education. Available data show that unplanned pregnancies are still common in Tanzania. About one-fourth of the births in the three years preceding the survey were reported to be unplanned (Bureau of Statistics and Macro International Inc., 1997). Also, childbearing begins early in the country, with just under one-half of the women becoming mothers by the time they reach age 18, and more than two-thirds having had a child by the time they are 20 years old. About 26 percent of the young women aged 15-19 are already mothers or pregnant with their first child, with teenage childbearing more common among mainland women (26 percent) than Zanzibar women (17 percent).

In his study of early and premarital sexual behaviour among female Ghanaians, Mba (2001) found that modernization and geographic region of residence are associated with the propensity to engage in early and premarital sexual activity. Several researchers note that young women sometimes feel under pressure to engage in premarital sex in order to prove their love to their boy-friends (Preston-Whyte 1994; Anarfi 1993; Goldstein 1993). Other studies maintain that young women are pressurized to prove that they are fertile by getting pregnant in order to increase their chances of marriage (Obbo 1993a; Standing and Kisekka 1989). It should be remarked that in many countries, sexual activity and childbearing typically begin within marriage. In some cultural settings, premarital relationships are tolerated and occasionally encouraged as a form of trial marriage, and demonstrated fecundity often leads to the formalization of the relationship (Bledsoe and Cohen, 1993). In other cultures, pregnancy can precipitate marriage because social opprobrium for unmarried mothers is strong. However, in most settings, births to unmarried adolescents are often unplanned or unwanted.

In Ekiti, Nigeria, Orubuloye et al. (1992) report that two-thirds of men's extramarital partners are single, and disturbingly, one-third of them are schoolgirls. This pattern is confirmed by Hogsborg and Aaby (1992), who conclude that in Guinea-Bissau, single women under age 26 appear to constitute the pool of non-marital partners for men of all ages. Most of the qualitative studies in the literature suggest that extramarital sexual activity has a primarily economic underpinning, with young women accepting material support, gifts, or money from their lovers or sugar-daddies (Mba 2001; Meekers and Calves 1997; Schoepf 1994; Awusabo-

Asare et al. 1993; Orubuloye et al. 1991). It is widely held in sub-Saharan Africa that men have an insatiable need to have sex and that this need must be satisfied if they are to remain in good health. The idea that retained semen is somehow poisonous and dangerous to health is frequently expressed. Caldwell et al. (1993) state that African cultures hold frequent sex to be healthy and strengthening, while Anarfi (1993: 47) argues that there is “the repetitive and overpowering nature of the sexual appetite in males”.

Despite the paucity of systematic data and the variability in sexual behaviour of young people, three broad patterns of their sexual and reproductive behaviour can be identified. The first pattern is common in Asia and is characterized by marriage at an early age, followed by early childbearing (McDevitt 1996; McCauley and Salter 1995). In this pattern, the proportion of adolescent mothers is high and premarital sexual activity is uncommon, as are premarital pregnancy and childbirth. Also, contraceptive use is increasing, while abortion is often illegal and available only by resort to unsafe procedures. Similarly, the incidence of sexually transmitted diseases is high in some areas, with subsequent infertility problems.

The second pattern is generally representative of the developed world (Bradner et al. 2000; Council of Europe 1998). Here, initiation of sexual activity is frequently premarital and occurs from the middle to the late teens, and age at marriage is generally high. According to this pattern, the incidence of premarital pregnancies is high and abortion is legal and common but not in all countries. Also, contraceptive use is high and fertility is low, while the transmission of sexually transmitted diseases is not negligible.

The third pattern is intermediate or transitional and is found particularly in urban settings in developing countries, where lifestyles are rapidly changing owing to socio-economic development (Darroch and Singh 1999; McDevitt 1996; Pillai and Benefo 1995; Gage and Meekers 1994). In this pattern, sexual initiation is increasingly premarital, as is pregnancy, while age at marriage and age at first birth are, in general, rising. Also, fertility is beginning to decline and contraceptive use is increasing.

These three models fail to account for the behaviour observed among young people in Africa. It can be argued that the first model is the best fit for patterns of sexual and reproductive behaviour in Africa barring an important difference, namely that premarital sexual activity is common in the region.

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and other Sexually Transmitted Diseases

Until recently, prevention and control of sexually transmitted diseases, especially among the youth, was a low priority for most countries and development agencies. Lack of awareness of the problem of sexually transmitted diseases (STDs) and their complications, competition for resources to control other important health problems and reluctance of public health policy makers to deal with diseases associated with sexual behaviour have all played a role in this neglect.

Similarly, most programmes for the prevention of STDs have, until recent past, focused on the prevention of complications (secondary prevention) (World Health Organisation, 1994). The prevention of transmission of infection (primary prevention) is at present receiving increased attention because of the global epidemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and the identification of several STDs as risk factors for the spread of HIV (UNAIDS, 2000; International Planned Parenthood Federation, 1995).

It should be noted that sexually transmitted infections, especially the HIV/AIDS epidemic, have always entailed suffering. In addition to the physical suffering caused by these infections, there is also considerable emotional pain. Shunning and stigmatization often afflict young

people with sexually transmitted diseases and HIV infection, as well as their families and friends. Unarguably, modern drugs can cure most of the bacterial sexually transmitted infections and help palliate the pain and discomfort caused by viral infection, including HIV. However, it is common knowledge that even simple drugs are unavailable in many sub-Saharan African communities (World Health Organization, 1995; 1986).

The HIV epidemic continues to grow with thousands of new infections occurring every day, and the primary means of transmission is heterosexual intercourse. Virtually no country is free of the virus and at the end of 1994, a cumulative total of 1,025,073 AIDS cases (adults and children) worldwide had been reported to the World Health Organization (WHO, 1995). The actual number of AIDS cases is not known because of under-diagnosis, incomplete reporting and reporting delays. However, young people are the hardest hit. The most recent empirical evidence suggests that out of the 36 million people living with HIV/AIDS, an overwhelming 95 percent live in developing countries, while 83 percent of all AIDS deaths are in Africa (Food and Agriculture Organization, 2001). The evidence further indicates that in nine sub-Saharan African countries, more than 10 percent of the adult population is HIV-positive. In Botswana, Namibia, Swaziland, and Zimbabwe, 20 to 26 percent of the population aged 15-49 is living with HIV/AIDS.

Gender and Age Dimensions of Vulnerability to STDs and HIV

Young women are more vulnerable than men to infection with a STD and to its complications (such as infertility, cancer and inflammatory diseases). Biologically, women are more susceptible to most STDs than men, partly because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse (World Health Organization, 1994). In addition, the risk of transmission of STDs, including HIV infection, is greater whenever the mucosa is damaged. As a result of such factors, most STDs, including HIV infection, are transmitted more readily from men to women than from women to men. The fact that young women with a STD are more likely to be asymptomatic and are therefore less likely to seek treatment results in their being subject to chronic infections with more long-term complications.

The factors that contribute to the higher rate of STDs, as well as HIV, in young women are also related to economic and gender inequalities. In sub-Saharan Africa and indeed many developing countries, the fact that men migrate to cities for work results in concentrations of men away from their families with a demand for sexual services from young unmarried women (Mba, 2001; Darroch and Singh, 1999; Meekers and Calves, 1997; Schoepf, 1994). Where cultures expect women to be passive and subservient to men, the young women have little or no control over decision-making relating to sexuality, nor do they have control over the sexual behaviour of their male partners, or over the use of condoms for the prevention of STD and HIV or pregnancy.

In Rakai, Uganda, and Nairobi, Kenya, unmarried women are found to be far more likely to be HIV-positive than the married ones (Hunter et al., 1994; Serwadda et al., 1992). The Nairobi study, in particular, shows that single sexually active women are twice as likely and formerly married women three times as likely as married women to be HIV-positive. In Tanzania, it has been found that single men and women have the highest rates of change of sexual partners (Rutenberg et al., 1994). Some women who report knowingly having sex with an STD-infected partner say they did so because of a belief that sex could cure venereal diseases (Awusabo-Asare et al., 1993). This belief apparently extends to HIV/AIDS. Blue-collar respondents in Ugandan focus group discussions report a belief that frequent sex can diminish the viral load of the HIV-infected and that young girls are safe to have sex, while adolescents themselves say that infected men bribed young girls for sex or raped them (Obbo, 1993b; Konde-Lule, 1993). Similarly, Awusabo-Asare and Anarfi (1997) report that people in Ghana see HIV/AIDS as a supernatural phenomenon that shapes attitude toward the infected person and the victim's health-seeking behaviour. Although their study sample is small to permit generalization, their

findings point to the need for health workers to be explicit in confronting traditional beliefs in prevention campaigns, especially among young people. Other small-scale studies also reveal that for both behavioural and biological reasons, STDs are more prevalent among young than old people. Nichols and his colleagues (1987) found that about 10-15 percent of female respondents aged 14-17 and 20 percent of those aged 18-21 reported having had an STD. Similarly, they found that 20 percent of male respondents aged 14-17 and 29-41 percent of those aged 18-21 reported having contracted an STD. Also, Mafany (1989) found that in Cameroon, one-third of the sexually active high-school males and one-fourth of their female counterparts reported having had an STD, while 50 percent of the girls and 38 percent of the boys had received no treatment for it. In Ethiopia, Duncan and his colleagues (1994) found that 92 percent of young girls who were in gynecological, postnatal, family planning and similar maternal health facilities were seropositive for at least one STD. In Kenya, studies have also reported elevated levels of STDs among younger than older adults (Lema et al., 1991; World Bank, 1989).

Educational Campaigns, Attitudes and Response

Where awareness of reproductive health problems and need for care is low, the symptoms of an STD may not be recognized as such. Stigmatization and various cultural norms impede appropriate health-care-seeking behaviour since most of these young women may be in school and are therefore unmarried. At the same time, acceptable and accessible services for diagnosis and treatment may not be available for those of them seeking health care.

Approaches using a variety of mass media channels of communication have been effective in increasing contraceptive usage rate. In some countries the level of condom use among young people has increased tremendously as a result of persistent communication efforts. Condom use for sexually experienced young men aged 20-24 years varies from under 20 percent in Lesotho, Tanzania, and Togo to over 50 percent in Guinea-Bissau and Zambia (Mehryar, 1995). Moreover, it can be said that the communication programmes resulted in an overall change in the social norms among young people in favour of condom use. There are many other examples of successful programmes and interventions in the prevention and care of HIV/AIDS and STDs. Communication and education programmes in schools and the workplace, peer education, service-based approaches to sexually transmitted diseases, voluntary counselling and testing programmes, condom social marketing and community distribution programmes, mass media programmes and a variety of others, have been successful in different countries (Messersmith et al. 2000; Nyamu 1999).

It should be stated, though, that despite these efforts, the fight against HIV/AIDS is yet to be won (Ghana News Agency 2001; Mbamaonyekwu 2001; 2000). It is true that some HIV/AIDS awareness and condom distribution campaigns have been launched in all parts of the region. Unfortunately the ugly tide of scourge does not seem to abate. In most parts of the world, most new HIV infections are among adolescents, particularly among females. Granted that the use of male and female condoms offers protection against STDs including HIV, yet the risks of condom slippage cannot be wished away and these risks increase with the prevalence of intercourse. Moreover, the probability of having sex without condom rises with the frequency of intercourse. Yet it does not take more than one sexual intercourse to contract or transmit the virus.

Although awareness that HIV/AIDS is sexually transmitted has penetrated many segments of young adults' population, misconceptions still abound to the extent that a significant number of young people have only superficial knowledge about STDs, including HIV/AIDS. A survey of secondary school students in Nigeria found that less than one-half of the respondents were aware that HIV is the virus that causes AIDS (Araoye and Adegoke 1996), while one-third of the respondents aged 15-19 years in another survey in Kenya believed that HIV/AIDS could be transmitted via mosquito bites (Kekovole et al. 1997).

It is noteworthy that in addition to the health risks of contracting STDs posed by early and premarital sexual behaviour among young people in the region, prevalence of sexual activity often increases the incidence of induced abortion, which often are performed under unhygienic circumstances with dire consequences to the young women (World Health Organization 1996; 1986). In the same vein, premarital childbearing are generally either unplanned or unwanted, and places the young single mothers in a precarious economic position. Both of these circumstances greatly increase the chance of poor outcomes in the short term, as well as in the long term. This is because both the mothers' and children's health and nutrition will likely be poor, and they may have to depend on their families or other relatives for support, with the attendant stigmatization, insult and abuse.

Discussion and Policy Considerations

Many sub-Saharan African societies that hitherto placed a high value on premarital virginity and which sought to guarantee this through constraints on the behaviour of unmarried young people and through a pattern of early marriage are now experiencing a weakening of social controls over behaviour. Moreover, in many of these settings, the customs that united young people in marriage before, at, or shortly after puberty are becoming less common. It should be noted that on one hand, early age at first marriage places young women at risk of early premarital exposure to sexual activity. On the other hand, due to increases in age at first marriage in parts of the region as a result of formal educational, both young women and men are at even greater risk of premarital sexual behaviour and the accompanying health hazards.

Increases in the proportion of young people engaged in premarital sexual activity raise concerns for a number of reasons. Although marriage does not alleviate all health problems associated with early sexual activity, it does mitigate them. Access to health-care services, including family planning and prenatal care, is often easier for married than unmarried women. The social and economic consequences of pregnancy and childbirth are also reduced through the process of marriage, which provides a legitimizing mechanism and support system.

As more young women are attending school and delaying marriage than ever before in sub-Saharan Africa, they are exposed to the risks of premarital sexual intercourse for longer periods of time, which places them to greater risks of unintended pregnancies, induced abortions and STDS, including HIV/AIDS. In fact, increases in pregnancy-related school drop-outs have been reported in some studies (Meeker et al., 1995; King and Hill, 1993). In most cases school girls who become pregnant have to resort to illegal (often unsafe) abortions or face expulsion from school. At the same time, young women who drop out of school due to pregnancy rarely return to complete their education. Consequently, their opportunities for socio-economic advancement in the youth are adversely affected significantly. It can be argued then that the net result of early and premarital sexual behaviour and reproduction reinforces the poverty of women because poor young mothers work more and earn less than do other mothers, and the timing of their childbearing is directly related to their children's nutritional status (World Health Organisation).

In responding to the challenge of unbridled sexual behaviour and the attendant risks of STDs, including HIV/AIDS, among young people in sub-Saharan Africa, there is the urgent need for the development of more relevant information, education and communication (IEC) programmes to build knowledge, motivation and skills. IEC programmes need to be developed based on a full understanding of the individual and the broader socio-economic factors that influence individual, institutional and group behaviour. They should focus on fostering health and responsible behaviour. IEC could also be used to promote ideas of equitable and mutually respectful and responsible gender relations, to increase male responsibility in pregnancy and the prevention of STDs and HIV, and to promote informed reproductive health choices, especially for young women. This is because biological and social factors make women and girls more vulnerable to HIV/AIDS than men and boys. Moreover, studies, some of which have been

highlighted in the preceding discussion, show that HIV infection rates in young women can be 3-5 times higher than among young men.

Because more young women are attending school and delaying marriage than ever before in sub-Saharan Africa, they are exposed to the risks of premarital sexual intercourse for longer periods of time, which place them to greater risks of unintended pregnancies, induced abortions, and STDs, including HIV/AIDS. In fact, increases in pregnancy-related school dropouts have been reported in some studies (Meekers et al., 1995; King and Hill, 1993). In most cases, school girls who become pregnant have to resort to illegal (often unsafe) abortions or face expulsion from school. At the same time, young women who drop out of school due to pregnancy rarely return to complete their education. Consequently, their opportunities for socioeconomic advancement in future are adversely affected significantly. It can be argued then that the net result of early and premarital sexual behaviour and reproduction reinforces the poverty of women because poor young mothers work more and earn less than do other mothers, and the timing of their childbearing is directly related to their children's nutritional status (World Health Organisation, 1996).

Since the current health programmes in some settings are falling short of helping young people acquire appropriate behaviours, knowledge and skills, the establishment of a supportive, enabling environment is imperative. A supportive environment should include a number of actions to change the social, economic, cultural and political environment in a manner conducive to better sexual and reproductive health, as well as programmes addressing the problems of HIV/AIDS and STDs. This should include a variety of possible actions. There is a strong need for advocacy to promote interventions and action. Advocacy should be geared towards a greater understanding of the magnitude of the problem and the need for action internationally and nationally. The soliciting of international community support is needed, including that of agencies and non-governmental organizations, to increase resources, develop some common guiding principles and establish collaboration and partnerships for programme implementation. Advocacy should draw the attention of communities and decision makers to the issue of sexual behaviour and reproductive health among the youth, HIV and STDs, and point towards nationally relevant solutions. National advocacy should provide the rationale for greater allocation of national resources for action on STDs and HIV/AIDS.

Data availability and data quality concerns have long constrained the assessment of young people's sexual behaviour in many parts of sub-Saharan Africa. Large-scale demographic surveys, such as World Fertility Survey (WFS), the Contraceptive Prevalence Surveys (CPS), the Family Planning Surveys (FPS) and the Demographic and Health Survey (DHS), as well as regional, national, and geographically limited surveys, have brought about a much-needed improvement in the quantity, quality, availability and international comparability of information on sexual and reproductive behaviour, as well as health-related issues. Despite these significant improvements, there is still limited data on many countries and for many relevant issues, such as young people's actual access to health services and health results of programme interventions and community factors in the region. Meeting these needs for timely and reliable information remains a major challenge facing the initiatives being launched presently to improve sexual and reproductive health in sub-Saharan Africa.

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TO CHANGE OR NOT TO CHANGE: OBSTACLES AND RESISTANCE TO SEXUAL BEHAVIOURAL CHANGE AMONG THE YOUTH IN GHANA IN THE ERA OF AIDS

John Kwasi Anarfi

Abstract

Ghana has one of the highest levels of reported cases of HIV/AIDS in the West African sub-region. The majority of infected persons are in their twenties. Young people are particularly vulnerable to STD/HIV infection for a number of reasons. They are confronted with complex and interlinked bio-social, economic and political structures and community factors. Although they are aware of STD/HIV, they do not practice safe sex or do not use condom consistently. They are more reluctant than older ones to seek treatment for STDs partly because of the attitudes of the older people, the health care providers and the general society to adolescent sexuality or may not be able to afford services.

The paper is based on data collected from in- and out-of-school youth at the national and regional levels on their perceptions and reactions to the epidemic. Field work was done in five out of ten regions in Ghana using both qualitative and quantitative instruments. The issues covered included their current attitudes and behaviours related to HIV/AIDS, their reaction to the need for change and their perceived constraints/barriers to behaviour change.

HIV/AIDS education messages have not taken the specific concerns of the young people into consideration. Most out-of-school youth are cut off from the mainstream educational and health care facilities. Young people are receptive to AIDS-related messages when they are made part of the planning and implementation of programmes.

Attempts at initiating behavioural change in the youth must take into consideration all the complex factors. The source of, and the agents for change, must be seen to be credible and the effort must be reinforced and sustained. The problem may be of barriers than just resistance/refusal of change on the part of the youth.

Introduction

When writing in 1992, Caldwell et. al. observed that there are 3 ways by which the long-term impact of HIV/AIDS on Sub-Saharan Africa could be averted. They included:

1. The possibility of a biomedical break through producing effective vaccines in sufficient quantities and cheaply enough to cover the whole region;
2. The possibility of a massive behavioural change; and
3. The possibility of the disease burning itself out.

The first possibility is still a mirage while projections indicating the third are not fully convincing. In all probability and in practical terms, it is the second which holds more promise to the region, but this has happened to only a limited extent among the younger population in Uganda and perhaps in Tanzania.

In Ghana, the statistics paint a gloomy picture. Since the first AIDS cases in 1986, the epidemic has spread slowly but steadily. Sentinel surveillance data indicate that HIV prevalence in the 15 to 49 year old age group in Ghana rose from 2.7% in 1994 to 4% in 1998 and is still

increasing. Although changes may be small or non-existent from year to year, the overall trend of rising prevalence clearly shows an epidemic that is still worsening in Ghana. It has been estimated that HIV prevalence for 15 to 49 year olds will increase from 4% in 1998 to 6.4% in 2004, 8.2% in 2009, and 9.5% in 2014. The figures indicate that the number of infected people in the population would increase from 430,000 in 1999 to 720,000 in 2004 and to 1.36 million in 2014.

Results from studies on Ghanaian youth aged 10 to 24 in 1992, 1995 and 1998 show that there has not been any meaningful change in HIV/AIDS-related behaviour over time (See Table 1). Within the period, the proportion of sexually active young people dropped sharply from 83% in 1992 to 53% in 1995, only to rise again to 63% in 1998 (Anarfi and Antwi 1995; Anarfi 1997; 1998). Similarly, there has not been any change in the mean age at sexual debut, hovering around 14 years to 16 years. Throughout the period, the proportion of the youth who are aware of HIV/AIDS has remained very high almost reaching 100% at the end of the period. Unfortunately, current use of the condom has declined and that was over the period when the proportion of sexually active population among the youth interviewed actually appreciated. The above statistics indicate that there has not been any significant change in behaviour related to HIV/AIDS among Ghanaian youth, despite a high level of awareness.

Table 1: Sexual Behaviour and Other Indicators over time: 1992, 1995 and 1998

Indicator	1992	1995	1998
Proportion sexually active	83%	53%	63%
Mean age at first sexual experience	16 years	14.5 years	16 years
Awareness of AIDS	98%	98%	99.7%
Ever use condom	34%	28%	35%
Use condom occasionally (last 3 Months)	19%	21%	12%

Sources: Anarfi and Antwi 1995; Anarfi 1997; Anarfi and Kanae 1999

Related Literature and the Conceptual Framework

East Africa is one region of the continent where HIV/AIDS has had a lot of impact. Many countries in that region have responded positively to the epidemic by way of interventions. The result is that almost everybody is aware of the causes and means of transmission of HIV/AIDS. In spite of this, for a very long time there was not any significant change in behaviour due to a number of reasons. One reason often cited was unemployment and lack of recreational facilities, which made the youth vulnerable to early sexual activities because they were idle most of the time. Related to sexual activity is the fact that the youth often indulge in unprotected sex. They do not think and plan about having sex and also tend to have multiple sexual partners (Amuyunzu-Nyamongo et. al. 1999).

Cultural inhibitions do not allow the youth to discuss with their parents, teachers and religious leaders about sex. Some people believe that the disease is contracted as a result of curses or breaking of social norms. Young people in East Africa and indeed elsewhere in sub-Saharan Africa, also see themselves as indestructible and believe that HIV/AIDS is God's punishment for sexual sins hence it does not affect good people (Amuyunzu-Nyamongo et. al 1999).

High illiteracy levels also hinder information sharing on HIV/AIDS and STDs. Illiterates are denied access to detailed and elaborate information in print and electronic media that are increasingly used by the government and other development agencies. Related to high illiteracy rates are misconceptions regarding HIV/AIDS, the use of condom and the effect of sex information on the young which act as hindrances to behavioural change. The youth do not see

the need for protected sex and rely on conventional stigmas such as physical discomfort or endangering trust as reasons to avoid condoms.

Another hindrance is poverty. It is a barrier at the national, community and individual levels. Lack of resources for health services and for dissemination of appropriate health education materials, prevent sensitization regarding HIV/AIDS and other STDs. Added to that is the lack of political will, which is a hindrance to young people's effective behaviour change. Some countries in East Africa find it hard to admit the magnitude and impact of HIV/AIDS because they need to maintain a particular international image, thereby not according it the seriousness it requires (Amuyunzu-Nyamongo et. al. 1999).

From the late 1980s, the AIDS information campaign in Zimbabwe did not make any positive impact due to several reasons. One was that HIV education was strongly prescriptive and biomedical in nature, and was mainly communicated through one mass medium and one-way lectures (Karla 1999). In addition, HIV/AIDS remained highly stigmatized, related to promiscuity and prostitution and difficult to acknowledge at personal level. Among married couples, there was the problem of difficulties in discussing sex, the association between condoms and promiscuity, and reduction of fertility.

Many people with HIV and their family members in Zimbabwe are fatalistic, believing that nothing can be done to prevent it, or that it is a punishment inflicted by God for individual or social wrongdoing. There are others also who refuse to accept the biological origin of the disease. Some HIV-positive persons, therefore, see condom use as socially risky or with little to be gained (Karla 1999).

There is an element of helplessness on the part of women as far as prevention of spread of HIV is concerned. In non-marital relationships women's ability to prevent the spread of infection is limited by their economic dependence on their partners. Their socio-economic dependence on men means that when partners are uncooperative women are left with the choice of continuing the relationship without condoms or breaking it off completely (Karla 1999). From the Zimbabwean study it was concluded that barriers to sexual behavioural change after HIV diagnosis in sub-Saharan Africa stemmed from women's lack of sexual decision-making power, men's dislike for condoms and denial of HIV. In addition, HIV positive people who did not disclose their HIV status feared that proposing to use condoms would raise their partner's suspicion, and lead to social rejection and stigma.

In recent years, the HIV epidemic in South Africa has rocketed unceremoniously. This is despite the fact that HIV is a frequent topic of discussion among young people and a matter which figures prominently in their sexual life histories. To date, many South Africans view HIV infection with a mixture of fatalism, helplessness, fear and even disbelief in its existence. Despite widespread education efforts, public sentiments towards HIV/AIDS and individuals affected by it remain extremely negative (Varga 1999).

The preference for "dry sex" without the use of a condom, lead to easier transmission of the epidemic. In Zulu youth culture, condom use suggests promiscuity and lack of trust; hence there is continued emphasis on unprotected sex as proof of love and commitment. The concept of a successful man in South Africa entails demonstration of multiple sexual conquests, hence most men have affairs indiscriminately and this has contributed to the huge leap in infection (Varga 1999).

Other hindrances to positive behavioural responses to HIV/AIDS, as elsewhere in Africa, include gender imbalance in sexual decision making. For example, Zulu men are permitted and even encouraged to have multiple sexual partners. But it is a damnable act for a woman to do so. Coercive sex is also viewed as acceptable by both young men and women and generally seen as a

male mandate. Such belief provides forced sex with considerable social legitimacy (Varga 1999).

Among the urban youth, poor communication over the circumstances of intercourse also acts as a barrier to HIV-related behaviour change. The youth simply do not discuss how and when sex will take place and are unprepared for it when it happens. In such a situation, peer pressure is the order of the day, which always supports the status quo.

Culture and religion have also played a part in the general under-reaction to HIV/AIDS in sub-Saharan Africa. Traditions that suggest that death is not final and hence not so fearful or alternatively that its timing is preordained and so inevitable, are great barriers to positive change. Similarly, some people have also associated the epidemic with witchcraft and so it cannot be avoided (Caldwell et. al. 1992).

People's attitudes and perceptions have also played a role in perpetuating the spread of HIV/AIDS. People feel ashamed at admitting to a sexually transmitted disease and young men especially feel that they are invincible or immune to infection. Discussion of the subject of AIDS is minimal even among health personnel in Africa. This is compounded by the fact that rural populations have low levels of education and usually regard AIDS as a disease of urban promiscuity (Caldwell et. al. 1992).

An unfortunate situation is that most Africans do not believe that HIV is the sole cause of AIDS deaths, and most are not completely convinced that no indigenous or bio-medical care exists or will not soon be found. These facts, combined with the reluctance to discuss the disease, mean that little pressure is put on African governments to move faster to contain the epidemic. The governments in turn fear provoking a crisis situation in their countries, and they know they have insufficient resources to meet such a crisis. They also fear the loss of tourist revenue if there is too much publicity (Caldwell et. al. 1992).

In Zambia as in much of the world, there is a strong belief in a host of spirits. It is believed that if the living refuse to listen to demands of the ancestral spirits then they inflict more drastic punishment on the people. It was within this context that ritualistic cleansing was practiced in Zambia. This ritual was expected in order to "chase" the spirit of the diseased from the clan and especially the spouse. The rapid spread of HIV/AIDS in Zambia was attributed in part to the practice of sexual ritual cleansing. In the face of the escalating rate of the spread of the disease, however, the practice has been modified somewhat (Malungo 1999).

In Nigeria, denial of the existence of the HIV/AIDS in the country was very widespread until the death of the famous musician Fela Anikulapo Kuti, who died of AIDS in 1997. Since then awareness of the disease has been very high. In spite of the acceptance that AIDS is now real in Nigeria, there has been resistance to social and behavioural change. Sex with prostitutes, casual sex, indiscriminate and unprotected sex and multiple sexual partners put men at risk of infection with HIV. Many men still believe that sex with only one person is not of man's nature and that sex with multiple partners or prostitutes cannot lead to AIDS if care is taken (Orubuloye and Oguntimehin 1999).

A formidable barrier to the control of HIV/AIDS is found in the community-health services interface. An enhanced and properly worked out interaction between the community and health service providers is very crucial in disease control. This interaction facilitates openness and understanding, which are very important in the dialogue or rapport requisite for the work of service providers. Unfortunately, there is a perceived weakness or shortcoming of the staff in the public health delivery system. These include lack of privacy, bad quality of care and equally bad attitudes (Bengt 1999). The result is that traditional healers and private medical practitioners are preferred alternatives. Unfortunately these two categories of caregivers have not been involved so much in the fight against HIV/AIDS in many African countries.

One of the frightening aspects of the AIDS disease is its ability to spread at an alarming rate within a given population. As observed above, in Ghana the disease is quickly spreading and could assume epidemic proportions soon if not controlled. It is therefore, appropriate to examine the factors within the social structure that have aided the spread of the disease and appears to make it difficult for people, particularly the youth, to effect any meaningful change in their sexual behaviour. One way is to look at the concept of sexuality now as against the background of sexual morality observed in traditional times.

Restraining factors

Sex is an inescapable aspect of human society. The way it is interpreted, however, differs from country to country and among individuals. Society, in its move to ensure rule and order has not left sexuality to nature. In every society there are rules that govern proper conduct.

In Ghana, social norms and rules existed in traditional times, which restricted one's sexual behaviour. There was very little sexual activity permitted or encouraged before marriage and even after marriage. Among many ethnic groups, sexual activity before marriage was prohibited and frowned upon. Pre-nuptial chastity was very much valued among the ethnic groups of the south. A distinct traditional rite socially adhered to was the puberty rite. The purpose of this rite was to mark a young girl's coming of age in terms of physiological development. A striking feature of the rite was the announcement of the girl's chastity. Among the Asante (a matrilineal group), candidates found to be non-virgins were killed or driven out of the tribe (Fiawoo 1982). This is because the rite was socially approved as acting as a guiding force for a chaste, pure, dutiful and respected woman and wife in the future. Among the Nzerna (of the extreme south-west of the country) also much emphasis was placed on pre-marital chastity of young girls. Infringement of the rules pertaining to their observance was regarded as a serious offence. Examples of the seriousness attached to pre-marital sex, divorce and adultery can also be found among patrilineal groupings both within and outside Ghana. Gluckman (1958), in a famous article described the Zulu social structure as highly regimented with drastic steps taken to enforce morality. So severe were these measures that adultery on the part of a woman was punished with flogging with thorny bushes and also by thrusting cactus into her vagina. Children born outside or before marriage were also not given any place in the estate of their genitor (Nukunya 1992).

Among the patrilineal Anlo tribe of Ghana, it was traditionally the practice for a girl of puberty age to go through a ceremony known as *Nudodo*. This ceremony announced to the whole village that the girl had reached marriageable age. The girl was paraded through the village dressed in rich beads. Until the performance of this ceremony, an Anlo girl could not be courted, but once done she could be courted and receive suitors. Marriage between an Anlo girl and her approved suitor also had to be subjected to certain laid down procedures. Most important was the consummation ceremony which testified to the faithfulness of the betrothed bride. The main idea behind this ceremony was the public declaration of the bride's virginity. The establishment of a girl's virginity was an occasion of great pride for the bride and her parents. She was honoured and lavished with many gifts. On the other hand, a girl who had premarital intercourse was disgraced and her seducer charged and fined for fornication (Nukunya 1969). Such was the emphasis placed on the consummation ceremony that many girls kept themselves pure and chaste so as not to bring dishonour to themselves and their parents.

Permissiveness

From a formerly restrictive stance, Ghanaian society has become more permissive in its attitude to sexual and immoral behaviour. The acceptance of and actual frequency of premarital sex have increased markedly. With the impact of western education, Christianity and urbanization, there has come to be an appreciation of western culture that has resulted in the gradual erosion of conventional traditional norms governing sexual morality. The anonymity of

urban life and consequent reduction in parental supervision has resulted in more promiscuous behaviour among the youth. Presently, one of the major social problems facing the Ghanaian society is teenage pregnancy. Many young girls today have sex before marrying. In Asante traditional society, the basic formality for the establishment of a marriage required the payment of *tiri nsa* (head wine). Often a "knocking fee" (which consists of a bottle of schnapps) was paid before the sum for the *tiri nsa* was agreed upon. Traditionally, the "knocking fee" established the man's intention to marry and the girl's family's acceptance of him as a prospective bridegroom. It did not entitle him to a sexual relation with the girl (Church 1978). These days, however, because of the greater sexual freedom enjoyed by the youth there are many who take the fee as giving them freedom to have sex with the girl. Often these relationships do not result in any marriage contract, but instead, cases of unwanted pregnancy and sexually transmitted diseases (Gyepi-Garbrah, 1985).

Another example of the breakdown of the conventional norms governing sexual immorality can be evidenced in the present societal attitude and cultural interpretation of the *Dipo* cult, which forms an important aspect of Krobo¹ culture. As a puberty rite, the *Dipo* ceremony aimed at tutoring young girls between the ages of 14 and 20 years in housekeeping, cooking and parenting. This normally lasted a year, at the end of which the girls emerged skilled, well-fed and ready to be courted by the young men and be married. They also had small scarifications on their wrists and at the back of their waist to signify to people that they had gone through the *Dipo* ritual and therefore could be courted. Girls without these scars had to be left alone.

Dipo, as practiced today only lasts for about five days and involves girls as young as eight years old. It is no longer a preparation for good marriage but a license for early sexual activity. In the past, girls who had not gone through the *Dipo* ritual and became pregnant were banished from the tribe – a threat which helped to protect girls from early pregnancy and sexually transmitted diseases (Hampton 1990). Nowadays, due to the early age at which girls are initiated, early pregnancy is no longer frowned upon. With the present high degree of sexual permissiveness, many assume that once they have undergone the *Dipo* rituals they may begin sexual activity. Again, with the few employment prospects in the Krobo area many young ladies having justified themselves by having gone through the *Dipo* rituals, leave the country to work in the neighbouring countries as commercial sex workers. Currently some of the highest cases of AIDS are found among the Krobos in the Eastern Region of Ghana. To some extent, it could be said that AIDS spread and HIV infection in the Krobo area are due to the present cultural interpretation of the *Dipo* cult and the practice of commercial sex.

Commercial sexual activity is an ever-present problem in Ghana currently. The practice has prevailed mainly as a result of economic hardship, favourable societal attitudes and misconceptions about the profession. In the Krobo area for instance, commercial sex appears to be a socially approved way of life. This is probably due to the fact that many of the sex workers return home from their sojourns abroad with rich clothes, jewelry, and a well kept appearance that speaks of success. Unfortunately, this attracts the other young women in the towns and villages, most of whom happen to be unemployed. With the outbreak of AIDS, more and more migrants are returning home sick with the disease. Some are compelled to sell the property they acquired in migration to get money to pay their medical bills but to no avail (Anarfi 1990).

¹ The Krobo are part of the Adangme ethnic group occupying a stretch of land with about half of it over the eastern end of the Akwapim hills and the other half over the plains ending in the Volta lake. Its major towns, Somanya and Krobo Odumase, lie about 70km north east of the nation's capital, Accra. To the south and east they share boundaries with other Adangme tribes like the Shai and Ningo and to the west with Akan-speaking groups like the Akwapims and the Akyem

Beliefs and other promotional attitudes

Beliefs in the life of any group of people are important in understanding their way of life, their interactive processes with one another and their relationship with the environment. In Ghana, there are no strong religious beliefs against immoral sex. In a different way, however, certain beliefs have been responsible for the careless and persistent sexual habits of certain individuals. For instance, there is a cultural perception about death which appears fatalistic. This belief is reflected in a popular Akan proverb that says *owuo atwedee baako mfo* (the mounting of death's ladder is not undertaken by an individual), a belief held by both educated and uneducated. This philosophy may underlie the failure of all programmes aimed at arousing behavioural change among Ghanaians so far.

Another factor that may be considered promotional in the spread of AIDS in Ghana surrounds the institution of marriage as perceived and practiced by the various ethnic groupings in Ghana. As in many African societies, polygyny is accepted in all the ethnic groupings in Ghana. As a result, there is the tendency for men to use polygamy as an excuse for promiscuity in as much as a man may be finding another wife (Bleek 1976). This degree of liberty enjoyed by most married men is partially due to the dominant position a man holds in African societies. In most instances, the authority structure of the home is vested in the man. Apart from this, husbands seem to have more rights conferred on them by marriage. In theory, both the wife and the husband are entitled to sexual satisfaction from each other. However, a wife's sexual rights in her husband are not absolute since African marriages are potentially polygynous. In cognizance of this, extra-marital affairs of a husband are often not considered a breach of the marital bond. In fact, polygamy is perceived by some as a check on prostitution (Vellenga 1983). In view of their position in African marriages, wives have very limited control over the extra marital affairs of their husbands. The danger to which they are exposed is worsened by the fact that most Ghanaians detest the use of contraceptives particularly condoms as a result of traditional beliefs, ignorance and mainly because they are not comfortable with it and therefore do not protect themselves and their partners during sexual intercourse.

In many strongly patrilineal societies, such as the Anlo of Ghana where marriage confers uxorial rights unto the man, it is inconceivable for a woman in such a marriage to refuse to have sex with the husband. Sexual intercourse becomes a marital duty and a wife has to perform this duty irrespective of the husband's promiscuous behaviour. This expectation can be explained by the traditional cultural interpretation placed on female sexuality which is still upheld by a lot of Ghanaians. Traditionally the sexual act was regarded as a service. In the traditional courtship system a man exchanged valued gifts in return for sexual services based on lines of reciprocity. In marriage the reciprocity involved the exchange of the woman's sexual and procreative services in return for maintenance (Dinan 1983). Wives, therefore, had to comply with their husbands, leaving them with very little control over their sexuality. At present, the traditional dominance and supervision over the wife by the husband has been reduced due in part, to a wife's economic autonomy and independence (Asante 1978). A woman may now have the right to refuse the sexual advances of her partner.

The vulnerability of women

Despite this, there is the tendency for women to still continue to have sex with promiscuous partners. One major reason for this relates to the fear of divorce and its consequences. Divorce, particularly when it occurs during a woman's reproductive years, could result in extension and relaxation of a woman's subsequent sexual network. This comes about because by her new status she is liable to remain and be subjected to erratic relations with men or she may remarry into polygynous unions where she could be subjected to the often frustrating experience of competing with co-wives for her husband's sexual services. In view of this some women would tolerate their husband's promiscuous life just so that they can remain in the marriage.

Many women are again trapped with insensitive partners as they seek to avoid having children with different fathers and avoid destabilizing the psychological and emotional balance as well as the economic welfare of their children. Also important in the consideration of the above is the essence of marriage and reproduction upheld by the Ghanaian society. The society treasures marriage and childbirth but apprehends spinsterhood and barrenness (Gaisie 1968). Evidence from the Ghana Fertility Survey (Ghana 1983) and the Ghana Demographic and Health Survey (Ghana 1989) has shown an increase in the proportion of women with eleven and more years of education in polygynous unions. This increase appears to be related to the fact that marriage is a desired status in Ghanaian society and women irrespective of educational or employment status could find themselves in polygynous unions, or continue living or sleeping with a promiscuous husband to avoid being single. Church (1978) has also observed that although there is a noticeable bias in favour of monogamy amongst young people, the unmarried and those whose marriages were in the early stages, they would not object to polygamy so long as the prospective husband was able to maintain the wife and her family well.

Much as marriage is cherished in all Ghanaian societies, divorces are also common and seem to be on the increase of late (Kusi-Appiah 1979; Bleek 1987). In the past divorce was considered a taboo which regulated to an extent a couple's behaviour. Among the matrilineal Akan, rampant divorces have been observed to be the outcome of the emphasis put on the lineage to the detriment of the marital union. A woman remains a member of the matriclan whether in or out of marriage. The breakdown in customary law and procedures governing marriage has also resulted in the escalation of divorces in all societies at present. The danger for the spread of AIDS is that remarriage is common and in fact widely practiced, a situation of widespread serial polygyny. The explanation for the almost universal remarriages is based on the belief that a divorced woman is considered as living in an uncompleted home and was, therefore, not given much respect in Ghanaian society. Thus, divorced persons remarry to avoid shame and disrespect.

Women again stand the risk of AIDS infection on resuming sexual relations with their partners after their period of postpartum abstinence. Usually it is the practice for men to have sexual partners other than their wives during this period (Bleek 1987; Caldwell et al 1989). In some societies such as the Meru of central Kenya this practice of substituting other women for wives during postpartum abstinence has become institutionalized (Mwambia 1989 quoted in Caldwell 1989). For most wives, there is very little they can do about their husbands' extramarital affairs. There are some who even encourage their husbands to have sex outside just so that their marriage will not suffer.

Economic factors

Economic necessity has been found to drive people into certain occupations that may put their health at risk (Karla n.d.). In Ghana, the desire for material wealth on the part of youthful women in a situation of inadequate decent jobs has resulted in a transactional type of sexual relation, of "sugar daddies" and "gold diggers" (Dinan 1983). The women involved in this relationship are mostly single with no immediate plans or intention to settle down and marry but are interested in finding patrons to aid them in their career advancement and occupational statuses. In return for these material benefits these women provide sexual services for their partners or sugar daddies, that is, rich older men. Bleek (1976) and Akuffo (1987) have observed that such transactional relations start early when young girls sleep with their boyfriends in return for small gifts and presents. Dinan (1977) explains that the desire of most women to remain in relationships without emotional attachments has been conditioned by their disillusion about marriage in the contemporary Ghanaian society. Marriage no longer gives women the social and economic security it is supposed to give as men do not marry for love and companionship but only to serve their selfish interest.

As stated above, education has contributed to the escalation of transactional sex in the Ghanaian community in recent times. Not only has education increased the number of years

between puberty and marriage, it has also imposed new tastes on the aspiring young women which they find difficult to contain without support. Certainly, parents are not willing to take on these extra demands in the face of the high cost of schooling and general maintenance. Female students, including university students, have been known to indulge in transactional sex. It has become fashionable for these young women to have "sugar daddies" in town. They are attracted into such relationships by the gifts offered them. Young students who enter the institutions see the expensive and beautiful clothing worn by such women and the weak-willed are also attracted into such relationships. Others, though, enter into them as a result of peer pressure and the need to affiliate with a certain group or be accepted by them. Although it is socially unapproved, ignoring it and acting as though the problem does not exist has rather made this kind of relationship become engrained in the university communities. One worrying aspect of the whole relationship is that the men involved are almost always married men who have only come to seek them as outside wives or mistresses.(Bleek 1976).

The contemporary Ghanaian society is caught up in a kind of dilemma often observed with societies going through transition. On the one hand, the young people have attained a certain degree of sexual permissiveness as a result of a breakdown of some of the restrictive practices. On the other hand, the older people have not been able to break away from some of the traditional notions. For example, discussion on sexual matters between the generations is still unknown in many Ghanaian homes. This has made the issue of sex education a very sensitive issue in Ghanaian society at present. There is still the belief that sex education will arouse some curiosity in children and result in their desire to experiment. In a study among the Anfoega Ewes it was noted that no formal education was available on the acceptable form of sex due to the fact that the people believed education on sex matters would make the youth curious and want to experiment (Drobo 1971). The problem is further compounded by the very little and in some cases lack of sex education in the curriculum and training programmes of most schools. The end result is that many young boys and girls rely on friends, the mass media and films for their source of information (Douchebe 1987). And when they have learnt, they want to experiment, often with disastrous results. The problem with the youngsters, particularly the girls, is that they are ignorant about the hormonal changes taking place in relation to their physiological development and are therefore unaware of the implications resulting from their sexual relationships with boys. What is particularly worrying is that most of these teenagers experiment with more than one partner and often do not protect themselves by using a condom (Anarfi and Antwi 1995; Anarfi 1997).

Results of a study conducted among selected students in the Central Region of Ghana indicate that socio-economic conditions influence people's attitudes to life (Awusabo-Asare et al 1999). For instance, some young people were pressured by their teachers, schoolmates, friends, relatives and neighbours to have sex with them. In some cases, the need to sell or give away sex to survive has contributed to the huge leap in infection of HIV/AIDS. Some of those affected with the disease contended that in spite of the spread of HIV people need to survive and could die from anything including AIDS. Dying from AIDS, they argued, is not different from death from other conditions. According to them whatever you do you will die, and the cause of death does not matter. This belief explains the misunderstanding or lack of motivation for behavioural change in the existing socio-economic circumstances.

From the foregoing, it is clear that certain socio-cultural factors and economic conditions favour the spread of AIDS in Ghana. Some of these factors have to do with institutions and structures in the society such as marriage especially polygamy, the culture of silence adopted by society towards sex education among the youth, a breakdown in puberty rites and economic motivation on the part of young girls and women in the society.

Conceptual Framework

This study adopts a conceptual framework developed by Mann and Tarantola (1996) to discuss the vulnerability of young people to HIV infection. The framework is based on the view that there are three broad sources of vulnerability to HIV infection among young people (see for instance, Awusabo-Asare et al, 1999; Twa-Twa, 1997)

Susceptibility and Vulnerability

Two concepts have emerged in the literature with regards to HIV infection around the world in general and in sub-Saharan Africa in particular. Those are *susceptibility* and *vulnerability*. *Susceptibility* refers to the likelihood that an individual or society will experience the epidemic, while *vulnerability* is defined as a range of factors which renders an individual or a group incapable of making and effecting free and informed decision, unable to take advantage of existing structures and receive adequate support. (Mann and Tarantola 1996). Vulnerability is thus the converse of *empowerment*.

Within the context of HIV infection, susceptibility is at two levels. These are individual and societal susceptibility to infection. *Individual* susceptibility is the biological and social potential for an individual to be prone to HIV infection, while *social* susceptibility is related to the relative wealth and power as well as the relative potential for effective mobilisation of resources and influence, gender relations, livelihood strategies and cultural values.

Vulnerability, as defined above, according to Mann and Tarantola (1996) exists at three inter-dependent levels. These are individual, social and programme-related vulnerabilities:

1. *Personal* (individual) vulnerability has two components, namely cognitive and behavioural factors. Cognitive factors involve informational needs and the ability to utilise information. Behavioural factors include:
 - Personal characteristics such as emotional development, perception of risk and attitudes toward risk-taking; personal attitudes to sex and sexuality.
 - Personal skills involve ability to negotiate for a wide range of risk-reduction behaviours such as abstinence or condom use.
2. *Programmatic* vulnerability encompasses the processes and activities that are available for reducing or resolving personal vulnerability. This involves the provision of information and education, counselling and peer support and skill training in sexual issues.
3. *Societal* vulnerability on the other hand involves the socio-cultural, economic, political and environmental factors that make a society or group within that society particularly susceptible to adverse effects of any event.

One can identify the categories of the population that are likely to be susceptible and vulnerable to any phenomenon such as HIV infection. In our system, women, children and young people are more vulnerable than any other group because of their basic biology, the perception of society and the unequal access to resources. Young people are also likely to be vulnerable due to their perception of risk-taking behaviour (Anarfi, 1999; Mann and Tarantola, 1996).

Available evidence also suggests that while some organizations may wish to undertake education programmes on HIV/AIDS, they are in most cases constrained by budgetary and management difficulties. Faced with conditions of low funding and budgetary cuts, such organizations are less likely to give priority to HIV/AIDS issues. Such conditions have created programme-related vulnerability in countries generally and in the organizations in particular.

From the above, it could be seen that under-reaction to the HIV/AIDS epidemic could come from any or all the three sources, namely, individual, societal or programmatic (i.e. government) level. The under-reaction may manifest itself either in the form of *resistance* or *obstacles* to change.

Resistance connotes:

- Active refusal to change
- Awareness of the need to change but not changing
- Awareness of the means of changing but not using/applying them
- Having the power to effect change but not using it

Obstacles on the other hand imply:

- Inability to change although willing to change, due to;
 - absence of relevant information
 - inability to utilize information (e.g. due to lack of education)
 - unavailability of programmes for reducing/resolving vulnerability
 - lack of political will
 - societal norms and expectations which support entrenched behaviours

The Study

Sources of data

The paper is based on data collected from in- and out-of-school youth at the regional level on their perceptions and reactions to the HIV/AIDS epidemic. Fieldwork was done in five out of the ten regions of Ghana namely, Greater Accra, Eastern, Ashanti, Northern and Upper East Regions. In effect, therefore, each of the three ecological zones of Ghana, comprising the Coastal Zone, the Forest Middle Zone and the Savannah North Zone, was covered in the study.

The choice of study areas in each of the selected regions was basically purposive. In Greater Accra, Ashanti, Northern and Upper East Regions, the capitals were selected together with a smaller settlement close to it to give the study urban and rural dimensions. In the Eastern Region Krobo Odumasi and Somanya were purposively selected as the study areas. These are the capitals of the two Krobo districts, Manya and Yilo, which for a very long time have been the epicentre of the HIV/AIDS epidemic in Ghana. These are two contiguous towns with several satellite villages surrounding them. In fact, selection of subjects for the in-depth interviews spread to some of the satellite villages to satisfy the rural-urban approach design of the study.

Both quantitative and qualitative methods were used in the collection of data. In addition to questionnaire interviews, 50 young people aged 10 to 24 years were engaged in in-depth interviews, 10 in each selected region. Views were also sought from old people, particularly in the northern regions. These are the areas of Ghana, which are still very traditional. The idea was, therefore, to capture more information on traditional beliefs and practices related to sexuality to supplement whatever was obtained from the young people. The issues covered included their current attitudes and behaviours related to HIV/AIDS, their reaction to the need for change and their perceived constraints/barriers to behavioural change. This paper is based on the results of the in-depth interviews.

Results

Knowledge, Attitude and Misconceptions

The young people interviewed confirmed most of the issues raised in the literature, as reviewed above. All of them were aware of HIV/AIDS and most of them had fairly good

knowledge about the mode of transmission and methods of prevention. Some of their comments were quite revealing and the following was a typical example:

In our conversation if someone mentions a girl who is suspected or said to have died of AIDS, there and then we discuss about it and educate ourselves about the mode of transmission; if someone has AIDS and uses a blade and another person also uses the same blade then he can get infected with AIDS. Or if any woman has it and you the man sleeps with her it will infect you.

There were, however, some serious misconceptions. The comments by a young man interviewed at the Kantamanto Market in Accra illustrates this point:

I think we get it from some of the foods we eat. Some are not suitable.

When asked to explain the kind of food that can cause AIDS he added:

You can see that not all the food sold in the market are suitable for us. For example pig feet from insanitary areas (gutters, toilets and refuse dumps). So if you eat pork you can get it. It brings minor diseases which lead to AIDS.

In addition to these clear misconceptions, they either overtly or covertly, seemed to blame females for the spread of the disease. Males were the main culprits. For example, when asked to show his source of information about HIV/AIDS a young man from the Northern Region remarked:

We always hear from Accra and campaign leaflets that we should control ourselves to prevent AIDS. It further says that AIDS is contracted by sleeping with a woman. So it is not advisable to be jumping from one woman to another.

On where the young women get the disease from, the same young man added:

We hear that the women go abroad and have sex with dogs and when they come back home and sleep with another man then the disease is transferred to him.

In the northern part of the country there is the general belief that HIV/AIDS originates from "French", that is, the neighbouring Francophone countries Burkina Faso and Cote d'Ivoire.

To a street youth in Accra, the people who are at risk of getting AIDS are "Those females who practice prostitution around circle. They spread the disease. Also those girls who wear short skirts". Explaining the role played by short dresses he added:

They attract men. There was an instance when a man picked a girl from here (i.e. the street) and, according to the girl, the man turned to a beast and had sex with her. She said the man covered her eyes so she could not see the actual animal and this can lead to AIDS.

The idea that females are to blame for HIV/AIDS was strongest in the north and it came out strongly in the interviews with older people. They attributed the cause of AIDS to women and some even call it "women sickness", implying that it is mostly carried by women and distributed to men who are promiscuous.

Protection

In that respect some of the girls who were willing to protect themselves had taken pains to understand some of the circumstances that could lead them into danger. A 19 year old female student illustrated some of the circumstances vividly in the following words:

I will not accompany friends to a boy's room and if I go I will make sure I sit in the sitting room. Also I will not go to a club house with friends to drink and even if we are drinking minerals in a group and I am going to visit the ladies I will make sure I take my drink along or drink all before going to urinate. If you

don't do that the boy will put a drug in your drink and later you will not know where you are and he will have sex with you.

In general terms, however, they did not do much to protect themselves. Although most of the young people interviewed perceived themselves as being at risk of contracting HIV, they did not appear to have any fear when going to have sex and by implication, do not immediately think of using condom for protection. The reason often given for this attitude was that their partners were faithful. A young girl said she did not use condom when having sex because her boyfriend "does not look like someone infected with the HIV/AIDS". Others depend on instant emotional feelings to determine whether to have sex with a person or not, or whether to use condom. For example, a young man said if he did not experience any fear when he comes into contact with a girl then it means there is no danger of HIV/AIDS. Such attitudes certainly border on misconceptions.

Obstacles to Change

The young people raised a number of issues that could count as obstacles to any desire they may have to want to change. Some of them relate to their parents. In all the regions, the young people interviewed complained of parents' inability to shoulder all their responsibilities towards their children thereby resulting in some of them ending up in the street with the girls resulting to selling sex for survival. Girls are more vulnerable in this respect since, in the face of limited resources, fathers prefer to harness all their resources to finance a male child's education to a girl child's. Many parents think that educating a girl would not benefit them directly as the girl would later marry and leave them. The general neglect of the girl child has compelled some of them to find any means to survive. In the words of a young man interviewed at Agormanya, *the young girls especially are using sex as a means of living, because there are no jobs and their parents too are unable to take care of them.*

The young people alluded to the kind of training they receive from their parents as some of the obstacles in their way. A young man on the street in Accra was at pain when trying to explain why some girls enter into commercial sex. Hear him:

Some parents do not give their children good training and when the children grow up they involve themselves in bad things.

He added:

Some fathers do not spend time at home with the children. Some mothers also push their daughters into sexual relations. And this encourages them to become prostitutes- they put on dresses which attract men to approach them for sex.

Some of the young people related the failure of their fathers to take up their responsibilities towards them to polygyny and the resultant large family sizes. A male street youth in Accra put it this way:

Some fathers have many wives and there are many problems at home and the children feel uncomfortable. The child has to leave home and struggle on his own.

Societal Influence

The young people observed that the general social environment in which they live is a great hindrance to their attempt to change their sexual behaviour. They complained a lot about the films that are shown in cinema houses and on the television. A young Ga female observed, "the foreign films show too much sex. After watching such films some people are unable to control their urge for sex". A similar observation was made about the type of music that is being sold to the public in recent times. The same girl made reference to a song by one Rex Omar, which is titled *Te wo kete ka*, which translates as, "recoup what has been invested in buying a mat."

Another dimension of societal influence was observed among the youth who spend most of their time on the street. These young people have developed their own sub-culture and operate within it. A 20-year-old girl interviewed at the Central Business District of Accra offered a good illustration of the influence when she said:

If you are 20 years and above and you have never had sex your friends will be teasing you that 'as for you, you are wasting your time and your vagina hole will block'.

Still on people who choose to stay as virgins till late another had this to say:

People tease them. They say they are either impotent or barren in the case of man and woman respectively.

Peer influence was not found only among the street youth. It appeared to be even stronger among students. In the words of a 19 year old female student,

You may be a good girl at home but when you go to school you will have friends who are bad and they will force you into it. They will teach you everything about sex and ask you to pick a boy friend. In some cases, they will rather look for a boy for you. If you are not careful and you listen to them you will become pregnant but they have drugs for abortion.

The same girl explained further:

Sure if you are in school and you are not that type and they are not your friends, they fear to come near you but if you give yourself to them they will spoil you. They will be teasing you that you are "bush", you don't have a boy and you are stupid. They will tell you that if you pick a boy, he will give you plenty of money and take you for shopping. So if you are not an intelligent girl they will spoil you.

Death

The young people interviewed generally confirmed what Awusabo-Asare et. al (1999) observed in their study in the Central Region of Ghana. There was the general belief that death is pre-ordained and that it will come when it will come. In the words of a 24-year-old man, "we cannot do anything about death, because whatever the case may be you will die". Most of the people interviewed therefore said that they did not fear to die. Perhaps this was related to the belief that death was not completely final and that it was a kind of transfer from one place to the other on the same earth. In the words of a young woman if a person dies, *he will go and settle at another place where people do not know that he is dead*. The few who feared to die were more concerned about the family members they would leave behind, especially mothers. They felt that they should not die before their mothers.

Fingers were also pointed at the government when some elderly people interviewed in the north made reference to some inadequacies in the AIDS intervention programmes in the country. An old woman from Bawku complained that the education on AIDS has not gone down well in the villages. She said most of the educational programmes are done on television, radio and in the newspapers. Meanwhile people in the villages cannot even afford their daily meals let alone talk of getting television or radio so as to hear about education on AIDS.

So much was said about poverty and related problems and how they have worsened the vulnerability of the youth to HIV infection. An elderly woman in the north opined that because of poverty the young people run away from their parents when they are still minors. They move to the urban areas like Accra, Kumasi and even Cote d'Ivoire to look for jobs for survival. Because these people are away from their parents, they tend to lose that parental control and advice, and when they later get jobs and some money the boys in particular are unable to resist the temptation of going in for sexual partners who are readily available. In his observation, a

young man interviewed in Accra remarked, "because of financial problems, although people are aware of AIDS in the whole area, they are still having sex here and there because of money."

Discussion and Conclusion

Influence of Western Education

In traditional times, life was a continuous training. It was the duty of parents especially and all adults in the extended family to ensure that children grew to become responsible adults. It was also the responsibility of parents (and also uncles in matrilineal societies) to ensure that young people get themselves established in life. Since the unit of production was the family, all enterprises were family owned. As heads of families, fathers/uncles controlled incomes that accrued from the enterprises.

Land has been the central focus of the livelihood of all tribal societies as it is their main support line. In all the tribes in Ghana, land is communally owned and is held in trust by the family elder, *abusuapanin*, among the Akan. Although every member of the family has right to the land, permission must be sought from the *abusuapanin* before a piece can be occupied. Again, the basic requirements of tools, seeds and money (and sometimes a helper in the form of a wife), must be provided by elders, mainly fathers and uncles. The nature of the arrangement was such that young people were obliged to bid their time until they were sponsored. A major feature of the arrangement was that parents looked for partners for their sons. In a few cases, young men could identify their partners but they were obliged to seek the approval of parents.

The arrangement did not give young men control over when to marry. When a young man got married depended on when parents have accumulated enough and have identified a right partner. The practice of polygyny meant that available marriageable young women were competed for by both young men and old men including already married ones. That always put the older men in a more advantageous position in that they already commanded some wealth. Of course the status of the father of the prospective young suitors counted in their favour, parents of the girls were also inclined to give in to the older men seeing them to be more responsible. Perhaps this explains the older age at first marriage of males in most traditional societies.

Western education has changed the situation in a number of ways. Young boys and girls are now kept longer in school thereby increasing the age at marriage for both of the sexes. There has emerged, as a result, an adolescent population again of both sexes. Education has also freed youngsters from traditional restrictions, bringing them together and giving them the opportunity to develop some intimacy – boyfriend and girlfriend relationships. Above all, western education has given young men the opportunity to develop their own careers and, thereby, accumulate money and other resources to be able to secure a wife. This in turn has freed young men from the control of parents in the choice of marriage partners. Young men now inform their parents of their intention to marry only as a sign of respect.

In another sense Western education has expanded the information sphere of young people. They now have access to numerous sources of information. Increasingly, they are becoming able now to contain the extended period between menarche and marriage through the use of contraceptives. The expanded sphere also means that young men now have a wider range of partners to choose from well beyond their tribal areas. In a study in Sekondi-Takoradi by Busia in 1948, nearly one-third of the sample surveyed were in inter-tribal marriages (Busia 1950). Although people still prefer to marry from their tribe, public opinion encourages inter-tribal marriages, which has become a permanent feature of modern Ghana.

The Influence of Christianity

Christianity has either added on or reinforced the changes brought on by education. One of the areas that have been influenced is pre-marital sex. There are no very forceful traditional customs or beliefs, which forbade premarital sex. Rather, what was abhorred was the practice of sexual intercourse before a girl's puberty rites were performed (Sarpong 1977; Bleek 1987). A girl found pregnant before the puberty ritual had to go through a shameful purification rite after which she was banished together with the man responsible for the pregnancy. To prevent the stigma, which such ritual would bring to the family and the banishment of their children, parents ensured that their children stayed away from sex before they had been taken through the puberty rites. It was believed that these practices put a check on pre-marital sexual activities and the resultant pregnancy. This is where Christianity seems to have had a headlong collusion with tradition in most Ghanaian tribes.

Although Christianity itself is against pre-marital sex branding it as a serious sin (fornication), in Ghana, it has not supported the various puberty rites either. It considers them as pagan worship. They have either been stopped completely in some places or changed in others as a result of Christian influence, rendering them ineffective checks on pre-marital sexual activities. Like elsewhere in the world, Christianity has not been able to enforce its stand on no pre-marital sex either, leaving the contemporary Ghanaian society in a kind of ambivalence. Studies have revealed that there is still the belief that sexual relations and pregnancy must take place within socially recognized bounds. Also most people still feel that sexual intercourse should not be allowed until the girl's parents were informed of the relationship (Anarfi 1992: 237). Nonetheless, pre-marital sex goes on in all Ghanaian societies and teenage pregnancy is now a major problem in the country. According to the latest Demographic and Health Survey of Ghana conducted in 1998, 14.1 per cent of girls below 20 years were either pregnant or were already mothers (Ghana Statistical Survey 1999).

In other studies, it was observed that majority of Ghanaians believe that a woman should be a virgin and actually wanted their daughters to be virgins, at marriage. In fact older people were more inclined towards this belief complaining bitterly about what they termed the "waywardness" of younger people (Anarfi 1992: 238). Interestingly, most of the women who claimed to be virgins at marriage said that it was because pre-marital sexual relations were against Christian teachings. Some traditional norms also still hold sway, such as the need to uphold family honour and the wish to win the respect of husbands at marriage. Such traditional and Christian values are still held against strong modernizing influences such as the belief that retaining ones virginal status in the contemporary world is impossible/difficult and the need for prospective couples to know themselves and gain sexual experience before marriage.

Marriage itself is caught up in the transitional crisis too. In Ghana, a relationship between a man and a woman that has not been sanctioned by rites is not regarded as a marriage. Rather it is called *mpeña aware*, i.e. a union of mutual consent among the Akans. Although *mpeña* unions in Ghana were traditionally accepted as preludes to marriage, they are not sanctioned by Christianity. Currently, two main types of marriages are recognized in Ghana, Christian and civil marriages on one hand and customary marriages on the other. The main difference between the two is that the former does not allow plural marriages and divorce while the latter allows both. There are also Muslim marriages but like customary marriages, they allow plural marriages as well as divorce. Perhaps because of its restrictions on plural marriages and divorce, Christian marriages have not caught up very well with Ghanaians of all tribes. The result is that despite its overwhelming presence in the country, Christianity has failed to make much impact on the form of Ghanaian marriages. It is now a common practice for people who profess to be Christians to invoke the customary practice of polygyny to support their extra-marital affairs.

Another area in which Christianity has failed to make a meaningful impact is in the area of divorce. Both divorce and subsequent remarriage are common and relatively easy in Ghana. It

follows that high levels of both serial and parallel polygyny exist. Our studies confirmed that most Ghanaian women work to earn a separate income for themselves and their families, especially their children, even in marriage. They also confirmed that marriages are less stable among matrilineal than among patrilineal communities.

Like pre-marital sexual relations, there are no very forceful traditional customs or beliefs, which forbade extra-marital sex. However, extramarital sexual relations for women have to be conducted rather clandestinely compared to men because public opinion is more tolerant of such behaviour by males. A married man commits no adultery if he sleeps with an unmarried woman. If such a relationship becomes public knowledge then the honour of his wife is considered to be defiled and it will be expected that he both compensate her and either break off the relationship or marry her lover. In the case of an extramarital affair of a married woman, both she and her lover are expected to compensate the injured husband. The lover will be fined for seducing the wife and she will be fined for defiling her husband (Rattray 1929). The post-partum sexual abstinence of wives has often given men the license to engage in extramarital affairs and society is generally tolerant of men engaging in it during this period. As part of the modernization process going on in the country the period of abstinence has become shorter than what obtained in traditional times. The length of female post-partum abstinence was observed to be as long as 6 months or more for first birth and at least 40 days for subsequent births (Anarfi 1992: 240).

In conclusion, young people in Ghana appear to have a formidable task in translating all the HIV/AIDS prevention messages into acceptable behavioural change. Young people put up some resistance to sexual behavioural change, some for the sake of pleasure they think they can get from sex and others as a matter of survival. There are, however, some obstacles or barriers to such a change found at both societal and programmatic levels. Government should step up its effort at controlling the spread of the disease by expanding the content and scope of the programmes. Messages must be tailored to suit all cultures as well as all categories of the population. Programmes must also include efforts at changing certain societal norms, expectations and perceptions which impact negatively on young people. This must be done with an eye on other powerful influences that may come from modernization/westernization.

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MATERNAL MORTALITY IN GHANA: THE OTHER SIDE¹

Kodjo Senah

Abstract

According to recent global estimates, some 585,000 women die annually from pregnancy-related complications. Most of these deaths occur in the developing world. In Ghana, efforts to reduce the high maternal mortality rate (ranging from about 200 to 740 deaths per 100,000 live births) have given birth to the institutionalization of policies and programmes most of which derive their explanatory model from the medical perspective. However, the determinants of maternal mortality are a complex web of biology and culture. This paper presents the 'other side' of the story: a wider overview of the casual pathways by which simple interventions may produce the desired effect.

Introduction

In all Ghanaian societies, the death of a woman from pregnancy-related complications is considered a tragic event, sometimes requiring elaborate ritual purification of the whole society. For instance, at Osu, in Accra, in the event of such an occurrence, all pregnant women are traditionally required to have a ritual bath in the sea soon after the burial of their colleague. In some communities in the Volta Region, the bodies of women who die in pregnancy are quickly buried, often at midnight. Maternal death is *honhon fi* (Akan: uncleanliness) and therefore, in all Ghanaian societies, elaborate dietary and behavioural codes are instituted for expectant women in order to ensure not only safe delivery but also the delivery of normal children.

In the contemporary world, maternal mortality is considered a violation of the rights of women² and its rate is perceived as a critical index of the level of development of a country. Consequently, nations the world over have instituted programs and policies within their available resources to combat this menace.

Global attention began to focus more seriously on maternal mortality when in 1985, Rosenfield and Maine (1985) published a thought-provoking article in the *Lancet*. In this classic article titled 'Maternal Mortality—a neglected tragedy—where is the M in MCH?', Rosenfield and Maine alerted the world to the fact that many developing countries were neglecting this important problem and that existing programs were unlikely to reduce the high maternal mortality rates in the developing world. Almost immediately Harrison's (1985) analysis of 22,774 consecutive hospital births in Zaria, Northern Nigeria, showed the appalling mortality associated with childbirth. He also drew attention to the importance of social and cultural factors as critical underlying factors in the causation of high mortality and morbidity associated with pregnancy and delivery in Nigeria. Another significant contribution to the crusade against maternal mortality was the WHO (1986) publication, 'Maternal Mortality: helping women off the road to death.' All these led to the Safe Motherhood Conference in Nairobi, Kenya in 1987. Speakers at this conference presented global statistics on death and complications resulting from pregnancy. They also showed that in sub-Saharan African, the lifetime risk that a woman would die in childbirth is 1 in 21 and that this is 400 times higher than the lifetime risk for her

¹ The author acknowledges the knowledge and the rich field experience he has acquired over the years as a member of the Ghana Prevention of Maternal Mortality Network.

² Article 24 of the 1992 Fourth Republican Constitution of Ghana guarantees women's right to special care before and after childbirth.

counterpart in Western Europe or North America. The conference concluded with strong recommendations about maternal health and so the Safe Motherhood Initiative was born. Since then, a number of international conferences have established goals related to the environment, population, development and health. The reduction of maternal mortality by half the 1990 levels by the year 2000 was a goal common to several of such conferences including in particular, the 1990 World Summit for Children, the 1994 Cairo International Conference on Population and Development and the 1995 Fourth World Conference on Women.

However, almost a decade and a half after the Nairobi conference, the problem of maternal mortality still confronts Ghana and other developing countries perhaps even more than ever before. This is because, to a large extent, programs and policies to address the problem are, as usual, heavily skewed toward the medical explanatory model. In Ghana this model has led to the building of several Maternal and Child Health Clinics (MCH) across the country, the training of over 6,000 traditional midwives, the development of the Safe Motherhood Protocol for all levels of health institutions and the institutionalisation of four free antenatal visits, among others. While these are laudable efforts, they do not necessarily address the heartbeat of the problem.

Thus the basic orientation of this paper is premised on the fact that the factors which promote health and precipitate ill health or death are not purely genetic or biological, but can be social, economic, cultural and psychological and that these elements can work together or against one another in the life of an individual; that in the case of maternal mortality, especially, any strategy designed against it must recognise these dynamics – the other side – and the resulting continuity of risk in the life of the woman. The microbiologist, Rene Dubos (1985) sums this up aptly when he argued that the prevalence and severity of microbial diseases are conditioned more by the ways of life of people than they are by the virulence of specific etiologic agents.

Maternal Mortality: A Statistical Overview

According to WHO/UNICEF (1996), globally some 585,000 women die annually from pregnancy – related complications. It is estimated that about 99 percent of such women come from the developing world, especially sub-Saharan Africa (WHO 1991b). WHO/UNICEF estimate Ghana's rate to be 740 per 100,000 live births while the Ministry of Health calculates this to be 214 per 1,000 live births. As to be expected, there are regional variations. The table below gives the details.

Table 1
Regional Distribution of Maternal Mortality (1996-2000)

Region	1996	1997	1998	1999	2000
Upper East	52	42	45	43	56
Upper West	13	33	14	22	30
Northern	38	39	61	73	60
Brong-Ahafo	70	89	80	91	62
Ashanti	141	128	140	134	177
Eastern	85	101	78	121	108
Central	57	93	117	106	108
Western	44	53	78	98	104
Volta	48	60	70	97	88
Greater Accra	37	49	93	28	63
National Total	585	687	777	813	851

Source: MOH/RCH Annual Reports 1996-2000

As the table shows, maternal mortality occurs in all the regions irrespective of the number of health institutions and trained personnel available. Another disturbing revelation is that rather than reducing, the number of cases is increasing annually; it is recorded that the figure for the year 2001 is 994 (MOH 2002). It must be stated at this juncture, however, that these are institution-based (hospital) figures. Like crime statistics, the 'dark figure' - the number of unreported cases will never be known, especially so in the Ghanaian context where domiciliary delivery outnumbers institutional delivery and where deaths are usually not reported. Institutional figures are also problematic because our health institutions woefully lack effective records system. Presumably, therefore, the more effective the records system, the more accurate the institutional figure. Globally, however, maternal mortality figures are fraught with a number of problems. These are due to the fact that:

- We do not know about all deaths of women of reproductive age (15 – 46 years).
- We do not know the cause of death
- We do not know whether or not the woman was pregnant at the time of death or had recently been so; and
- Few countries count birth and death and even fewer register the cause of death.

Whatever the statistical difficulties, the trends are not only disturbing but also are symptomatic of serious problems within the communities and the national health care sector. Indeed, each maternal death must be considered one too many because of its destabilizing effect on the family and the whole society.

The Medical Explanatory Model

The most common clinical causes of maternal death and chronic morbidity during conception and delivery are:

Haemorrhage

Bleeding during pregnancy may indicate several conditions. In early pregnancy it indicates threatened abortion. In later pregnancy, it suggests problems in placentation. The gravity of haemorrhage is that in anaemic women, even a small amount of blood loss can be fatal. Postpartum haemorrhage is one of the most common reasons for blood transfusion, an intervention that has become dangerous with the advent of HIV/AIDS.

Anaemia

The WHO has estimated that 52 percent of pregnant women in Africa – 56 percent in West Africa- have haemoglobin levels below 100g/L (WHO 1982). Severe anaemia can contribute to maternal mortality by impairing a pregnant woman's ability to resist infection or severe haemorrhage. In Ghana, parasitic infestation, especially malaria, significantly contributes to this condition.

Obstructed Labour

This is a complication in which the process of labour does not function normally due to mechanical blockage of the birth canal. In very severe cases, it may lead to fistulation in which urine and faecal matter gain entry into the reproductive system. Obstructed labour may be due to early pregnancy, inadequate nutrition during childhood, foeto-pelvic disproportion, multiparity and abnormal foetal presentation.

Abortion

This is voluntary or involuntary termination of pregnancy before 20 weeks of gestation. It is characterized by bleeding, lower abdominal pains, and passage of foetal and placental tissue.

Hypertensive Disorders

In pregnancy these are associated with pedal and facial oedema and protein in urine. They are the most difficult of the obstetric emergencies to prevent and manage. Yet they are an important cause of maternal death in Africa. If untreated, they may progress to eclampsia characterized by convulsion, brain damage, renal failure and death.

Sepsis

Infection occurs when aseptic procedures are not followed, when the amniotic sac ruptures long before delivery occurs, when vaginal examinations are too frequent or when obstructed labour occurs. Long term consequences of puerperal sepsis include pelvic inflammatory diseases, secondary infertility and in rare cases, maternal tetanus.

Others

Other conditions that cause maternal morbidity or mortality include ectopic pregnancy, renal failure and cardiac disorders.

Some of the conditions mentioned can be predicted while most of them can be prevented or managed if the right conditions prevail. How these conditions interact with the socio-cultural environment to override the right conditions is the focus of the next segment of the discussion and the essence of this paper.

The Socio-Cultural Context

Pregnancy and Taboos

The first step towards maternal mortality is conception and delivery. Although these are biological events, they are significantly influenced by the cultural usages and nuances of the community. According to Sarpong (1974: 84), among the Asante 'pregnancy is considered a happy phenomenon and traditionally, its inception is the target of most sexual activities especially in marriage.' This is true of other ethnic groups in Ghana. In kinship – based societies such as ours, the mathematics of kinship enjoins every adult kin not only to procreate but also to do generously or prolifically. In this regard, according to Sarpong (1974), in offering prayers for the newly married, the Asante appeal to God, the gods and their ancestral spirits to bless the bride with the womb of an elephant. In a similar vein, the Ga specifically request for ten children. It is in this respect of numerous progeny that Fortes (1960) has commented that the childless Ghanaian is regarded with pity not unmixed with scorn: he or she may be considered a wizard or witch or a victim of the machination of demonic forces. Thus the high cultural value placed on conception and multiparity often lead several women to their graves.

In order to ensure safe delivery of normal babies, each society prescribes certain dietary and behavioural taboos or observance, which pregnancy women must comply with. In many societies in this country, it is culturally regarded immodest to show early signs of pregnancy until it is visible (vide Arhin, 2001). Consequently, often the prenatal screening for risk factors is missed.

However, by far, the most prevalent restrictions on pregnancy relate to dietary taboos. In some societies in this country pregnant women are not expected to eat snail lest the child may be born drooling; they must not eat eggs lest the child grows to become a thief. Among the Kassena

and Nankana of the Upper East Region, pregnant women are restricted to vegetarian diet; they must not eat meat and groundnut lest they give birth to 'spirit children'³ (Senah 1993). In her study among the Akwapim, Darko (1992) observed that expectant women were forbidden to buy tomatoes, pepper, okro and garden eggs from the market. If they did, it is believed that their children will be infected with severe rashes and will consequently suffer from some form of disability. Similar taboos and restrictions have been found among the people of Anyaman in the Dangme - West District (Arhin 2001). Clearly, while some of these taboos may help to check foeto-pelvic disproportion, a very fatal condition, they may exacerbate the already deficient nutritional and anaemic status of pregnant women and subsequently affect the growth and development of the child.

Traditional Midwives

The large arsenal of customary practices employed to deal with the period from pregnancy through the puerperium is in the custody of the traditional midwives who dominate the obstetric and gynaecologic scene in much of rural Ghana. Generally a well-respected village elder, the midwife is considered an authority on the traditional medical lore associated with childbearing and rearing, traditional modes of family planning and treatment of infertility and lactational deficiencies. She speaks the language of her clients, allows them to position themselves in ways comfortable for delivery, charges far less, accepts payment in kind and handles exertions of childbirth. Perhaps, even more important, she provides strong emotional support during and after delivery. In Ghana, some 6,000 traditional midwives, already highly regarded by members of the community, have been given medical and paramedical training and have proven to be valuable adjuncts to the national health care system. The large majority of them, however, are untrained. In the context where most deliveries occur outside the health facilities and are handled by both trained and untrained traditional midwives, the parturient may lose her life in the event of life-threatening complication such as haemorrhage, obstructed labour or sepsis which cannot be managed by traditional midwives.

Induced Abortion (*Abortus Provocatus*)

Induced abortion evokes a great deal of passion and controversy which border on religion, culture, ethics and morality. In Ghana, it is said to be the primary cause of maternal mortality. In traditional Ghanaian societies, termination of pregnancy is frowned upon; indeed, it is considered murder (Gyekye 1996). It is, therefore, resorted to in great secrecy.

In spite of the PNDC law 102 which effected amendment to the Criminal Code (1960)⁴ and thereby liberalized to a significant degree, the abortion legal regime, many abortionists – trained and quacks- still operate and carry out the procedure in insalubrious environment because the law generally criminalizes abortion.

Estimates of a country's abortion figures are very difficult to obtain; they are at best intelligent quesstimates. However, as far back as 1969, Ampofo (1970) calculated the average

³ In all Ghanaian societies some children are regarded as spirits, especially if the circumstances surrounding their birth appear abnormal or if such children grow with abnormal features or congenital malformations. In some cases such children are eliminated through infanticide. Among the Kasena and Nankana of Upper East Region of Ghana, children born breech or whose birth is followed by a chain of calamities or born supposedly with milk teeth or the sixth digit may qualify as spirit children. Among the Kasena such children are known as *chuchuru*; among the Nankana, they are known as *kinkirigo*.

⁴ The 1960 Criminal Code of Ghana virtually outlawed all forms of abortion procedures in the country. In 1985 however, an amendment to the law on abortion relatively liberalized access to the procedure by specifying five conditions under which legal abortion may be procured. These are: (a) if the pregnant woman is a minor; (< 16 yrs); (b) if the pregnancy is as a result of rape or incest; (c) when the pregnancy threatens the life of the pregnant woman; (d) if the pregnant woman is mentally challenged; and (e) if the foetus cannot thrive or if the child is likely to be born with serious congenital malformations.

yearly number of abortions at the Korle-Bu Teaching Hospital between 1963 and 1967 to be 2,541 while for the same period, the average yearly number of births was 7,036. In a study of patients with complications of induced abortion admitted to the same hospital between May 1993 and May 1994, Lassey (1995) recorded 212 acute cases. Recent studies by Anarfi (1996), Nabila and Fayorsey (1996), and Kenyah (2000), indicate that the practice is fairly common.

According to the Ghana Demographic and Health Survey (Ghana Statistical Service and Macro International Inc.1998)12 percent of all pregnancies that occurred in the ten years before the study did not end in a live birth. Also, the study reported that nearly one in four pregnancies to women aged 15-19 years was lost early through spontaneous or induced abortion. Furthermore, it observed that early pregnancy losses were especially high among women aged 15-19 with about two in five pregnancies to women in this age group ending in an early pregnancy loss. In another study on how girls living in Accra cope with unintended pregnancies, Measure DHS+ www.measuredhs.com found that the 29 girls (aged 15-24) interviewed collectively experienced 64 pregnancies half of which resulted in abortions.

In Ghana, the danger with abortion is that when performed especially, by untrained abortionists, sepsis may occur because of the use of improperly sterilized instruments in insalubrious environment. However, by far, the largest number of acute complications is due to self-induced abortion. Writing on the 'anthropology of abortion', in a Kwahu town, Bleek and Asante-Darko (1986) revealed the modes and methods – both allopathic and indigenous – employed in the exercise. Among the 'allopathic' methods include the following: Menstrogen tablets or injection; Mensicol capsules taken with alcoholic drink; Alophen Pills; Primodes Forte; Gynavion Pills and Dr. Bongean's Pills, among others. The herbs and herbal preparations used include *nkrangyedua* (*Jatropha Curcas*); *Nyanyara* (*Passiflora Foetida*; sugar cane; *nunum* (*Ocimum Americanum*); cassava leaf stalk (*Manihot Utilissima*) and *Sorowisa* (*Piper Guineense*), and severe beating or vigorous sexual intercourse, among others. The local newspapers often carry stories on abortion in which some 'medicines' were used often with disastrous consequences.

Reasons for induced abortion range from socio-cultural to psychological. While the law frowns on abortion, many women will risk their lives to avoid unwanted births when they have powerful reasons for not wanting to be pregnant – such as concern for their own health, the welfare of the children they already have, their desire to continue work, schooling or apprenticeship. Is there a way to prevent women from dying without liberalizing access to abortion services? This is a moot point.

Against the background of these macro-level societal issues, the question to ask is: How do pregnant women (and their relations) and the health care systems respond to obstetric emergencies? The most common obstetric complications vary in their demand for speedy intervention. However, Maine et al. (1987) have estimated the average interval from the onset to death for the major obstetric complications as shown below:

Table 2
Estimated Average Interval from Onset of Complication to Death

COMPLICATION	HOURS	DAYS
Haemorrhage: Postpartum	2	
Haemorrhage: Antepartum	12	
Ruptured Uterus		1
Eclampsia		2
Obstructed Labour		3
Infection		6

Source: Maine et al. (1987)

The Delays

Clearly, while speedy intervention is essential in the management of obstetric emergencies, the ability of the health system to effect rapid intervention is mediated by socio-cultural factors which, thanks to the Prevention of Maternal Mortality Project (PMM)⁵ has come to be known as the THREE DELAYS. The writer, however, recognises four of such delays as discussed below:

(a) *Delay in the Recognition of a Problem*

As has been emphasised *ad nauseam*, society plays a critical role in the promotion or reduction in the incidence of maternal morbidity and mortality. Medical anthropologists have stressed that the concepts of 'health', 'sickness' and 'problem' are all cultural constructs and consequently they may be reinterpreted to mask the element of medical danger. Consequently, there are instances when grossly oedematous pregnant women are said to be expecting twins or a baby boy when medically they may be on the path to death as a result of pregnancy-induced hypertension. Again, there are instances when pregnant women who spot 'small' quantity of blood regard this as normal. Again in some societies in Ghana, it is the norm that the pains of onset of labour must be borne with stoicism until the foetus is due for expulsion. This non-recognition of obstetric emergency situations resulting from cultural reconstructions can be fatal.

(b) *Delay in the decision to take appropriate action*

Even when the emergency situation has been appreciated there is considerable delay in taking appropriate action. This may be due to lack of knowledge about where to locate the appropriate facility or the lack of money to access the services of this facility. In the rural areas especially, where women are generally poorer, their dependence on their male counterparts becomes problematic in times of emergency when the men do not also have the resources or are absent at the time. Consequently, obstetric emergencies may find their way to traditional midwives, spiritual homes or shrines.

Another aspect of this delay is that in the event of obstructed labour, women are made to confess their alleged marital infidelity in the belief that such a confession will lend to the expulsion of the foetus. In addition to this, in the northern regions of Ghana, especially, a local herbal preparation often of oxytocic derivation, is administered in obstructed labour. In the Northern Region this is known as *Kalugotim* which is reported to have caused many cases of ruptured uterus; it enhances labour contractions without a corresponding dilatation of the uterus. Hence the rupture.

(c) *Delay in arriving at a health facility*

When the decision to access the services of a health facility has been taken, there is a further delay in arriving at the facility, which may be several kilometres away. The distance factor is complicated by lack of vehicles, bad roads and high transport fares. In many rural areas, a parturient may be hammocked several kilometres to the next village or road junction where a vehicle may be found. In the Afram Plains, she may be transported on a tractor.

⁵ The Prevention of Maternal Mortality Network (PMM) was a multi-site study on maternal mortality carried out in Ghana, Nigeria and Sierra Leone between 1988 and 1996. The study was funded by Carnegie Corporation of New York and was technically back-stopped by Columbia University. Each national team was made up of clinical, social science and public health professionals. Today, the useful lessons derived from this study are being spread throughout the African continent by the Regional Office of Prevention of Maternal Mortality located at Dzorwulu in Accra.

(d) *Delay within the health facility*

The health facility finally accessed from the village may be a private maternity home, an MCH clinic, a district or a regional hospital. However each of these facilities has its own problems which may delay quick intervention. For instance, many private midwives have had no refresher courses since they graduated. There are many private midwives who have no training in *Life Saving Skills* and the use of the partogram and in other modern obstetric techniques. In some cases also the midwives, for financial reasons, delay referral in the hope that the parturient may deliver spontaneously. Beside these, most private maternity homes have no ambulance and the necessary equipment and medical supplies to handle obstetric emergencies. Perhaps, a far more greater danger is the large army of untrained midwives who operate with impunity especially, in the rural areas.

The MCH clinics, most of which operate within the officially stipulated working hours are in no better position than the maternity homes; they are in no position to provide essential obstetric functions. In the district and regional hospitals also, often there are no obstetricians and gynaecologists and anaesthetists. Others do not have an ambulance, blood and blood bank, adequate number of or complete laparotomy set, modern autoclaves, emergency medical supplies and regular supply of water and electricity, among others. Beside, their operating theatres are ill-equipped to handle many major surgical procedures. Indeed, until recently, Winneba Hospital used to depend on the Korle-Bu Teaching Hospital for its blood supplies. How long can a case of postpartum haemorrhage be kept alive while the hospital ambulance drives through the thick traffic to Korle-Bu and back?

Discussion

The task of this paper has been to show how medical conditions and socio-cultural factors intertwine to produce maternal morbidity and mortality. However, as may be appreciated, maternal mortality is largely a preventable tragedy. Yet in Ghana as in many developing nations, this tragedy continues to afflict hundreds of women annually. This is not only because its socio-cultural components are largely ignored by policy makers, but also because the tragedy is gendered; it is experienced largely by women who are politically voiceless and financially weak. Certainly, if every year, **only** ten (10) Ghanaian politicians die in road accidents, this will not only hit the headlines but also will call for prompt action from government. The PMM experience has shown that reducing maternal mortality, especially, in the developing world does, not require the building of high-tech health centres. Nor does it require huge capital investment. Indeed, much of the resources needed to stem the tide lie untapped within the communities and the health facilities. For instance, if community members including transport owners are sensitised enough to appreciate the danger signals of obstetric complications and are empowered to design home-made solutions; and if the health facilities, especially those at the peripheral zones are supplied with adequately trained personnel and basic equipment to offer quality essential obstetric care in times of emergency, so many lives would be saved. A nation that sends its troops to war unprepared cannot hope to win any war. In spite of what Ghana has done to contain the problem, it is clear that the nation's state of preparedness is woefully deficient. And this is a serious indictment, for as Tenon (1788) has rightly observed, 'No one is more worthy of care than the pregnant woman who carries within her the support of empires and the gem of future generations.'

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ABORTION: THE CASE OF CHENARD WARD, KORLE BU FROM 2000 TO 2001

Richard W.N. Yeboah and Monica C. Kom

Abstract

This paper examines the number of abortion cases attended to in the Chenard Ward of the Korle Bu Teaching Hospital, Accra during the years 2000 and 2001. A total of 1,935 abortion cases were handled in the year 2000 and 1,838 in 2001. Though there was a 5% decrease in the number of cases in 2001, there was an increase in 'incomplete abortions', which happened to be the most frequent, 78% and 83% in 2000 and 2001 respectively. The majority of the abortions were found among women in the age bracket 21-30: 58% in 2000 and 55% in 2001. There were also 63 (3.3%) and 42 (2.3%) abortions in 2000 and 2001 respectively between the ages of 41 and 50 years. These figures call for the intensification of the campaign for safer sex practices, family planning and the teaching that there is good care for those that call to the hospital early enough.

Introduction

Abortion of any kind is of importance to government all over the world because of the complications that are dangerous to the lives of women. Between 10 and 15 percent of all pregnancies terminate as spontaneous abortion, and about 10 – 60% are terminated by an induction either legally or illegally. About 80% occurs in the first trimester that is within the first to the third months of pregnancy. This can lead to hazards such as pain, ill health, infertility as well as other long-term complications (Taylor and Ablordey 1993). In fact WHO (1994) estimates that half a million women die each year from complications of pregnancy and childbirth and 28% of this has been associated with unsafe abortion.

WHO (1997) reports that an estimated 53 million pregnancies are terminated by induced abortion each year in the world. One third of these abortions are performed in unsafe conditions resulting in some 50,000 – 100,000 deaths each year. Many more women have complications, which may have long-term consequences for their health. Glenn (1996) indicates that about 50 million self-induced abortions occur per year worldwide and half of these occur outside the health care system. These figures are alarming, the more so as most of these occur in developing countries.

Since most of the self-induced abortions are performed outside the health care system, the risks are higher for the women. In order to reduce the risks and loss of lives, there are still struggles as to whether abortion should be legalised or not though it is illegal in Ghana now (see PNDCL 102; 1985). The argument may stem from the fact that many abortions take place outside the hospitals and in some cases lead to complications and death. According to Sai (1996) the laws against abortion are mainly old laws, and it is worth recalling that part of the rationale for most 19th century abortion laws was to save women from quacks and unsafe and experimental surgery. To make a firm argument on this issue it is necessary to know the details of what has been happening.

Many women over the years have used induced abortion as a means of birth control, that is, to terminate unwanted pregnancies whilst others have it done for medical reasons. A few pregnancies are terminated spontaneously. Whatever the cause of abortion, it still has adverse effects on the individual and the nation at large.

Induced abortion in particular is a significant public health problem, especially in developing countries such as Ghana where it is often illegal (International Fertility Research Programme 1981). Because of its illegality, most women seek to terminate their pregnancies by unqualified personnel under unhygienic conditions and environments with the use of dangerous agents of abortion. The consequences of this are usually acute complications such as bleeding and infection or permanent damages to the reproductive system or even death of the individual. In addition, abortion of all types, causes financial and time loss to the individual and the family. A sizeable number of physicians, nurses and other health workers spend considerable time caring for women with complications from abortions. This results in the straining of the already limited medical and economic resources of the nation. There is also a loss of productivity since most of these women are among the working populace.

For about three decades now, modern contraceptives have been in use in Ghana. These modern contraceptives and safer sex practices are advertised daily to help prevent unwanted pregnancies as well as sexually transmitted diseases. It is expected that the rate of induced abortions per year would decrease, but they seem to be occurring in high numbers each year. It is against this background that this study sought to examine the situation in the Chenard Ward of the Korle Bu Teaching Hospital and to come out with policy recommendations.

The objectives of the study are to find out the number of abortion cases attended to in the Chenard Ward in the years 2000 and 2001, and investigate the various types of abortions attended to during this period and the age groups of the patients. It also seeks to find out why the pregnancies were terminated and determine the social effect of these abortions and make policy recommendations to address the problem of abortion.

The Study

Secondary data were extracted from the records of the Chenard Ward at the Korle Bu Teaching Hospital. All cases reported were recorded there. Some nurses were interviewed to find out the reasons given by the patients for abortion.

Chenard Ward is a gynaecological emergency ward under the Department of Obstetrics and Gynaecology of the Korle Bu Teaching Hospital (KTH). It has a bed capacity of 50. The ward is well endowed with various categories of experienced health workers. All gynaecological emergencies such as ectopic gestation and all forms of abortions are admitted to the ward. The total number of admissions per month stands at an average of one hundred and thirty-five. Out of this number seventy, ie. 51% are abortion related. Incomplete abortion cases, the most common abortion, form 71% of the abortion patients who are admitted to the ward.

During the year 2000 the number of abortion cases handled by the Chenard Ward was 1,935. In 2001, the number reduced by 5% to 1,838 (Table 1). This gives an average of 161 and 153 abortions per month in 2000 and 2001 respectively or not less than 3 abortions daily. These were only those that were reported in Korle Bu alone, not considering that there were abortions reported to other hospitals and those that were illegally done are never recorded. The data shows only 38 abortions recorded in April 2000, far below the average. This is because there was a strike by health workers and services were not available and admissions fell. Very high numbers were recorded for November and December of both years. It is assumed that most women get pregnant around July to September when the weather is very cold. In November/ December, when the pregnancies are about two to three months old, the unwanted ones are terminated.

Table 1
Total Number of Abortions per month in 2000 and 2001

Months	2000	2001
January	208	171
February	157	142
March	173	143
April	38	174
May	141	132
June	117	108
July	137	122
August	142	127
September	175	169
October	159	154
November	295	201
December	203	195
Total	1,935	1,838

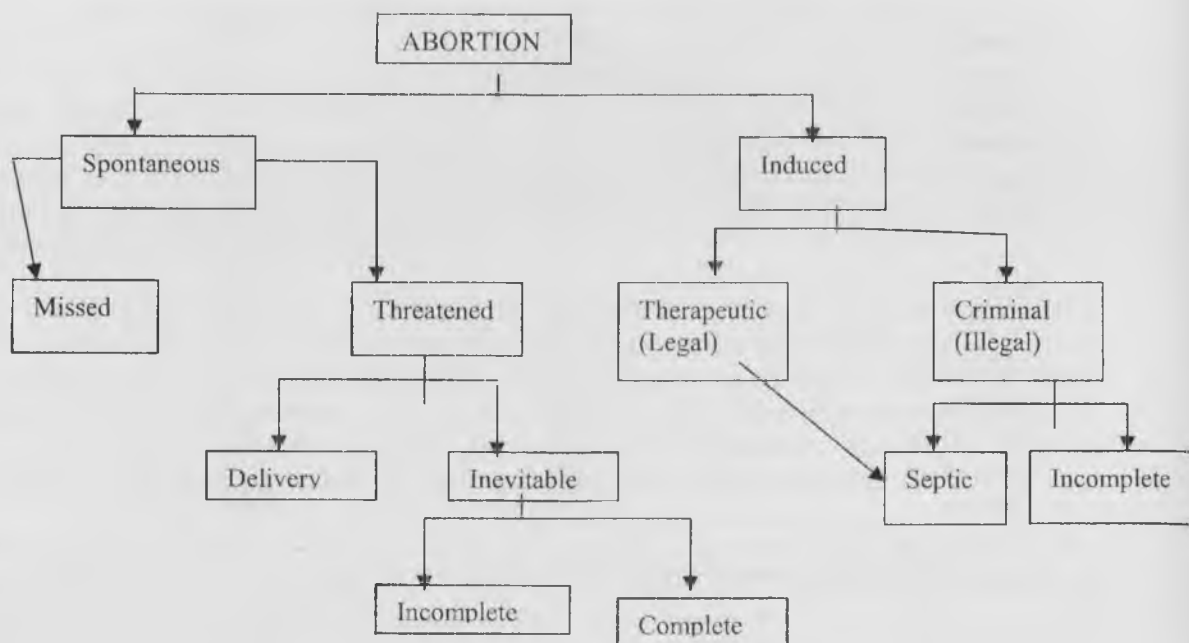
Source: Derived from Chenard Ward, Korle Bu, 2002

All forms of abortion fall under two main categories: spontaneous (miscarriages) and induced as shown in Figure 1. Induced abortion is the voluntary termination of pregnancy by oneself or someone else. It could be either therapeutic or criminal.

In Korle Bu Teaching Hospital, abortions are classified into five types. All five types of abortion cases were reported and handled in Chenard Ward during the years 2000 and 2001. These include incomplete abortion, inevitable abortion, septic abortion, threatened abortion and missed abortion.

Bennett and Brown (1999) show the types of abortions as in figure 1.

Figure 1
Types of Abortion



Source: Bennett and Brown (1999)

Tables 2 and 3 show the various types of abortions attended to and their numbers by the hospital per month in 2000 and 2001. In both years, the Incomplete Abortions were the dominant types. In 2000, 78% of the abortions were of the Incomplete type. This increased to 83% in 2001. Though there was a reduction in the total number of abortions in 2001 by 5%, there was rather an increase in the Incomplete Abortion. This shows that this type of abortion is very common and if there should be any intervention, the focus should be on the reduction of this type of abortion. According to the nurses interviewed, most of the Incomplete abortions attended to were the induced (criminal or illegal) type. The patients come after they have attempted the abortion and it is incomplete.

Inevitable Abortion follows after incomplete abortion forming 10.5% of abortion cases in 2000 and 7.8% in 2001. It is usually due to threatened abortion. Threatened and missed abortions together were 7.9% in 2000 and 6.2% in 2001. These types of abortions have minimal complications.

Septic abortion, on the other hand, results from complications of induced abortion mostly of the criminal type due to the use of contaminated instruments under unhygienic conditions. It was the least recorded in 2000 (3.5%) and in 2001 (2.6%).

From these figures, it could be deduced that reported cases of induced abortion were high despite family planning education that has been introduced in the country since 1970.

Table 2
Number of Abortions in 2000 by Types

Months	Incomplete	Inevitable	Septic	Threatened	Missed	Total
January	164	13	7	13	11	208
February	124	17	5	3	8	157
March	112	34	10	5	12	173
April	23	10	3	2	0	38
May	100	15	7	14	5	141
June	91	13	2	7	4	117
July	105	20	4	2	6	137
August	100	21	6	7	8	142
September	146	13	9	3	4	175
October	137	5	8	4	5	159
November	266	16	1	5	7	295
December	152	29	5	10	7	203
Total	1,510	206	67	75	77	1,935
Percentage	78	10.6	3.5	3.9	4.0	100

Source: Derived from Chenard Ward, Korle Bu, 2002

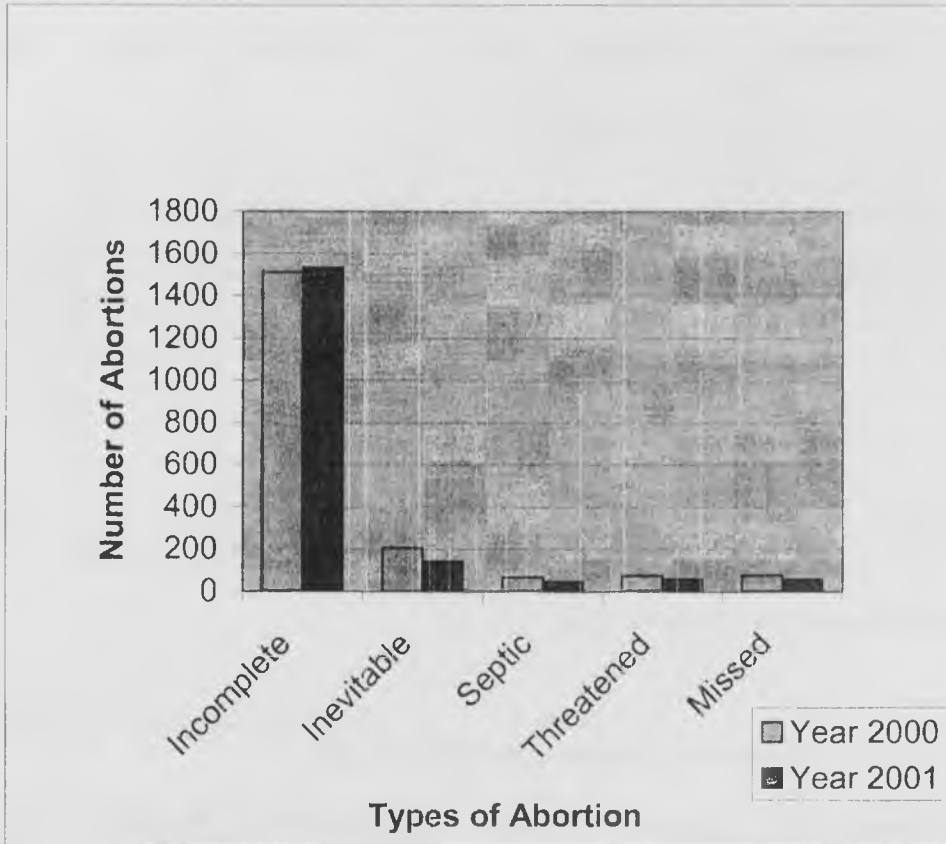
Table 3
Number of Abortions in 2001 by Types

Months	Incomplete	Inevitable	Septic	Threatened	Missed	Total
January	126	26	5	7	7	171
February	102	19	6	8	7	142
March	118	8	1	9	7	143
April	145	13	4	8	4	174
May	112	5	4	4	7	132
June	92	9	-	5	2	108
July	107	7	3	1	4	122
August	110	9	-	4	4	127
September	148	10	4	4	3	169
October	131	13	5	2	3	154
November	174	12	9	3	3	201
December	167	13	7	4	4	195
Total	1,532	144	48	59	55	1,838
Percentage	83.4	7.8	2.6	3.2	3.0	100

Source: Derived from Chenard Ward, Korle Bu, 2002

Figure 2 compares the total number of each type of abortion during the two years. In both years, Incomplete Abortion was the highest and it was higher in 2001 than 2000.

Figure 2
Types of Abortion Recorded in Chenard Ward, 2000 and 2001



Source: Derived from Chenard Ward, Korle Bu, 2002

Age of patients attended to for abortion

Table 4 shows that the majority of the cases treated were between ages 21 and 30. These ages constitute 57.8% of the cases in 2000 and 55.4% in 2001. Over 95% of the cases fell between 16 and 40 years and most of these were of the incomplete type of abortion. Almost all of the cases recorded above 40 years also fell under the incomplete type.

There were few instances of abortions in the extremes. There was a case in 2000 when the patient was above 50 years and it was of the Incomplete Abortion type. There were ten cases of girls under fifteen, five in each year.

Abortions occur to women of all ages but the most proportion of the cases examined fall in the active reproductive ages. The number of abortions recorded for women above 40 were few, and decreased in 2001. There is the need to prevent unwanted pregnancies among all age groups but especially for those above 40 years who do not want any more children.

It is surprising that few teenage pregnancies were aborted during the years under consideration though there has been wide-spread fear of increasing teen-age pregnancy in the country of late. It could be that most teen-age pregnancies aborted do not usually end up at health institutions such as the Chenard Ward.

Table 4
Number of Abortions By Age Group

Age Group	2000		2001	
	Number	Percentage	Number	Percentage
16 – 20	259	13.4	264	14.4
21 – 30	1,118	57.8	1,019	55.4
31 – 40	492	25.4	513	27.9
41 – 50	66	3.4	42	2.3
Total	1,935	100	1,838	100

Source: Derived from Chenard Ward, Korle Bu, 2002

Reasons given for abortion

The study could not follow up the patients to find out why they had terminated their pregnancies. The nurses reported the reasons given by the patients for the abortions. These confirmed the findings of Koim (1999) in an earlier study when she followed up patients in the Chenard Ward in Korle Bu Teaching Hospital. They also agree with the findings of Akinrinola, Susheeba and Haas (1998). The reasons given were:

- i) Unmarried: some of the patients said they did not have husbands and were not sure they could care for the child when born
- ii) To space births: some patients who were married and living with their husbands resorted to abortion when they had unplanned pregnancies, usually when their last child was not old enough, according to their judgement.
- iii) Still in school: some patients were students who were still in school and could not combine the pregnancy with studies. In some of these cases, they had aborted the pregnancy without the knowledge of their parents.
- iv) Financial problems: this cuts across most of the patients. They claim they do not have money to take care of the pregnancy to maturity, much less to cater for a child.
- v) No responsible man: the women realise that their partners are irresponsible and will not be able to take care of them during pregnancy nor when the child is born. In some cases the men refuse responsibility for the pregnancy or run away to hide in a place unknown to the woman.
- vi) Deteriorating health: these abortions are often spontaneous or advised by a medical officer. They are not normally unwanted pregnancies but they cannot be carried to maturity.

The major reasons recorded were i, iii, iv and v. These were unmarried, still in school, financial problems and no responsible man.

Unsafe abortion is illegal (see PNDCL 102 1985) in Ghana hence offenders are supposed to be prosecuted. According to the nurses, however, none of the patients was brought before any law court.

Social Implications and Effects

Abortion may reduce the fertility rate of a nation. It also creates psychological and social problems such as those related to infertility. In Ghana, infertility in any marriage is of serious concern to both the couple and the extended families. In some cases the extended families create many problems for the couple which may lead to divorce. This is because children are considered as custodians of the family lineage.

Secondly, almost all religions frown on abortion, such that individuals who undergo abortion suffer the guilt of committing an unpardonable offence. The traditional believers resort to means of pacifying the gods, which becomes another cost to them. In some communities most mishaps like droughts are attributed to offences against the gods, including abortions. Christians likewise consult with their pastors to confess and ask for cleansing through prayer, thus adding to the duties of the pastors and spiritual leaders.

Thirdly, the patient undergoes psychological torture due to guilt. It becomes more serious when the patient suffers permanent damage to her reproductive system.

In the past, until a girl underwent puberty rites she could not be sexually active nor be married, hence, abortion among teenagers and the immature was not common. In recent times, puberty rites are seldom performed, yet the girls are given sex education early enough. Many believe that giving girls sex education at early ages makes them promiscuous. Many young girls get pregnant before they are ready for motherhood. They seek abortion for fear of parents who frown at such behaviour or in order to continue their education.

In the same vein, it is not an accepted norm for married couples to engage in abortion. Abortion among couples is considered an abomination to the gods and ancestors and calls for cleansing. The cleansing process is so difficult that it creates a lot of psychological problems that the victim hardly overcomes.

Abortion does not permit the children to be born. These children could have been the best human resources the nation could depend on but they never entered the world. Ghana therefore lost 3,773 children in 2000 and 2001 at Korle Bu alone. There is also the fact that this could be a way of reducing the fertility rate.

A nation's human resource is an asset for productivity. Women who have abortions of any type are in the active and productive age group. Abortions take them out of work. Each abortion, without complications, takes the woman out of work for between 3 and 14 days. The number of days off work increases with complications. In the case of Chenard Ward in 2000 and 2001, Ghana lost between 3 and 14 working days times 3,773 people. In addition, the psychological effect on the patient can make her less productive for some time. The duration of loss of productivity depends on the attributes of the individual.

Emergency treatment of abortion complications consumes a significant portion of scarce hospital resources in many developing countries (Brasier et al. 1998). In recent years, there has been constant news of brain drain among workers in the medical field. This has brought about increases in the medical personnel-patient ratios. The few medical staff spend much time attending to abortion patients instead of taking care of patients suffering from other diseases.

The average cost of a normal abortion, without complications, is two hundred thousand cedis (¢200,000). The individual bears the cost of treatment. Complications that lead to anaemia, infections and even permanent infertility could occur, which increases the cost to the patient.

Conclusion

Abortion, especially unsafe abortion, has been a problem in Ghana and needs attention. The number of recorded abortions in Korle Bu Teaching Hospital alone is considerable. The number of abortions performed outside the health system and in private health systems is estimated to be far larger than that reported to the health system. It shows that the situation is very serious.

The increase in the Incomplete Abortion type is of concern. This type of abortion is very important and if there should be any intervention, the focus should be on this type of abortion.

The study shows that abortions cut across all ages and occur especially among women in the active reproductive ages. Though the numbers of abortions recorded for women above 40 years were few, and decreased in 2001, there is the need to prevent unwanted pregnancies during those ages since these could be more complicated.

Recommendations

The health institutions are doing well in the midst of the constraints facing them. The education and campaigns going on in the country are having some positive effect. We however recommend that:

1. Family planning education and promotion of the use of contraceptives should be continued and intensified.
2. Family life education should be encouraged to alert young women to the dangers of abortion.
3. None of the patients who conducted an illegal abortion was prosecuted. This makes the law on illegality of unsafe abortion ineffective. Until abortion is legalised, patients who terminate their pregnancies without medical advice or care should be made to face the law (see PNDCL 102 1985). In addition, those who perform the abortions for them should also be made to face the law. The law on abortion should be either revised or enforced.

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NUTRITION AND REPRODUCTION

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Abstract

The general health status including reproductive health of every adult of reproductive age alive today has already been determined to a large extent by the quality of the nutritional environment from his or her conception through infancy, childhood and adolescence to his or her present age. The effects of intrauterine malnutrition can persist throughout life. Poor feeding practices during the first 2 years of life have immediate and often long-term negative consequences on growth and development. Poor nutrition during the growing years affects growth and development potential, while nutritional stress during adolescence and the reproductive years affects the health of especially women and consequently, the next generation. There are critical periods at the different stages in the life cycle, during which specific nutrient deprivations result in irreversible damage, which limit the full growth and functional potential of the individual. This paper discusses the role of nutrition in human development from conception to reproductive age, highlighting the negative effects of nutritional deprivation during the process. Since life begins at conception, and the female is responsible for ensuring that a full-term, healthy, viable infant is born and adequately fed to maturity, attention will be drawn to recommended feeding and dietary needs of women that would break the cycle of poor health and nutrition that passes on from generation to generation.

Introduction

Life begins at conception and despite the fact that there are some aspects of fetal and newborn health which are beyond the parents' control, there is much evidence to show that good nutrition during the childbearing years for both females and males significantly determines the baby's health and future (Wardlaw et al. 1994). As Sizer and Whitney (1997) put it: "Our nutrition is not personal as we normally think for it affects not only our own lives but that of generations to be born".

For example, some recent research findings suggest that inadequate vitamin and mineral intake in the months before a woman conceives and during the first month's of pregnancy may lead to birth defects (Butterworth 1993). The LINKAGES Project report (2001) on essential health sector actions to improve maternal nutrition in Africa has pointed out that maternal malnutrition prior to and during pregnancy causes intrauterine growth retardation, leading to two thirds of low birth weight babies in developing countries whose neonatal mortality rates are two or three times higher than normal weight babies. Researchers have associated low levels of folic acid in men with decreased sperm count and sperm density, which affects reproductive performance. Again men with low levels of vitamin C have more genetic damage in their sperms, which can cause birth defects in babies (Sanders 2001). Lifelong dietary habits are therefore important in determining reproductive health and performance.

Since the female is responsible for ensuring that a full-term healthy, viable infant is born and adequately nursed, maternal nutrition should be properly focused during all phases of reproductive life, to break the cycle of poor health and nutrition that passes on from generation to generation. The focus becomes more urgent because according to McGuire and Popkin (1990), in most developing countries, women spend a large proportion of their reproductive years

pregnant, lactating or both. Women in Africa are pregnant or lactating, on average, 30 to 48 percent of the time between the ages of 15 and 45 years.

The need to focus on women's nutrition throughout the reproductive years has evidence in history of the effect of maternal malnutrition on the course and outcome of pregnancy. Many studies have suggested that the better the state of a mother's nutrition before or at the time of conception, the greater the chance of normal pregnancy leading to the birth of a healthy baby (Williams 1993).

Guthrie (1989) and Wardlaw et al. (1994) have recounted early research supporting the importance of diet preceding pregnancy. They have illustrated with data on babies born during a period of wartime starvation. Babies who were conceived before the hunger broke out by mothers whose previous diets were good were shorter and lighter than babies born to mothers' whose diets were adequate throughout pregnancy.

Moreover, among the babies conceived before the hunger, there were fewer stillbirths, premature births, and congenital mal-formations compared to babies conceived during the hunger period. A reduced rate of conception also occurred during the hunger period. However, birth weights, infant health and the numbers of new pregnancies quickly returned to pre-war levels when the hunger came to an end.

On the basis of data from animal studies and cross country comparisons, poor maternal nutrition has been implicated as one of the key "adverse environmental influences in utero," which could lead to compromised fetal and placental growth and adverse long term consequences (Baker 1992).

Guthrie (1989) has also referred to studies which have showed that mothers on good diets experience few complications during pregnancy and give birth to infants with a greater chance of survival. For example, Thomson and Billewicz (1963) reported decades ago, that the incidence of premature births, caesarean section, and prenatal deaths increased as the dietary rating of maternal health fell, as illustrated in Table 1.

Table 1
Incidence of Obstetric Abnormalities by Maternal Health and Physique

Abnormality	Maternal Health and Physique			
	V. good	Good	Fair	Poor/V. poor
Prematurity (%)	5.1	6.4	10.4	12.1
Caesarean Section (%)	2.7	3.5	4.2	5.4
Prenatal deaths per 1000 births	26.9	29.2	44.8	62.8

Source: Guthrie (1993)

After birth, the new born infant faces the challenge of attaining physical maturation during which the body functions are fully developed including sexual maturation and reproductive capacity. In this regard, good feeding providing adequate nourishment ought to receive attention during infancy, childhood and adolescence to prevent the often long-term negative consequences of malnutrition on growth and development.

This paper presents the role of nutrition in human development with emphasis on prenatal development during pregnancy, lactation and through the growing years to adolescence, when reproductive age is attained. The negative effects of nutritional deprivation are highlighted while attention is drawn to recommended dietary and feeding needs at the various stages.

The Role of Nutrition in Pregnancy and Fetal Development

Nutrition is one key to a successful pregnancy (National Academy of Sciences, 1990). Indeed, the nutrition of the woman who is pregnant or who intends to be will be critical to the health of her child in years to come. As such, before she becomes pregnant, a woman must be well nourished because although most women are often not aware they are pregnant during the first few weeks, the embryo undergoes significant developmental changes that depend on the mother's prior nutritional status (Wardlaw et al. 1994; Sizer & Whitney 1997). Fertilization or conception is followed by rapid cell division and by two weeks after fertilization, the ball of cells is implanted in the uterus. From 2 to 8 weeks, during which critical cell differentiation occurs to develop the embryo, demands for abundant maternal nutrient base is crucial for such rapid development. By the end of the 7th or 8th week the embryo can be identified as human with a complete central nervous system, a beating heart and a fully formed digestive system. From 8 to 40 weeks, the fetus grows rapidly to full form.

Table 2
Recommended Dietary Allowances (RDA) of Some Selected Nutrients for Pregnancy and Lactation (National Research Council, 1989 Revision)

Nutrients	Non pregnant girl		Non pregnant woman	During pregnancy All ages	Lactation	
	11-14yr 46 kg 101 lb	15-18yr 55 kg 120 lb	25 yr 63 kg 138 lb		(600 ml/dy) First 6 months	(750ml/dy) Second 6 months
Calories	2200	2200	2200	No change in the first trimester: add 300 kcal/day for second and third trimesters	2840	2710
Protein (g)	46	44	50	Add 10 g/day	Add 15 g/day	Add 12 g/day
Calcium (mg)	1200	1200	800	1200 mg throughout		
Iron (mg)	15	15	15	30 mg throughout	15	15
Vitamin A (μ g RE)	800	800	800	800 μ g (RE throughout)	1300	1200
Thiamin (mg)	1.1	1.1	1.1	1.5 mg throughout	1.6 mg throughout	
Riboflavin	1.3	1.3	1.3	1.6 mg throughout	1.8	1.7
Niacin (mg NE)	15	15	15	17 mg NE throughout	20 mg NE throughout	
Ascorbic acid (mg)	50	60	60	70 mg throughout	95	90
Vitamin D (μ g)	10	10	5	10 μ g throughout	10 μ g throughout	

Source: Williams (1993).

Each organ grows with its own characteristic pattern and timing, and depends most on its supply of nutrients during its own intensive growth period known as critical period. Events during the critical period can occur only at that time and at no other. Therefore, the nutrients and other conditions needed during this period must be supplied on time if the organ is to reach its full potential. If an organ is limited during a critical period, recovery is impossible.

The first trimester is an especially critical period when poor nutrition can result in birth defects. For example, malnutrition prior to pregnancy could lead to failure of implantation or cause abnormalities resulting in loss of the zygote even before the woman knows she is pregnant. Another example is that since the heart and brain are well developed at 14 weeks, the lungs 10 weeks later, early malnutrition could impair the heart and brain and late malnutrition could impair the lungs. Thus, early malnutrition often does irreversible damage, although this may not become fully apparent until maturity and may never be attributed to events of pregnancy. The energy and nutrient requirements of pregnancy far exceed those of the non-pregnant woman (see Table 2).

The mother's diet must supply all the nutritional demands of the fetus and her own body. For micronutrients, vitamin/mineral supplements are needed where the diet cannot supply them. The energy increment is needed to spare protein for tissue building, to sustain rapid fetal growth, to ensure maternal fat storage necessary to provide energy reserves for labour and delivery and for maintaining lactation after birth. Appropriate weight gain during pregnancy indicates whether sufficient calories are being provided. Adequate weight gain for a mother is one of the best predictors of pregnancy outcome. Her diet should allow for about 2 to 4 pounds (0.9 to 1.8 kg) of weight gain during the 1st trimester, and then subsequent gain of ¾ to 1 pound (0.3 to 0.5 kg) weekly during the second and third trimesters.

It is recommended that setting weight gain goals with the pregnant woman must be according to her pre-pregnancy Body Mass Index (BMI or weight for height ratio), pregnant nutritional status, and whether or not she is carrying multiple fetuses (National Academy of Sciences 1990).

Table 3 gives the recommended weight gain in pregnancy based on pre-pregnancy BMI.

Table 3
Recommended Weight Gain in Pregnancy Based on Pre-pregnancy Body Mass Index (BMI)

<u>Pre-Pregnancy Weight-for-Height</u>	<u>Recommended Total Gain (Pound)</u>
* Low (BMI of < 19.8) Underweight Women	28 - 40
* Normal (BMI of 19.8 to 26.0) Normal weight women	25 - 35
* High (BMI of > 26.0 to 29.0) Overweight women	15 - 25
* <u>Obese women (BMI of 29.0)</u>	<u>≤ 15</u>

Source: National Academy of Sciences (1990).

Total weight gain goal normally averages 25 to 35 pounds (11.5 to 16 kg) which has been shown to yield optimal health for both fetus and mother. For adolescent mothers, it is recommended that they strive for the upper end of the range and a woman carrying twins should target a weight of 35 to 45 lbs (16 to 20.5 kg). Mothers who fail to gain weight are likely to deliver infants of low birth weights (<5 ½ lbs) or 2,500 g) who are nearly forty times likely to die in the first year of life than normal weight infants. The LINKAGES Project (2001) has reported that many African women consume less than the recommended allowance for calories and that between 5 to 20% of women in various African countries are underweight. In Ghana, the mean BMI is 22.1 and that one in nine women in Ghana fall below the cut-off 18.5, indicating that the level of chronic energy deficiency in Ghana is relatively high (GSS and MI, 1999). In 12 out of 17 African countries, 10% or more babies are born with low birth weight, a reflection of poor

weight gain during pregnancy. According to Ghana Health Service data, (GHS, 2002) the low birth weight rate for 2002 was 10%, an increase of 17% over the 2001 figure of 8.3%. Failure to gain weight during the second trimester is also likely to result in premature deliveries and toxemia, which when severe can cause maternal death.

The growth of the fetus makes heavy demands for protein. Besides, protein is needed for the enlargement of the uterus, mammary glands, and placenta. Protein is also needed for the increased maternal circulating blood volume and for the formation of amniotic fluid. Protein intake influences birth length within the limits of heredity. Taller babies being born to mothers with high – protein diets than those with low-protein diets.

Protein restriction during fetal life has been associated with a decrease in the number of cells in tissues at the time of birth, a situation particularly serious in the case of the brain which is relatively well developed in prenatal life and may be irreversibly stunted. Brown (2000) has reported that one in 4 babies born in developing countries have intrauterine growth retardation and are at risk of mental impairment.

The incidence of abortion in early pregnancy among women on low protein diets has also been found to be almost two times as high as it is in women on high-protein diets (Guthrie, 1989).

The needs for iron, calcium and zinc increase during pregnancy. Increased iron is needed to synthesise the greater amount of haemoglobin needed and to provide liver stores for the fetus to last it for 4 to 5 months after birth. Maternal iron stores also help fortify the mother against iron losses at delivery. Severe iron deficiency anaemia in pregnancy leads to premature delivery, low birth weight babies, and increases risk of infant death in the first few weeks of life (Williams, 1993; Wardlaw et al., 1994). Anaemic women are more likely to have prolonged labour which predisposes them to sepsis and increases risk of death (Gillespie 1998).

In 12 African countries surveyed, anaemia rates among pregnant women ranged from 43% in Nigeria to 80% in Tanzania (LINKAGES, 2001) and anaemia has been found to be responsible for an estimated 20% of maternal deaths (Ross & Thomas, 1996).

Calcium increase of 40% above the RDA is needed for fetal development especially during the third trimester of growth when skeletal tissues are growing rapidly and teeth are forming. (Williams, 1993; Wardlaw et al., 1994). Adolescents have a greater requirement for calcium during pregnancy to meet the needs of the fetus and the growing mother. In pregnancy, there is need for calcium storage rather than depletion to support demands of lactation later. Low calcium intake leads to withdrawal of calcium from maternal reserves which may weaken her bones (Sizer and Whitney, 1997).

Zinc needs increase by 25% above the RDA. The extra protein foods in the diet should supply this much zinc. It is a mineral which has its most profound influence on rapidly growing tissues, therefore, its effect on reproduction is significant. Maternal zinc deficiency is clearly associated with low birth weight (Guthrie, 1989; Wardlaw et al., 1994). Zinc deficiency is suggested as a cause of central nervous system problems (Guthrie, 1989), premature rupture of membranes and pre-eclampsia (Maeda and Tanaka, 1996). Zinc deficiency has been observed in 36 to 46% of pregnant women studied in Malawi (Gibson and Huddle, 1998).

Levels of iodine that will normally prevent goitre in the non-pregnant mother prove inadequate in pregnancy leading to goitre in the mother. When a mother has goitre the chances of her offspring developing goitre are increased ten times and the incidence of cretinism (retarded growth and mental retardation) the severe form of iodine deficiency in infants rises. Adolescent girls need special attention with regards to meeting iodine needs since a deficiency could lead to development of goitre, increasing the risk of having babies who are cretins

(Guthrie, 1989). Although the introduction of iodized salt has led to a major decline in goitre, iodine deficiency still remains a problem in some African countries as pointed out by WHO/UNICEF/ICCIDD (1997) and referred to by LINKAGES (2001).

Vitamin needs generally increase and of special interest are the needs for vitamin D and folate. Vitamin D needs double to aid calcium absorption for fetal bone formation. To provide it, pregnant women should get regular exposure to sunlight. It is established that entering pregnancy without adequate folate stores pose the risk of having infants with neural tube defects, such as spina bifida - protrusion of the spinal cord through gaps in the vertebral column- (Czeizel & Dudas 1992; Sizer and Whitney 1997). The early weeks of pregnancy are a critical period for the neural tube, which develops to form the brain and the spinal cord. By the 6th week of gestation it is supposed to have closed. In severe cases, the brain may fail to develop at all, and the infant dies. More common problems include club foot, dislocated hip (which in females could in adult life cause obstetric problems), kidney disorders, curvature of the spine, mental retardation and muscle weakness (Sizer & Whitney, 1997).

It is reported that each year nearly 400,000 infants are born in the United States of America with neural tube defects, half believed to be related to inadequate maternal folate during the earliest weeks of pregnancy (Sizer & Whitney 1997).

Megaloblastic anaemia, a common type of anaemia of pregnancy results from folate deficiency. Infants born to such mothers also have this type of anaemia. Folic acid deficiency has been found to be common in pregnant women in many parts of Africa (LINKAGES 2001).

The water-soluble vitamins including vitamin C, thiamin, riboflavin and niacin are of special need during pregnancy because they are important in a number of metabolic activities related to energy production, tissue protein synthesis, and function of muscle and nerve tissues. Since they are not stored to any appreciable extent, the pregnant woman must rely on a daily intake. Vitamin C needs deserve special mention since it is essential to the formation of connective tissue and vascular systems as well as increasing absorption of iron (Williams 1993). It is worth noting that animal studies have linked lack of riboflavin on the 13th and 14th day of gestation with interference with cartilage formation, resulting in skeletal malformations (Williams 1993).

The teenage pregnant mother deserves special nutritional guidance to be able to cope with the high demands of energy and nutrients of the growing fetus superimposed on her own growth needs. As a result of malnutrition common among pregnant teenage girls, there is high incidence of stillbirths, premature deliveries of infants with low birth weight leading to higher mortality rates of babies, more congenital defects, and inadequate nutrient stores for infants to carry them through the initial period of extrauterine life. In all aspects, the malnourished teen mother is a high obstetric risk especially when the interval between menarche and conception is short (Guthrie 1989; Fraser et al. 1995).

Modification of Diet and Feeding Plan during Pregnancy

Since the mother's diet must supply all the high demands of energy and nutrients, a great burden is placed on her to increase her food intake. A woman who has good food habits and is well nourished when she becomes pregnant needs to alter her diet only by increasing intake of foods she is accustomed to. Obviously, the extra quantity of food needed cannot be incorporated in 3 regular meals. In such a case, nutritious snacks, kept relatively low in satiety value so that appetite is not decreased at regular meals must be included.

The meal plan will therefore follow a plan like this:

- | | |
|-----------------------|-------------------------|
| 1. Breakfast. | 4. Mid-afternoon snack. |
| 2. Mid-morning snack. | 5. Supper |
| 3. Lunch. | |

In essence, two important principles govern the diet of the pregnant woman:

- i. that she eats a sufficient quantity of food including a wide variety of foods and
- ii. that she eats regularly, avoiding any habits of fasting or skipping meals.

We must always remember that specific nutrients, not specific foods are required for a successful pregnancy and these nutrients are found in a wide variety of locally available foods. The LINKAGES Project (2001) has identified the following health sector actions to address nutritional needs of pregnant and lactating women so as to improve maternal nutrition in Africa.

- Adequate food intake. This can be achieved by encouraging women to increase intake during pregnancy and lactation and to counsel them to reduce energy expenditure and rest more.
- Adequate micronutrient intake by counselling mothers to diversify their diets through increased daily consumption of fruits, vegetables, animal products and fortified foods.
- Where food sources are poor or not available, consumption of micronutrient supplements must be encouraged.
- To reduce malaria infection in pregnant women in endemic areas through the use of anti-malarial curative and/or prophylactic drugs and use of insecticide-treated materials.
- Reduction of hookworm infection in pregnant women in endemic areas through preventive measures and use of prescribed drugs.
- Birth spacing of 3 years or longer by promoting optimal breast feeding (2 years or more) and promote family planning as a health and nutrition intervention, and counsel on the need for recuperative period to build energy and micronutrient stores.

Nutrition and Lactation

The responsibility of breast-feeding falls solely on the mother and as such, her dietary needs are high (Table 2) and must be met because adequate nourishment is essential to successful lactation (Sizer and Whitney 1997). A normal developing baby doubles its birth weight in about 5 to 6 months which is evidence of the demands the breast fed infant makes of the mother. Except for folate and iron needs, the energy and nutrient demands exceed those of pregnancy. As such, the diet should always be of good quality to prevent depletion of maternal tissue reserves. The need for the extra energy, protein, minerals and vitamins is to cover the cost of secreting milk, the amounts secreted in the milk, and to protect maternal tissue reserves. There is concern about the impact of lactation on the bone mineral status of the adolescent mother, which can predispose her to low bone density limiting her health throughout the reproductive years. Generally, the effect of nutritional deprivation on the lactating mother is to reduce the quantity, not the quality of the milk (Sizer and Whitney 1997).

Modification of Diet and Feeding Plan during Lactation

Like, the pregnant woman, the extra quantity of food needed to supply the lactating mother's high nutrient requirements cannot be incorporated in 3 regular meals. The same recommended meal pattern for the pregnant woman would be appropriate for the lactating mother too. That is, by including nutritious snacks, ensuring that meals are regular, diversified and of sufficient quantities. The suggestions made by LINKAGES Project (2001) already given under the plan for pregnant women are also applicable to the lactating mother.

An adequate diet during pregnancy is one of the best bases for the initiation of breast-feeding. If the woman has gained weight properly during pregnancy, about 1/3 of the extra needed energy can be met from maternal fat stores over a 100 day period of lactation (Wardlaw et al. 1994). Boyne (1992) points out that breast-feeding allows for gradual loss of extra body fat accumulated

during pregnancy especially if breast-feeding is continued for 6 months or more. This shows how practical the link between pregnancy and breast-feeding is.

Nutrition and the Growing Years

Infancy: 0-24 months

This is a period of very rapid growth during which an adequately nourished child doubles his birth weight by 6 months and triples it by one year. The current recommended approach to infant feeding is to exclusively breast-feed for the first six months before supplementary foods and water are introduced.

The United States National Academy of Sciences confirms that human milk is tailored to meet infant nutritional needs for the first 4 to 6 months of life. Wardlaw et al. (1994) have stressed that human milk allows for adequate hydration of the infant, provided the baby is exclusively breast-fed. This assertion should allay the fears of mothers who do not practice exclusive breast-feeding for fear that their babies will be dehydrated. In Ghana, the rates of exclusive breastfeeding are still low. In 2001, the rates at four months and six months were 35% and 17% respectively. It is however hoped that by the end of 2003, the rates would have increased to 40% and 25% respectively (GHS, 2002). There are many established nutritional, immunologic, physiologic, psychological and practical advantages to breast feeding (Williams 1993). For example, human milk changes to meet the changing nutrient and energy needs of the growing infant; since the mother transfers certain immune properties in her milk to her nursing infant, the child experiences fewer infections. The infant is also not exposed to infectious organisms in the environment that contaminate milk preparations and equipment for bottle feeding, especially as occurs in poor living conditions. Fewer allergies and intolerances occur with breast-feeding compared with using cow's milk which contains a number of allergy-causing proteins that human milk does not have. Human milk is easier to digest, since it forms a softer curd for the infant to digest. Moreover breast milk is convenient and economical, since the milk is always ready and sterile, and the mother is free from the time and expense involved in buying and preparing formula. Furthermore, psychological bonding occurs as mother and child relate to one another during feeding. Breast-feeding must be on demand.

Since breast-milk provides all the essential energy and nutrients in quantities required for optimal growth, there is no nutritional need for introducing solid foods to infants before 4 – 6 months.

The need for introducing solid foods is determined by:

- nutritional needs,
- physiological readiness and
- physical maturity.

By 6 months milk alone will not supply all the nutritional needs to support the actively growing infant. At the same time, the enzymes for digesting complex carbohydrates and protein besides those found in milk will be present. The kidneys would then be mature enough to handle high-protein diets. Physically, the infants jaws would have matured enough, the swallowing technique would have developed and with increase in saliva production, semi-solid foods would be easier to swallow.

It is therefore the right time to introduce gradually semi-solid and solid foods to the baby.

Guide to Introducing Solid Foods

The sequence of introduction of semi-solid and solid foods could be as follows:

1. Introduce fruit juices to supply vitamin C.
2. Introduce the local cereals as porridge, one at a time so that the child will develop

the taste for each of their distinctive flavours. Cereals will contribute energy, iron, riboflavin and niacin.

3. Introduce well-ripe whole fruits, finely mashed at first.
4. Introduce mildly flavoured vegetables, smoothly mashed. The vegetables could be served as stew with softly mashed cereal preparation. This is when some fat or oil could be introduced to provide a concentrated energy source to reduce the bulk of the weaning meal. Fruits and vegetables supply the infant's needs for a variety of vitamins and minerals.
5. Introduce animal products like eggs, meat, poultry, liver and fish to provide protein for the rapid growth demands of the infant. Some infants cannot tolerate egg white to start with so egg yolk must be used and the white introduced as the child approaches 1 year of age. Fish meal comes in very handy where meats are unaffordable.
6. Introduce legumes – alternative rich sources of protein. The seeds must be dehulled to improve digestion and prevent the problem of gas production which causes stomach upsets.
7. Introduce plantain and root crops. These tend to be bulky so when the child grows older nearing 10 to 12 months, he can handle them without over-tasking the capacity of the stomach.

Note:

- Each new food should be introduced in small quantities and gradually increased.
- The texture of food determines the child's attitude to the food being served to him. Therefore, it is important to consider the sequence of textures. Textures should begin with soft sloppy (porridge type) to mashed, minced or finely ground, to chopped.
- Over time, the child is introduced to a wide variety of foods and by 8 to 9 months, he should have attained a fairly good ability to eat family foods: mashed, chopped, or soft cooked foods, mildly seasoned.
- Increase quantity and frequency of complementary feeding while maintaining breast-feeding.
- Usually, a combination of meals and snacks should constitute complementary feeding.

LINKAGES (1999) suggested that complementary foods should be fed to 6 to 8 months old infants 2 – 3 times daily; 9 to 11 months old infants 3 – 4 times daily; and to 12 to 24 months old children 4 – 5 times per day. For good feeding practices during the first two years greatly reduce the risk that a girl will reach maturity stunted and at risk of obstetric complications and the delivery of a low birth weight infant.

Preschool Child (3 – 6 Yrs)

In comparison with the rapid growth rate during the 1st year, the child's growth rate slows down between 3 and 6 years but nutrient requirements are still high. Therefore, food continues to play a significant role in the child's growth and development.

Guide to Feeding the Pre-school Child

Emphasis here is on appropriate texture of meals, which are energy and nutrient dense to supply the child with high protein, enough energy, vitamins and minerals, and provided in quantities that the child can consume to maintain adequate growth. Careful food selection and preparation are essential to ensure that the child receives the right amounts of nutrients. Therefore, a variety of foods must be offered in a loving, caring atmosphere. Nutritious snacks play significant roles during the preschool years to help ensure sufficient food intake since the child's small stomach capacity cannot cope with large amounts of food at a sitting.

Inappropriate feeding practices during the first five years of life lead to malnutrition, often resulting in irreversible damage to physical and mental growth. Severe forms lead to the clinical syndromes of kwashiorkor and marasmus. Childhood malnutrition results in growth failure and

this represents the most prevalent expression of childhood malnutrition in developing countries (West 1991).

Worldwide, 200 million children of preschool age have stunted growth (Brown, 2000). FAO (1996) has also indicated that 199 million children below 5 years in developing countries suffer from chronic protein and energy deficiencies and data compiled by Administrative Committee on Coordination / Subcommittee on Nutrition (ACC/SCN) (1997) showed that 34% of them are stunted. Data on Ghanaian children under age five show that 26% are stunted, an indication that there is chronic malnutrition among young children (GSS and MI, 1999).

The physical, social and economic costs of early childhood malnutrition have far-reaching consequences and must be stopped. Kwashiorkor and marasmus are fatal if left untreated. Malnutrition increases morbidity and undermines the child's health. Torun and Chew (1994) explained that treatment of mild to moderate malnutrition corrects the acute signs, but children's catch-up growth may take a long time or might never be achieved. This results in stunting and a small body size, which may influence maximal adult working capacity and increase obstetric risk in females.

School-Age Child (6 – 11 Years)

The school-age period is marked by slow growth rate but body changes occur gradually. This is the stage during which body reserves are being laid down for the rapid adolescent growth ahead (Williams, 1993). Malnutrition will delay the growth spurt and hence affect sexual maturation.

Although no sexual distinction is made between the nutritional needs of boys and girls at this age, several studies show that boys have higher energy needs than girls and they tend to eat more.

Recommended Feeding and Dietary Needs

- Children must be fed a wide variety of foods including fruits and vegetables in sufficient quantities to meet their nutritional requirements.
 - Nutritious snacks preferably fruits should form part of the daily feeding plan to help meet their food needs.
 - Children must be fed 3 regular meals and 2 snacks.
- Obesity, a form of malnutrition must be checked at this age since it tends to persist into adulthood with its accompanying health problems.

Adolescence (12 – 19 Years)

This period of transition from childhood to adulthood is a relatively short period characterised by dramatic accelerated physical, biochemical, and emotional development. It is a period marked by a rapid enlargement of organs and tissues and sexual maturation (Guthrie 1989; Williams, 1993).

The recommended dietary allowances of this phase have some of the highest nutritive needs for males, and for females, is surpassed only by needs during pregnancy and lactation. Both males and females attain adult stature between 18 and 20 years although bone mass continues to increase until about 25 years. The minerals most likely to be inadequate are calcium, iron and zinc, all of which have a substantially increased need with rapid growth. Because zinc has its most profound influence on rapidly growing tissues, its effect on reproduction is significant. Zinc deficiency during adolescence retards growth and impairs or retards sexual maturation in both males and females. In males, sexual development coincides with the beginning of the growth spurt both of which are influenced by zinc. Zinc deficient males have shown retarded

development of the organ that produces sex cells. In animal studies, severely deficient animals are not able to reproduce (Guthrie, 1989).

Williams (1993) points out that in the adolescent female, the hip breadth increases and the bony pelvis widens in preparation for reproduction. Poor intakes of calcium and other nutrients needed for bone formation will result in a narrow pelvis which may pose an obstetric risk. Iron needs are of particular concern in teenage girls to make up for menstrual losses and prevent iron deficiency anaemia. If the nutritive intake of an adolescent girl has been inadequate before she conceives she is less able to cope with the added stress of pregnancy.

Recommended Feeding and Dietary Needs

- Need increased food intake comprising 3 regular meals and at least 2 nutritious snacks.
- Need for a variety of foods including daily consumption of fruits and vegetables to improve diet quality and micronutrient intake.
- Need vitamin/mineral supplements containing iron, vitamin A, zinc and others if micronutrient requirements cannot be met through available food sources.
- Need to use iodised salt, especially females.

Conclusion

I have so far attempted to demonstrate the effects of adequate nutrition and malnutrition on general and reproductive health throughout the different critical developmental stages in the life cycle. I have emphasised pregnancy and lactation because the nutritional status of women is a major determinant of both maternal and infant health and survival. Since pregnancy is considered a happy phenomenon in almost all societies, the need to ensure a successful course and outcome of pregnancy cannot therefore be an overemphasis.

Under favourable conditions, every child eventually becomes an adult and so for that child to reach adulthood and attain physical health including reproductive capacity, adequate nutrition during the growing years must not be overlooked. To sustain the process which maintains the wholeness of the body structure and function, good nutrition is needed to make the body ready for reproduction and when it takes place in the female.

Sound eating and dietary practices are needed by all throughout the life cycle. Therefore, to achieve adequate nutrition for all, nutrition education needs to be constantly intensified, certain cultural practices which restrict sound eating practices especially for women and children must be eliminated, micronutrient supplementation for pregnant and lactating women is a must, especially among the poor, and women's workload must be reduced.

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FAMILY RESOURCES AND REPRODUCTIVE HEALTH OF GIRLS: A FOCUS ON MONEY AND *TUGBEWOWO*: PUBERTY RITES AMONG THE DODOME EWES

Laetitia A.P. Hevi-Yiboe

Abstract

There has been considerable concern about the reproductive health status of girls in Ghana in recent years due to the increase in premarital sexual activities amongst the youth, socio-economic implications of teenage pregnancy and illegal abortions. The major objective of this paper is to throw some light on how proper use of family resources could help resolve the problem. All families have certain resources such as money, time, energy, skills of members, and some community resources like schools and traditional society's puberty rites. However, most families do not have access to enough money to meet all the needs of all family members. Traditionally, resources are shared without due regard to needs of individual members, but rather using gender and age as yardsticks with the resultant inequalities in access; with men always getting more than their fair share and women and children not getting enough. It is important that parents make every effort to provide the needs of their children especially the girls, so that they do not accept money from men who in turn ask for sexual favours. In traditional societies in the past, specific rites were instituted to safeguard the reproductive health of the members. Examples of these rites were puberty rites. In Dodome, the puberty rite for girls is called *Tugbewowo* but it has been suspended for some years now. As part of these rites, girls are supposed to remain virgins till after the rites are performed. They are taught the arts of womanhood, motherhood etc. and are prepared to take their places as women in society. Modernization has eroded most of these resources that prepared girls to become effective members of society, producing teenage single parents. The rites served as an incentive for mothers to constantly remind their daughters of society's expectations of them and thus they preserved their chastity. That is no longer the case. An exploratory study in Dodome revealed that the majority would like *tugbewowo* to be reintroduced. It is recommended that (1) families be empowered financially to be able to meet needs of members (2) that a detailed study be carried out into *tugbewowo* with the aim of understanding and modernizing the rites for reintroduction in Dodome and the Ho district as a whole. It is concluded that the time has come to seek African solutions to African problems and end the adoption of Western values.

Introduction

There has been considerable concern about the reproductive health of women and girls in Ghana in recent years. This is due mainly to the serious nature of reproductive health problems such as sexually transmitted diseases, unintended pregnancies and complications from childbirth especially of teenage mothers. Ghana like many other developing countries faces serious reproductive health problems and it has been realized that it is only through well coordinated efforts and a willingness to invest huge resources in these efforts that the problems can be solved. (Ashford 1997).

Observations and researches have revealed an alarming increase in pre-marital sex among the youth. It has also been realized that the reproductive health of many women and girls is quite poor. The high incidence of sexual activity amongst unmarried adolescents and young

adults in Ghana is quite widespread, resulting in unintended pregnancies and illegal abortions. (Adjei, Biritwum, Ashitey and Hill 2002)

Teenage pregnancies are on the increase in Dodome and in many rural areas in the Ho District. This is of great concern to parents and extended family. After the Junior Secondary School Examinations, many of the teenage girls have no opportunities for advancement and thus end up pregnant within a year or two. Only a few girls are able to continue to the Senior Secondary School because parents are too poor to send the girls for further education or due to some other reasons. A few of them decide to go and stay in the cities and they invariably learn a trade and postpone sexual activity and therefore pregnancy. The results of the 1998 Ghana Demographic and Health Survey (Ghana Statistical Survey 1999), revealed an increase in the median age at first birth from 20 years in 1993 to 21 years in 1998 on the national level (See Table 1). This is not the case from observations in Dodome. The situation is rather getting out of hand with very young girls getting pregnant these days. Education however has the same effect in Dodome and the Ho District in general as on the national level by compelling the girls to postpone sexual activity and thus pregnancy at an early age (Table 2). It could be said that pursuing further studies or apprenticeship provides girls with a clear objective and something to look forward to, and therefore sexual activity becomes secondary and unnecessary. It is therefore imperative on parents to plan the use of their resources so that provision is made for higher education of the girls to increase their chances of a better life in future.

Table 1 Age at First Birth

Percent distribution of women 15-49 by age at first birth, according to current age, Ghana 1998										
Current age	Women with no births	Age at first birth						Total	Number of women	Median age at first birth
		<15	15-17	18-19	20-21	22-24	25+			
15-19	88.3	0.3	7.2	4.2	NA	NA	NA	100.0	910	a
20-24	39.2	2.0	17.9	20.7	14.8	5.5	NA	100.0	900	a
25-29	17.6	2.6	18.8	19.4	18.9	14.9	7.8	100.0	867	20.9
30-34	6.1	5.2	21.3	23.1	16.9	15.7	11.7	100.0	653	20.0
35-39	3.2	3.4	20.9	20.9	19.4	17.5	13.8	100.0	625	20.4
40-44	1.1	4.5	23.8	22.4	19.4	16.3	12.6	100.0	473	19.9
45-49	2.5	4.0	25.9	22.0	15.5	14.6	15.6	100.0	415	19.8
NA = Not Applicable										
The medians for cohorts 15-19 could not be determined because half of the women had not had a birth before reaching the lowest age 0 the age group.										

Source: Ghana Statistical Survey 1999: 35

Adolescent pregnancies may lead to school drop-out among girls, while the boys responsible are not affected in any way. This may result in shattered dreams, limited career opportunities, increased health risk from complications and several other negative effects for the girls. The general decline in traditional norms and practices that prevented pre-marital pregnancies is a contributing factor to this state of affairs. Research has also revealed that children born to very young mothers are at an increased risk of illness and death (Ghana Statistical Service 1999). The national figure for teenage pregnancies is about 14% for 15 year olds and 32% for 19 years while the situation in Dodome is much worse than that (Table 2).

Table 2 Median age at first birth by background characteristics

Median age at first birth among women 25-49, by current age and selected background characteristics, Ghana 1998						
Background Characteristics	Current age				Women age	
	25-29	30-34	35-39	40-44	45-49	25-29
Residence						
Urban	22.8	20.9	20.7	20.2	20.4	21.0
Rural	20.4	19.6	20.2	19.8	19.6	20.0
Region						
Western	20.2	19.5	19.1	18.7	21.0	19.7
Central	21.2	18.8	20.4	19.7	20.2	20.0
Greater Accra	24.5	21.8	21.1	21.6	20.9	22.0
Volta	20.9	19.9	21.1	20.0	19.3	20.4
Eastern	20.2	20.2	20.6	19.5	18.3	20.0
Ashanti	20.8	19.7	19.6	19.1	19.9	19.9
Brong Ahafo	20.0	19.7	19.7	19.5	18.5	19.6
Northern	20.6	19.9	20.4	20.4	19.6	20.2
Upper West	20.6	21.3	21.4	21.1	21.0	21.2
Upper East	20.4	19.4	20.8	21.5	23.4	20.8
Education						
No education	19.6	19.7	19.8	20.2	19.6	19.7
Primary	20.2	19.6	20.5	20.1	19.4	20.0
Middle/JSS	21.6	19.8	20.2	19.4	19.6	20.3
Secondary+	a	24.6	23.9	23.3	24.2	24.9
Total	20.9	20.0	20.4	19.9	19.8	20.3

Note: The medians for cohorts 15-19 and 20-24 could not be determined because half of the women had not had a birth before reaching the lowest age of the age group.
Medians were calculated for this cohort because less than 50 percent of women in the age group 25-29 in this category had a birth by age 25.

Girls grow up in families and the adolescent girl belongs to a family. It is therefore important that in discussions on reproductive health, attention be paid to the part that the family as a whole must play. Often, the emphasis is on the adolescents without placing them in the context of the family and therefore, the interventions that are implemented address only part of the problem. It is time to start looking at the problem from a holistic point of view with the family as the focal point. It is only then that we can hope to make any meaningful impact.

In every family, it is the responsibility of parents to provide the needs of the children and to guide the development of the members. Families use whatever resources that are available to them to meet the needs of the family and for the development of members. It is important therefore that family members, especially the parents be able to identify all the resources available to them and be able to allocate and use these resources efficiently for effective development of the young ones. Some family resources are money, time, energy, house space and abilities of members. In many homes, money is a limited resource and the general socio-economic conditions in the country make it difficult for many families to satisfy the needs of all members of the family. (Nickell, Rice and Tucker 1976).

Families need to accept this limitation and take sound decisions regarding the use of money so that the basic needs of the adolescent/teenage girls are met. Otherwise, they will fall prey to men who will offer them money and then turn round and demand sexual favours in return. Many unsuspecting young girls are victims of this kind of situation, especially in the big towns and cities. Parents must therefore provide the needs of their wards and must give them enough guidance to protect them against these evil men. The family's money must be used on those members who need it most and not necessarily by mother or father even though they earn the money. The needs of all children are paramount.

In the past our ancestors instituted certain rites and practices that safeguarded the sexual health of the members of the society. These informal institutions known as puberty rites were resources which the families utilized to guide and direct their young ones in order to protect the reproductive health of the members. However, modernization has eroded most of these practices and has exposed young girls to a lot of risk. One such resource was *Tugbewɔwɔ* in Dodome. This has been suspended and there is an urgent need to revive it for the benefit of the whole society because, as noted by Adjei, Biritwum et al. (2002), the high incidence of sexual activity amongst unmarried adolescents and young adults in Ghana can be attributed largely to a general decline in traditional norms that prevented premarital pregnancies and partly to development and westernization. This paper therefore discusses *Tugbewɔwɔ*, the puberty rites of the people of Dodome with the view that something could be done to revive it and similar practices all over Ghana to contribute to the creation of a healthier society. Government must be willing to invest resources in this endeavor for the benefit of future generations.

Puberty rites mark the transition of girls into women and are a normal life event for most traditional societies. These ceremonies, marking this important stage in the life of an individual are sacred and very important indeed. They come with many social and spiritual obligations and roles (Gaibole 2002). Their main purpose is to instruct the young girl, in her new adult responsibilities, to confer on her, adult privileges and to celebrate the occasion with festivities. In many societies, puberty rites for girls are more common and different from those for boys, but in most Ghanaian societies they are for girls only. There are usually three to four elements involved in puberty rites and these are (1) Separation from the larger societies (2) Preparation and instruction by the elders (3) A transition phase (4) A welcoming or acceptance phase marked by celebrations (Elam 1998).

Puberty rites for girls have survived in several societies around the world in spite of the so-called modernization of the world. Even in societies where Christianity has taken roots, puberty rites still serve a purpose. A few examples are:-

- 1) The Tupinamtu girls puberty rites of the Tupinamba and the Urubu-Kaapor people, both of Brazil, have survived the years in spite of modernization and the influence of the Portuguese. Many aspects of the rites have changed or have been modified but the rites still teach the young woman the skills needed for housekeeping and other responsibilities of a woman (Kakumasu 2002).
- 2) The *Iria* of the Okrika tribe of the River State of Southern Nigeria which is performed when the girl reaches a mature age, about 17 years (Elam 1998).
- 3) The *Na'ii'ees* – The Sunrise Dance is the puberty ceremony of the traditional Western Apache which occurs soon after a girl has gone through menarche. She is initiated alone (Elam, 1998)
- 4) The *Dipo* of the Krobo ethnic group of Ghana and
- 5) The *Bragorɔ* of the Ashantis also of Ghana. (Osei-Adu, 2002).

Hopefully, *Tugbewɔwɔ* of the Dodome Ewes can be added to this list in the near future.

In the past, there were various types of puberty rites or “rites of passage” which marked the transition of girls and boys into women and men in different parts of Ghana. These rites varied slightly from one ethnic group to another and from one region to the other, but they had the same objectives: to transfer the status of woman and man to the hitherto little girl and boy and to protect their sexuality. Further, there were rules and regulations, sometimes taboos, regarding these rites. For example, in Dodome, before a girl child went through these rites known as *tugbewɔwɔ*, she must not have had sexual intercourse with any man. If a girl went contrary to this, there were sanctions. The nature of the sanctions was such that majority of girls would want to have nothing to do with them. Therefore they “took very good care of themselves”. Unfortunately, many ethnic groups in Ghana today, do not pay much attention to these puberty rites.

The main objectives of this paper therefore are (1) to bring out the relevance of *tugbewɔwɔ* to our modern society (2) to show that it can contribute tremendously to a sound enviable reproductive health status in women and (3) to make a case for it’s reintroduction in Dodome in particular and the whole of the Ho district in general. Dodome traditional area is in the Ho district, of the Volta Region.

***Tugbewɔwɔ*: the Process**

Tugbewɔwɔ is the name of the rites that initiated teenage girls into womanhood in Dodome and indeed the entire Ho district in the past. Many communities stopped the practice decades ago but it was continued in Dodome until the early nineteen eighties. Nobody is able to state precise reasons for the present state of affairs and the elders say that the practice it has not been stopped but, only suspended. But for how long and why? Nobody has the answers to these questions.

Like puberty rites all over the world, *tugbewɔwɔ* involves at least three of the four elements usually mentioned in relation to puberty rites as (1) Preparation and instruction by older members of the family (2) A transition phase and (3) A welcoming phase where the initiated is now accepted as a woman. There is however, no clear-cut separation from society during *tugbewɔwɔ* in Dodome (Elam 1998).

The word *Tugbewɔwɔ* literally means the “Celebration of Beauty”. Indeed at the age of puberty, girls are at the climax of their beauty and those who comport themselves well and live morally upright lives really deserve a celebration of this beauty and their transition into womanhood. The whole village joins in the celebration – one old lady compares it with the certificate that those who study hard at the Junior Secondary School get after their Basic Education Certificate Examinations. “Those who work hard get distinction: *Tugbewɔwɔ* is the distinction for a girl who has comported herself well and has reached the stage where the whole community proclaims her a woman; no more a small girl” and she is accepted into the women’s fold.

Tugbewɔwɔ is a word that reminded every mother of a female child or children that she had an important obligation towards society and warned every young girl that she needed to stay “far away” from a man’s bed until the time was right and she had gone through these rites. It was a rite that both mother and adolescent girl looked forward to with mixed emotions of joy, anxiety and a little fear on the part of the mother. There is fear on the part of the mother because if her daughter should disappoint her, if she should have an affair with any man and get pregnant, then she would bring a lot of shame and disgrace to the family and dishonour to herself. Then all her cautions, advice, teachings and toils would have been in vain. It was a word that helped every girl from Dodome become strong and able to fight all the advances of the men. The author herself went through it and testifies to its effectiveness.

At the onset of the initiation rites, the girl is given lessons on womanhood, motherhood, and how to be a good wife and mother. As soon as a girl is old enough to understand the concept, which is from about age seven years, she is given little doses of information at the appropriate time about *tugbewɔwɔ*, so that by age nine, a girl is fully aware of these rites and knows the expectations of society of her. She must remain a virgin till it is done and therefore she must comport herself well and behave as a good and decent girl. The mother seized whatever opportunities that came her way to talk to her about the importance of keeping away from men. Sometimes, the mother and father would call the young girl at dawn, and tell her all about *tugbewɔwɔ* and the shame and disgrace that would come on her and the whole family if she should get pregnant before it is done. As soon as the breasts begin to enlarge, the aunts and grandmothers seize every opportunity to tell her about the need to keep herself away from men. They say, for example, “young girl, very soon you will have your period and you will become a woman. Be informed that in this family (extended family), nobody has ever become pregnant before the initiation rites, and make sure you are not the first. We do not want any shame and disgrace, not to talk of the humiliation you will subject yourself to”, etc. etc. The burden on the girl is also quite heavy but it helps the girl to “take good care” of herself.

Indeed, these puberty rites used to be performed for young girls in all the traditional areas of the Ho District and beyond. However, for many years the practice was allowed to die out in many areas. It was only in Dodome that this practice continued until the early nineteen eighties when a supposed misunderstanding between some elderly women and elders of the Dodome traditional area, resulted in its suspension up to date. Since then, the lives of many promising girls have been sacrificed on the altar of men who use their authority to have premarital sex with the girls. This is because, the girls at the moment have no weapons to fight with. In the past, the clause, *Wome wɔ tugbe nam o* which means, “I have not gone through the *tugbewɔwɔ* rites yet” was enough to cool the most aggressive seducer! Why should we take this effective tool away from the girl child?

During the rites, the mother presented the girl with presents such as clothing, beads, gold jewellery, cooking utensils and other items that will enable the girl to start life as a woman. The father was not obliged to give anything in particular, so he could give whatever he wanted. This was usually new clothes and money. The father also provided the drinks needed for the occasion. All the women from the whole family; the extended family, gave gifts that may range from beads, scarves to household equipment. All adults in the village are expected to present gifts and this was usually in the form of money.

Many people believe that, like many other traditional practices, the cares of today’s world with its difficult socio-economic conditions and poverty are to blame for the neglect of *tugbewɔwɔ*. After all, the gains of *tugbewɔwɔ* are not immediately visible. Meanwhile, “man” must eat and survive. Secondly, some believe that the so called Christians who condemned everything Ghanaian have succeeded in creating confusion in the minds of the people, so that they are not sure whether it is right or wrong to be part of many indigenous ceremonies including *tugbewɔwɔ*. If this second argument is true, or even partially true, then there is a need to help the people distinguish between good and bad traditional practices. We have many rich and useful traditional practices in Ghana and efforts must be made to modernize and preserve the beneficial ones, while the destructive ones are discarded.

Tugbewɔwɔ is definitely one of the few positive traditional practices which must be studied carefully, modified to suit modern situations and promoted, so that it will come alive again and protect young girls. When it is re-introduced, life in the rural areas in particular will improve and it will help preserve the chastity of young girls and protect them from teenage pregnancy, unwanted babies, risk of contracting HIV/AIDS and becoming mothers when they are still children themselves and not ready for motherhood.

Objectives of *Tugbewawo*

The major objective of *Tugbewawo* is to initiate girls into womanhood and to confer on girls all the advantages and responsibilities of being a woman. After this initiation, the individual is able to join women at gatherings and is expected to sit with the women and no more with the children at all functions. The way she dresses is changed completely from, for example, wearing a single cloth to wearing a double one and she must cover her head always. She is also ready for marriage and a prospective suitor can set in motion the steps and processes that would make her his wife.

An important aspect of *tugbewawo* is the lessons that the young girls are given in the art of being a woman, a wife and a mother. All her obligations and responsibilities to herself, her family and society are explained to her and she is taught personal hygiene including how to keep herself when she is in her menstrual period.

Advantages of *Tugbewawo*

The advantages of *tugbewawo* are numerous and some are discussed here.

- There were lessons on personal hygiene, housekeeping and how to be a good hostess.
- The girls enjoyed a lot of praises and kind words from the elderly women during the initiation rites and since there are not many occasions for this, it boosted the girls' image and gave her courage to face the unknown world.
- The expectations of *tugbewawo* gave the girl enough incentives to be determined to wait till marriage or at least after *tugbewawo* to indulge in sexual intercourse. Therefore, the incidence of teenage pregnancies was extremely low. Almost all girls got married first before they got pregnant.
- All pregnant women had husbands who were responsible for and took care of them and the children. There were no neglected mother and child as we see today.
- The problem of single-parenting and its attendant sufferings was not a burden on society. The rare occurrences were absorbed into their own families. However, the economic problems of today coupled with the numbers have made this impossible.
- Gifts bestowed in the girl by the parents and members of society prepare her financially for marriage.

By the time a girl has gone through these rites, she is ready both psychologically, physically, socially and financially to start her own home.

But today what do we see? Young girls who have not had any training whatsoever in womanhood, forcing themselves to become women by becoming pregnant. Most of these girls engage in sexual relationships without realizing the consequences and when they get pregnant, many are desperate. It seems many girls are unaware of the fact that even your first sexual encounter can result in pregnancy and thus become very miserable after "just once". Many of these girls themselves children, become single mothers and start life with suffering and pain and many never really get out of the suffering. Many otherwise brilliant and gifted girls just waste away in the village due to what can be termed "neglect of the older generation."

It seems that because the sanctions that go with *tugbewawo* are no more being enforced, many mothers do not see the need to inculcate the virtues of morality into their daughters. Many mothers I spoke to blame the present day children, who would not listen to advice and direction. So if *tugbewawo* is enforced again, it will compel mothers and aunties and

grandmothers to find time to inculcate good moral values into the young girls before they are polluted by society. Family life education or sex education in the schools does not seem to adequately replace the role these rites and their attendant expectations played in the lives of the people.

Another important advantage of *tugbewawaw* is its influence on men's behaviour towards young girls. Any man who had sex with a girl who had not yet gone through these rites, was considered cruel, heartless and not "quite correct". From generation to generation, he is pointed out to growing children as someone who was capable of doing things that could hurt children, therefore must be avoided. The act therefore attracted a stigma that majority of men did not want. So it helped to discipline the men also and acted as a positive double edged sword, cautioning both the young girls and the men. At the moment, however, young girls are "free for all" and men have nothing to lose. So they use them anyhow and the girls become pregnant at an age when they are still children and some have not even understood what menstruation is all about.

Disadvantages of *Tugbewawaw*

Like all human institutions, *tugbewawaw* also has its disadvantages. Four very obvious ones are discussed here, two of which are consequences of pregnancy before *tugbewawaw* and two are disadvantages for mothers with teenage girls.

Consequences of Pregnancy without *Tugbewawaw*

1. The stigma attached to such a girl for life.
2. The fine imposed on the mother

The stigma: If a girl got pregnant before these rites, she was referred to as becoming pregnant while naked (*efw amafui*). Little girls usually go about scantily dressed but during the rites, she was taught how to dress properly as a woman. Therefore she who had not gone through the rites was 'naked'. This term, *amafui* separated her from the other women in the village for the rest of her life. What is more, the stigma is transferred to her children also and that first born's life was governed by all kinds of taboos, especially if the child is a boy.

The Fine: Another consequence of getting pregnant before *tugbewawaw* was that a fine was imposed on a mother whose daughter got pregnant before the rites were performed for her. This fine amounted to quite a large sum of money. The assumption it seems was that such a mother had not done a good enough job of bringing up the daughter. This condemnation of mothers who have worked really hard at training their children is rather discouraging and humiliating. After all, mothers can only talk to and explain values to their daughters but could not follow them around and control their actions. This must change to something more positive.

Disadvantages of *Tugbewawaw* for mothers of teenage girls

1. The anxiety that mothers with teenage daughters go through and
2. The financial costs involved, especially the financial burden on the mother.

Anxiety: Mothers with daughters who had reached or were approaching puberty experienced much anxiety and were under immense pressure. They directed most of their attention to preparations toward the girls' *tugbewawaw* for several years. She spent a lot of time and energy on activities that would enable her to get money such as making *dzomi* and preparing *gari* or the local soap for sale. Every penny must be put away in order to be able to organize the activities, and buy the appropriate gifts for the daughter. It is said that the quality and quantity of gifts the mother gave to a daughter indicated her love and affection for

her and more importantly suggested to the world how proud she was of her. So mothers had to work hard and save money over a long period of time while fathers played almost no part at all, giving whatever he feels like to the girl. These must change so that the responsibility would be equally shared by mothers and fathers as far as the financial aspects go. The anxiety is over enough money, the girls' ability to resist temptation, the degree to which she would do what her mother told her and not what an irresponsible man would say. How can all these be reduced? Presently, with the rites suspended, mothers have no pressures on them and as a result have relaxed to the extent that some are neglecting their duties and are not giving proper training to their children. Everything is blamed on modern society as if modern society has decreed that all children must be left to grow up like wild weeds; without any control. Many young girls are at a loss as to what to do; all in the name of modern society. Therefore, some children pick up unacceptable practices and information from their peers instead of the right and acceptable behaviours from their parents. Can the children, today's children be blamed for the situations they find themselves in? No! not completely. It is true that modern society presents several challenges to both parents and children alike. Children are exposed to information from sources that their parents had never known in the form of news papers, books, T.V. programmes, radio and as though that were not enough, the internet which provides information on virtually anything, some good but some not helpful for children. Unfortunately, many children have access to the internet while their parents do not.

Therefore it is true that bringing up today's children is a more challenging task than in the past. However, the responsibility still lies on parents, especially mothers to train their young ones. If the training starts at the right time, the young ones can grow up and face the challenges of modern society. If parents wait till children have acquired bad habits and behaviours from outside and then try to change them, it is very difficult, if not impossible. So timing is very important in training children and they must be shown much love and given attention so that they realize that their parents want the best for them.

Attitude to Reintroduction of *Tugbewɔwɔ*

An exploratory study to find out the attitudes of the people towards the revival of *tugbewɔwɔ* revealed an overwhelming support for its revival or re-introduction.

Forty women and fifteen older men were interviewed on their attitudes towards the fact that *Tugbewɔwɔ* has been suspended for several years and whether it should be revived or not. All the men indicated that the matter was entirely over to the women because *tugbewɔwɔ* is women's responsibility. It was clear that the men are not ready to assume a role that was traditionally a woman's role. However, all of them commented on the high incidence of unwanted pregnancies and unmarried pregnant girls, and blamed them on the freedom that has resulted since *tugbewɔwɔ* was suspended. They felt things would be corrected if the rites are revived but all the men did not seem to realize that this was as much their responsibility as that of the women. This must change; the men must get involved

Fortunately, the attitude of those women interviewed, who knew the value of *tugbewɔwɔ* was one of concern and great desire for reintroduction of the rites. The responses are presented in Table 3.

Table 3: Women's Attitudes toward the Revival of *Tugbewaw* in Dodome

Age of Women	Total No.	Should <i>Tugbewaw</i> be revived?					Comments
		Yes	No	Undecided			
Elderly 60 – 80	10	10	100%	-	0%	-	The moral decay is too much and girls are being destroyed
40 – 59	10	8	80%	2	20%	-	Those who said no said there is no money for the rites but they are good for the girls
30 – 39	10	6	60%	4	40%	-	Those who said No indicated that they did not understand the whole concept of <i>Tugbewaw</i> .
Under Thirty	10	4	40%	2	20%	4 = 40%	All displayed a limited knowledge and understanding of the rites of <i>tugbewaw</i> and thus do not know its importance
Grand Total	40	28	70%	8	20%	4 = 10%	

Source: Field work

The initial plan was to interview as many men as women but after a while it was considered a waste of time because all the men said the same thing – it is up to the women. It is the women who go through it so they must decide. When the men were asked if they felt the effect of the suspension, they said yes but six of them added, that the same problem is everywhere. However, nine men said they were concerned greatly about the increasing number of unmarried teenagers who become pregnant these days. They felt the women must do something about it to get *tugbewaw* back on track. Just as many household problems in our culture, the men felt they do not have to get involved; the women must sort it all out. The time however, has come for our men to get involved more actively in the training and shaping of the character of the young ones.

The very old women are all quite unhappy about the situation and would want the rites revived. Some complained that the men are not doing enough for the welfare of women and girls. Eight out of ten women (80%) between the ages of 40 – 59 years wanted the rites reintroduced while two (20%) said no because, as they said, they had teenage daughters but had no money to finance the *tugbewaw* rites. So even though they saw a need for it, it should be left alone so that they the poor would be free. But is it really freedom when the girls are wasting away and not getting ahead in life? It is suggested that the financial aspects of the *tugbewaw* be reviewed so as to reduce the pressure on the mothers.

The younger the women the more likely they were to say no to *tugbewaw*. Most of the younger women admitted they have not really understood the concept and thus did not care whether it was discontinued or reintroduced. This is because since its suspension, mothers have not been making much reference to it to their daughters as before, so many young women do not understand its meaning and benefits.

All the women aged forty and above were either married or divorced, while five were widowed. However, most of those aged 39 years and below were either living with their parents or living with a man who is the father of their child/children but who has not married them properly according to the laid down customary marriage rites of the people. This is of great concern to many parents of girls and is mainly a result of the breakdown of morality among girls which in turn could be blamed on the absence of the puberty rites.

In order to improve the reproductive health of young girls and women in Dodome, *tugbewɔwɔ* must be reintroduced so that the family life education (FLE) aspect could help the girls develop a healthy attitude to womanhood, motherhood marriage and family life as a whole. If this is not done, it will not be long before HIV/AIDS will have its grip on many young girls and their babies. And this will be very sad indeed!

Conclusion

In conclusion, it can be said that *Tugbewɔwɔ* is a positive traditional practice with numerous advantages which far outweigh the disadvantages and which must therefore be reintroduced in Dodome with modifications. It is also clear that the main reason many women are not pushing for its reintroduction is the costs involved. It is as though each woman is wishing that her child would outgrow *tugbewɔwɔ* before it is reintroduced. The women do not seem to realize that sometimes the cost of avoiding these costs are much higher. For example, what can be more expensive than a young teenage girl's unwanted pregnancy with all the risks involved. The increased teenage pregnancies often result in difficult and life threatening labours, malnutrition of both mother and child and poor mental and physical health of these "baby mothers". Some hardly have any clothes to wear and others curse themselves daily, but it is too late!! What about the shattered dreams of these girls?

It is therefore up to the older generation to reintroduce *tugbewɔwɔ* to save the situation and to protect the innocent and ignorant young girls. Clearly, *tugbewɔwɔ* is a resource which could be available to all the families of Dodome; to women and the family as a whole to train young girls in order to reduce the incidence of serious reproductive health problems among the youth. Like all resources, it is of no benefit if it is not used appropriately.

Recommendations

It is recommended that a more detailed study be carried out on *tugbewɔwɔ* for a thorough understanding of the various rites involved, their significance and usefulness. Then these rites could be modified to suit modern circumstances. The modifications must focus on drastic cost reduction among other things.

It is also recommended that all girls of the same age could be initiated at the same time so that it becomes a once a year affair in each village instead, of each mother doing it when she pleases. This could lead to less cost per family. It could also attract those living outside to come home for the rites. It could become a tourist attraction when packaged for that purpose. In order to generate and maintain interest in *tugbewɔwɔ*, girls that go through it can form year groups or clubs which can come together from time to time to help one another and for general development of women in the area.

Finally, it is recommended that a workshop be organized to study and discuss the issues with the elders, the elderly women, the young women and to come out with the modalities for the modernized version of *Tugbewɔwɔ*.

In order to improve the reproductive health of the young, especially young girls, it is important to recognize the important role of the family in this regard. If children start well in

life, if they are properly trained and cared for, with all basic needs provided by their own families, there will be great improvements in this direction. However, the family income of many Ghanaian families is woefully below what is needed to meet the basic needs of family members. Therefore, children look elsewhere to satisfy their needs with the girls becoming pray for men and the boys taking to the streets for armed robbery. Families must be financially empowered by one programme or another so that they can play their roles properly. This needs to happen in the near future to avoid total disaster amongst the youth.

Posterity will not forgive us, if through our negligence and indifference we lose all the traditional practices that make us Ghanaian and rather prefer to grope in the dark! Indeed, generations unborn will not take kindly to the lukewarm attitude of the present generation to the rate at which our culture is being consumed by Western values and ideologies, because sooner or later, these foreign values will not provide the solutions to the realities on the ground. We need to push some Ghanaian solutions for this modern age problems because the western ideas fit situations that are different from the situations in Ghana.

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BOOK REVIEW

SAMUEL AGYEI MENSAH and JOHN B. CASTERLINE, Editors, *Reproduction and Social Context in Sub Saharan Africa: a Collection of Micro-demographic Studies*. Contributions in Afro-American and African Studies No. 206. Westport, Connecticut and London: Greenwood Press (2003). Pp. 206. ISBN 0-313-31908-1

This volume contains eight chapters of localized contextual studies which use both qualitative and quantitative methods and investigate a number of topics in more depth than is possible with standard demographic survey approaches. They aim to demonstrate how such a micro-in depth approach can deepen our knowledge of reproductive behaviour and reproductive change in Sub Saharan Africa.

Seven countries are included in the various studies, which cover topics ranging from social identity and minority group influences to adolescent fertility, reproductive decision making and the impact of development programs, social organization and birth timing on fertility change. The authors of the chapters come from all over Africa and elsewhere. They include several disciplinary approaches – anthropology, demography, economics, geography, sociology and public health.

The editors drew the collection together with the express purpose of trying to rectify imbalances and omissions of previous survey work. In particular, they wanted to bring together a collection of localized studies that would complement national surveys. They eschewed a purely ethnographic or anthropological approach and tried to show the diversity of the region by including studies from different sub regions. They also tried to represent different stages of Africa's fertility transition. At the same time, the collection is admittedly eclectic and does not purport to be comprehensive or representative.

All the essays are original contributions. The volume is introduced by the editors and concluded by Jack and Pat Caldwell, who attempt to situate the reproductive stability and change in the region during the past two decades within the context of an overview of the global fertility transition. As they emphasize, the studies in this collection are of great value as they put flesh on the DHS's statistical proof that fertility decline is underway, and show how and why the mechanisms operate to postpone or forego births. Moreover, they show at the individual and state level the reactions to new circumstances.

This is a valuable collection of essays which needs to be made readily available to students of population studies in the region, and the authors are to be commended for their effort in producing such a useful text.

Christine Oppong

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