The influence of social connectedness and monitoring on adolescent sexual activity in Ghana

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Abstract
This paper examines the connectedness of unmarried adolescents to parents, friends and key social institutions. The focus is on the role these groups play with respect to information, communication and monitoring about sexual and reproductive health as well as the association of parental monitoring and communication with sexual activity and condom use. We draw on 2004 nationally-representative survey data from 12-19 year olds and qualitative evidence from focus group discussions and in-depth interviews with adolescents in 2003. The qualitative data show clear gender differences in communication: daughters get messages about avoiding pregnancy while sons are told only to "be careful." While fathers tend to be autocratic, mothers are considered to be sympathetic but not very helpful with information about sexual issues. Other adults, such as grandparents, are viewed as being very helpful about sex-related matters. Multivariate analyses of the survey data show a negative relationship between parental monitoring and recent sexual activity for both males and females and that the higher the level of monitoring, the lower the likelihood of recent sexual activity. Parental communication with adolescents about sex-related matters was not associated with sexual activity for males but had a positive association for female adolescents. Once adolescents are already sexually-active, parental monitoring and communication have little bearing on the use of condoms (one of the most common methods used by adolescents).

Introduction

Positive parent-child communication is considered a stabilizing factor for young adults. As the first agents of socialization in the lives of young people, parents provide the focus for the development of self. Conceptually, the home provides the initial focal point for social support, acquisition of knowledge, networking and an enabling environment with positive reinforcement for development (Clark 1994; Olson and DeFrain 2000; Nukunya 2004). Socialization, which involves the passing on of the received knowledge, values and mores of the older generation to the next one, provides the framework for developing trust in and connectedness to others. With changing socio-economic conditions, other agents such as peers, religious as well as secular organizations and the media have emerged as major sources of inter-personal communication for young people. Some of these agents are competing with parents and other family members as primary sources of information on sexual and reproductive health as well as bonding.

Due to the generalized epidemic of HIV/AIDS, various forms of communication have been adopted to provide information and support on sexual and reproductive health to young people. One focus of HIV and pregnancy prevention programmes and funding is to encourage parent-child communication about sex with the expectation that more "open" communication between parents and children will lead to lower levels of risk-taking among their children. Among the major sources of HIV and pregnancy prevention information sources are the print and electronic media, group and inter-personal communication.

The aim of this paper is to examine the connectedness of male and female adolescents (ages 12-19) to these primary social groups of parents, other family relations and friends; the role these groups play in adolescents' lives with respect to information and communication about sexual and reproductive health and monitoring of adolescents' activities; and the association of parental monitoring and communication with adolescents' sexual activity and condom use. We draw on 2004 nationally-representative survey data from 12-19 year olds and qualitative evidence from focus group discussions and in-depth interviews with adolescents in 2003.

Background

According to the 2000 Census of Population and Housing, young people in Ghana aged 10-19 years accounted for 22% of the total population of 18.9 million. The proportions aged 10-19 for males and females were 23% and 21%, respectively. Within the ten administrative regions, the proportion varied from 20% in the Northern Region, one of the study areas, to 23% in the Brong Ahafo Region. Recognizing the implications of such a large proportion of young people in the total population, the Government came out with an Adolescent Reproductive Health Policy in 2000.

Ghana is ethnically heterogeneous and includes the matrilineal Akan (49%), and the patrilineal Ga-Dangme (8%), Ewe (13%), Mole-Dagbani (17%) and other groups. Household structure is such that it consists of a range of related and non-related members, with children (37%) and other relatives (22%) accounting for 59% of household members (Ghana Statistical Service 2002). As observed by Nukunya (2004),

"(I)n many societies [in Ghana], even after marriage, the bride can remain with her parents until the first two or three children are born" (p. 53).

In this paper, parent-child interaction is conceptualized to operate at two levels – communication and monitoring. Communication involves all forms of discussion ranging from asking of questions to sessions on issues associated with sexual and reproductive health. Monitoring, which covers issues such as the friends and play mates of children and where children are likely to be at a point in time, has become important as a result of changing patterns of socialization. Although parents, especially fathers, are expected to be responsible for the monitoring of children, the complex household structure in Ghana means that biological parents will not necessarily be the ones responsible for communication and monitoring of children on a wide range of issues, including sexual and reproductive health. Parents and the other family members were involved in the monitoring of young people, especially females, because they were expected to ensure chastity before marriage. Girls who became pregnant before rites of passage were ostracized and this cast a slur not only on the image of the girl but also the corporate clan (Nukunya 1969; Sarpong 1977). However, the home is no longer the main arena for socialization for some children. The school, religious and secular organizations (e.g., Boys Scout, Girls' Guide) and the media have all emerged as agents of socialization (Nukunya 2004).

Although there are a number of different ethnic groups in Ghana, they seem to have similar philosophy on the socialization of children. Among all the ethnic groups, community leaders constituted a second tier of members, after parents and other family members, for monitoring the behaviour of young people. As custodians of tradition, they were responsible for initiation ceremonies. A third tier was play/age mates, who often compensated for inadequate parent-child contact (Lura 1985; Mandela 1994). All these three tiers of communication and monitoring are undergoing changes due to the influences of education, urbanization and migration (Nukunya 2004). It is the current roles that these different groups play in young peoples' lives that this paper explores.

A number of studies in Ghana and other sub-Saharan African countries have shown that parent-child communication about sex-related matters is relatively uncommon, and is fraught with discomfort, especially communication with fathers (Ampofo 2001; Amuyunzu-Nyamongo et al. 2005; Kiragu et al. 1996; Tweedie and Witte 2000). Evidence from Ghana on the relationship between family communication about sex and the sexual behaviour of adolescents is decidedly weak. One study of 1998 nationally-representative survey data from Ghana of 12-24 year olds found that communication with family members about avoiding sex was negatively associated with ever having had sex for unmarried males but had no effect for unmarried females (Mehryar et al. 2003). Communication with family members about contraceptive methods was positively associated with ever having had sex for both unmarried females and males, a finding which runs counter to the expectation that more open communication makes for lower levels of sexual behaviour and yet also begs the question of which came first, having sex or talking about contraceptives. There were no associations between family communication about sex or contraceptives with number of lifetime partners or having multiple, recent sex partners and no consistent effects of family communication on condom use at first or last sex among unmarried females and males (Mehryar et al. 2003).

Other research, much of it focused on adolescents in low income communities in the United States, also suggests that parental communication has little bearing on adolescent sexual or contraceptive behaviour, and instead it is parental monitoring—such as knowing where your children are at night or knowing who your children's friends are—that is negatively associated with adolescent risk behaviours (such as premarital sexual intercourse or substance use). One prospective cohort study of 14-19 year old African American adolescents examined acquisition of sexually-transmitted infections (STIs) and found that high levels of parental supervision were associated with reduced incidence of gonorrhea and chlamydia (after adjusting for age and baseline infection), yet there was no association between parental communication and reduced incidence of these STIs (Bettinger et al. 2004). Two studies of adolescents in low-income neighborhoods in the United States also found negative associations between parental monitoring and STIs (DiClemete et al. 2001) and sexual risk behaviours (such as not using a condom at last sex or having multiple sexual partners) (DiClemete et al. 2001; Li, Feigelman and Stanton 2000). While another study in the United States based on a national sample of middle school students showed that parenting involvement and decision-making in their children's lives had different effects on sexual initiation depending on how economically advantaged the neighborhood was (Roche et al. 2005).

There is some evidence that parental monitoring holds the same negative relationship with adolescent risk behaviours in sub-Saharan African countries. One proxy measure for parental influence is simply whether a mother and/or father live with their children in the same household. One survey-based study in a slum in Nairobi, Kenya showed that when the father lived in the household, his never-married 12-19 year old daughters were much less likely to have ever had sex, to have had an unwanted pregnancy or to have been recently sexually-active than when neither parent or only the mother lived in the household (Ngom, Magadi and Owuor 2003). Studies that test the relationship of both family communication and monitoring with adolescent sexual behaviour in Ghana or other sub-Saharan African countries are virtually non-existent. Thus, the evidence discussed in this paper will help programmatic efforts in Ghana and other countries most effectively involve parents in efforts to help young people avoid HIV, STIs and unwanted pregnancy.

Data sources and methods

The data for this study are part of a four-country project in sub-Saharan Africa called *Protecting the Next Generation*, in collaboration with the Alan Guttmacher Institute (AGI) of the United States. The project seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, healthcare providers and the media, in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people.

This paper draws from three recent and distinct sources of data on adolescents in Ghana: Focus group discussions (FGDs) with 14-19 year olds, in-depth interviews with 12-19 year olds, and a nationally-representative survey of 12-19 year olds. A total of 16 focus group discussions were conducted in 2003. Young people were selected from both

urban and rural areas, representing a mixture of male and female and in-school and out-of-school adolescents. Discussions were conducted with homogenous groups of adolescents, segregated by sex, urban/rural residence, and school status (in or out-of-school). Overall, each FGD had between 8 and 12 participants and discussions lasted an average of 2-2 ½ hours. The discussions were tape-recorded, transcribed and translated from local languages into English.

In 2003 102 in-depth interviews (IDIs) were also conducted among 12-19 year old males and females. The IDIs were designed to have an equal number of urban and rural residents, males and females, in-school and out-of school individuals, and adolescents with a child—either as married or unmarried. Special populations who were considered to be at higher risk of exposure to HIV/STI and pregnancy were targeted for interview. These were street children, boys in a bostal[1] institution, refugees and girls who have run away from home and were in shelters and on the street. An in-depth interview methodology was used to explore why some young people are at possible risk of HIV, other STIs or unwanted pregnancy while others are not in ways that are not likely to be captured in structured survey interviews.

The IDIs and FGDs were conducted in three regions of the country – the Greater Accra Region, the Ashanti and the Northern regions. The Greater Accra region, where the national capital is located, is ethnically heterogeneous. Although the region is ethnically a Ga area, the group accounted for 30% of the region's population while the Akan constituted 40%. The second region, Ashanti, is a predominantly Akan area and they accounted for 52% of the population in the region. The capital of the Ashanti Region, Kumasi, is the second largest city in the country and is centrally located and a nodal point for all north-south traffic in the country. The third region, Northern, is one the least urbanized regions, 27% compared to the national average of 44%, and one of the least developed. Ethnically, it is dominated by the Mole-Dagbani (52%) (Ghana Statistical Service 2002). In 1999 nearly 70% of the population in the Northern Region was classified as poor while the proportion for the Greater Accra Region was 5% and 28% in the Ashanti Region (Ghana Statistical Service 2000).

The qualitative data (transcripts) were coded using a coding scheme developed by the research team and coding was conducted with N6 qualitative software. Text searches on relevant topic areas were read and study authors prepared summary matrices of the substantive themes on the topic area by gender of the study participants. Summary text was then written based on common themes arising from the matrices.

The third source of data we drawn on is a nationally-representative, household-based survey of 12-19 years olds in early 2004. Interviews lasted about 45 minutes and the survey sample included 4,410 adolescents. The survey questionnaires were translated (and back-translated) into major local languages and pre-tested. Informed consent was obtained for all adolescents and consent was also obtained from parents or guardians for unmarried adolescents aged 12-17 years.

Communication measures are based on four separate questions in the survey: 1) the types of people who talked to the adolescent about sex-related matters; 2) who adolescents got information from about contraceptive methods; 3) who adolescents got information from about HIV/AIDS; and 4) who adolescents got information from about sexually-transmitted infections apart from HIV. The phrase "sex-related matters" was a

[1] This is a special home for children under 18 years of age who have committed offences.

phrase purposefully kept vague because prior questions had been about specific areas of reproductive health, and there was need for an additional measure about general issues of an intimate nature. That question was preceded by a statement that the questions were going to be about people who may have talked to the respondent about personal things. All four questions were open-ended—response categories were not read out to the respondent.

Information about monitoring was from three questions about how much adolescents thought their parents or guardians knew about 1) where the respondent goes out at night, 2) what the respondent does with free time and 3) who the respondent's friends are. An index of parental monitoring was constructed by summing responses to these three questions. One point was assigned for parents "do not know", two points for "sometimes know" and three points for parents "always know." The range was from 3 to 9 points and the mean was relatively high across all sex and age groups, from a low of 7.3 among older males (age 15-19) to a high of 8.1 among younger females (age 12-14). Three variables for level of monitoring were constructed based on the distribution of the monitoring index: low parental monitoring (3-5 points), medium (6-8 points) and high (9 points).

Several measures from the survey data of the social ties of adolescents were also examined: co residence with parents or parent-figures, the number and gender of adolescents' close friends, current school attendance, frequency of participation (if at all) in religious services and membership in any social group or club. For adolescents who either did not know where their biological parents were living or whose parents had died, questions were asked about whether there was someone like a mother-figure (or father-figure) to them and whether they lived with them. The co residence measure thus refers to biological parents and parent-figures.

The two dependent variables of interest in this analysis are whether an adolescent had sexual intercourse in the 12 months prior to the survey interview and, for those who are sexually-active, whether an adolescent (or partner) used a male condom at last sex. The key sets of independent variables of interest are communication and monitoring. For the multivariate analysis of condom use among sexually-active adolescents, four measures of condom knowledge, attitudes and self-efficacy were also included: whether the respondent ever saw a formal condom demonstration, whether the respondent thought that using a condom meant distrust of the sex partner, whether the respondent was embarrassed to ask for or buy condoms and whether the respondent was not at all confident in using a condom (for females the question was with respect to confidence in getting a partner to use a condom). Other control variables included in both models of sexual activity and condom use were age, urban residence and the household wealth quintile. Household wealth quintiles were constructed using the protocol from Demographic Health Surveys work (Rutstein and Johnson 2004).

The survey sample is restricted to unmarried adolescents aged 12-19 years because married adolescents (4% of females and less than 1% of males) are assumed to be already sexually-active, getting pregnant is normative and married adolescents are more likely to be under the influence of a spouse rather than parents or other guardians. Frequency distributions and logistic regression models were used to examine the associations of monitoring and communication with current adolescent sexual activity (i.e., whether they have had sexual intercourse in the 12 months prior to the survey) and,

for those who had ever had sex whether they engaged in protective behaviour by using a male condom at last sex, the most commonly used method among unmarried adolescents.

Findings

Social ties

Table 1 shows several measures of the connections of unmarried adolescents to their parents, friends and social groups such as participating in religious services or being a member of a club. Less than half of unmarried 12-19 year olds in Ghana live with both parents (or parent-figures), and while the majority of unmarried adolescents live with at least one parent or parent-figure, about 1 in 4 live with none. If sharing a household with a mother and father means parents have more control over or investment in their adolescent children, then a substantial proportion of adolescents do not have that available to them. But the pattern reflects the general situation of complex household composition in the country whereby biological parents are not necessarily the immediate contact person. Oppong (1973) has observed that among the Dagbon (sub-group of the Mole-Dagbani) parents are not considered to be the best people to bring up children, leading to a high level of fostering in this group. The results from the survey indicate that the parent-child relationship is not the most relevant adult-child tie to work through for addressing the sexual and reproductive health information needs and behaviour change of many Ghanaian adolescents.

[Table 1 about here]

On average, Ghanaian adolescents tend to have a large network of friends (about 4-6 close friends) with males having a larger number of close friends on average than females. While each sex has more close friends of the same sex than the opposite sex, about half of all unmarried adolescents in Ghana have close friends of *both* sexes. Mixed-sex friendship networks are common for males of all ages and increase for females as they get older. Very few adolescents say they have no close friends (5% or less).

School enrollment has been shown in other studies to be associated with lower levels of sexual experience, whereby schooling serves as a proxy for a variety of things that could postpone sexual activity—family background factors that encourage both staying longer in school and delaying sexual activity, high expectations for the future, time being occupied by other activities and so on. In Ghana, unmarried adolescents are enrolled in school at relatively high levels and with small gender gaps compared to other West African countries: about 9 in 10 of 12-14 year olds are currently attending school. The proportion in school at older ages drops to 63% of 15-19 year old females and 68% of males.

The vast majority of unmarried adolescents attend religious services once a week or more (91% of females and 85% of males), with attendance more than once a week common among older adolescents than younger. About 1 in 10 adolescents attend services less than once a week or not at all (slightly more males than females are not frequent attendees of religious services). Membership in a social group or club is less common than religious service attendance: 32% of females and 21% of males say they belong to a social group. However, of those who belong to a social group, church or

Muslim youth groups are the most common types (data not shown), thus suggesting a widespread role that religious activity assumes in young people's lives in Ghana.

Communication

How much do Ghanaian adolescents rely on family members, particularly parents, and friends for information about contraceptive methods, STIs, HIV or other sex-related matters? Table 2 shows distributions from the survey data of different types of people who have talked with unmarried adolescents about these topics. The first panel shows the types of people who talked to the adolescent respondent about sex-related matters.

[Table 2 about here]

Female adolescents are more often talked to by family members about sexual matters (46%) than are males (28%), and family involvement is more common among older than younger adolescents. The most common family member involved is the mother (33% of females and 16% of males) and then the father (13 and 12% of females and males, respectively). The data also confirm anecdotes and arguments about one aspect of social change in Ghana: people who traditionally talked to adolescents about sex-related matters (older aunts, grandmothers) are not doing so today. Aunts, uncles, grandmothers or grandfathers were mentioned by less than 10% of unmarried adolescents as source of information on sexual and reproductive health. So while those who traditionally talked to adolescents are not doing so now, parents have, to a large extent, not picked up the slack either, especially for males.

Friends assume as large a role for adolescents in talking about sex-related matters and sexual and reproductive health as family members (or an even larger one for male adolescents). About 1 in 4 females and males had friends, usually of the same sex, talk to them about sex-related matters. Another important "non-family" source is teachers (data not shown), which taken together with friends means that people outside of adolescents' families are the more common types of people talking to adolescents about sex-related matters than people within the family.

The three panels that follow in Table 2 show how often family and friends are named by adolescents as sources of information about contraceptive methods, STIs and HIV/AIDS. Again, these questions were open-ended and so adolescents spontaneously mentioned different sources (only family and friends sources are shown here). The denominator in each panel is adolescents who know of the relevant topic (i.e., contraceptive methods or HIV/AIDS (the vast majority of adolescents are aware of HIV or at least one contraceptive method) or STIs (less than half of 12-19 year olds are aware of STIs apart from HIV)). In general, 1 in 5 unmarried adolescents or fewer relied on family for information about any of these critical sexual and reproductive health issues. Males were less likely to get information from family on these issues than females. When parents were a source of information, especially for females, it was usually mothers, rather than fathers. Friends were more often a source of information about contraceptive methods than were any family (23% and 24% of females and males, respectively, who knew of at least one contraceptive method had gotten information from friends compared to 17% and 14% who had gotten information from family). In fact, for

males, friends were more commonly used for information for contraceptive methods, STIs and HIV than was family.

A weak point of the survey data is that the exact content and tone of these talks are not clear. Evidence from the focus group discussions, however, shows some of the challenges of intergenerational communication about sex-related matters. From the discussions it was evident that young people were more prepared to discuss or seek advice on sexual and reproductive health issues from peers than any other group. This was because peers were seen to be sympathetic and ready to listen. As pointed out by one participant (aged 16 years):

> *In some homes it is a taboo to mention anything connected with sex. In such homes young people do not talk about their problems. They keep quiet at home and then talk to friends instead.*

Responses from the IDIs reinforce those from the survey and indicate that both mothers and fathers were more likely to talk to their daughters than their sons about avoiding early sex, especially within the context of formal education and pregnancy. One thirteen-year old girl indicated that: "My father had told me to abstain from sex." Another 13 year-old stated that: "Father keeps on saying that I should never have sex before marriage." The results from the IDIs indicate that parents in urban areas were more likely to communicate issues on sexual and reproductive health than those in rural areas.

Although mothers were more likely to be consulted than fathers, the perception of mothers as people to discuss these kinds of issues with was not very positive. From the focus group discussions, mothers could be classified into four types namely, those who were approachable (and were in the minority), those who always passed the buck and indicated that the child should go and ask someone else such as the grandmother or the father, those who shouted the children down any time a discussion was brought up about sexual and reproductive health, and those mothers who were thought to have discussed their problems with others. Such mothers were referred to as 'gossipers'.

> *Some mothers have 'okro' mouth (they cannot keep (secrets) their mouths shut). If you tell them anything they will in turn inform your father and when that happens you are dead!*
> Female aged 17 years

Fathers were described as tyrants who did not listen and also took action against their children's friends of the opposite sex, especially males who visited their daughters. As one of the young women stated (aged 18 years):

> *You know, some parents are strict and therefore you cannot discuss some of these things with them. When I was in junior secondary school, a boy visited me in the house. My father came out and suspected that the boy was my boyfriend. My father knocked the boy down and when he got up he took off. At school the next day he told the other boys about his experience and advised the other boys not to visit me in the house. Such parents can embarrass you at times.*

The lack of communication with parents was also steeped in the attitudes of some parents towards issues associated with sexuality. Norms for adolescent sexual behaviour tacitly approve of male sexual networking but not for females. While females are expected to be virgins at marriage, the same is not expected of males (Nukunya 1969). Therefore, parents advise sons to be careful, but 'warn' daughters about sexual encounters with boys. As a result, girls are less likely to report non-consensual sex to parents because they (the children) can be punished for allowing that to happen to them and in extreme cases for bringing shame to the family, especially if the perpetrator is a member of the family. Thus, in one IDI, a 14 year old girl who was raped could not inform her parents because she had been warned about interaction with males.

> *[…]*
> *Interviewer: After the sexual intercourse who did you report to?*
> *Respondent: I did not tell anybody because my father had already warned me about them (Teachers in Training) and had told me not to fetch water for them again. So I was afraid to tell my parents.*
> *Interviewer: Did he warn you not to tell anybody?*
> *Respondent: No, he did not. But I was afraid that if I told my parents my father will beat me.*

Some of the participants recognized that some parents could be helpful. But the experience above illustrates the communication gap between parents and children, even where they live in the same household. The general impression was that parents had not created the necessary environment and relationship with their adolescent children for them to feel confident about discussing sexual and reproductive issues with them. This is occurring in the face of a breakdown in the second tier of the traditional mode of communicating sexual and reproductive health matters to young people: older members in the community. As parents were not directly responsible, it removed part of the embarrassment associated with discussing sexual issues with one's own children.

In the IDIs, teachers and religious leaders also emerged as sources of information, but they were not mentioned as frequently as parents. One would have expected that due to the attention given to population and family life education in the formal school system, teachers and the school will be one of the major sources of information in the modern system. It appears that teachers are not giving serious attention to sexual and reproductive health issues in the school system. There is the need to re-package sexual and reproductive health issues in the school system.

Monitoring

An important role that parents and guardians can play in the sexual and reproductive health of their children is simply being aware of what their children are doing and who their friends are. In general, the training of boys is the responsibility of males while girls are expected to be trained by females. Among the matrilineal system, the maternal uncle is expected to be interested in sons of his uterine sister who are his potential heirs. In the patrilineal system, males and females of the patriclan are responsible for the monitoring

of males and females respectively (Nukunya 2004). Table 3 shows adolescents' perceptions of how aware their parents or guardians are about where they go at night, what they do with their free time and who their friends are. Stark gender differences emerge in that many more adolescent females report that their parents or guardians "always know" where they go at night, what they do with their free time and who their friends are compared to males of the same age. High parental monitoring (i.e., reports that parents "always know") decreases as adolescents grow older (comparing 12-14 year olds to 15-19 year olds), but not dramatically. Even among 15-19 year old males, more than half say their parents or guardians always know where they are at night, who their friends are and how they spend their free time.

[Table 3 about here]

On monitoring, 1 in 10 unmarried adolescents or fewer say their parents or guardians do not know about their activities or friends. The overall level of monitoring (including all three questions) in the last panel of table 3 confirms that female adolescents report much higher levels of monitoring than do males and that the group with very low levels of monitoring is small. While small in number, this group of unmarried adolescents whose parents or guardians lack awareness about what is happening in their lives might be more willing to try (or more vulnerable to experience) risky behaviours, such as unprotected sexual intercourse.

In the IDIs, there were no direct conversations about parents or guardians monitoring adolescents' activities. However, there were references to the people who were aware of the boyfriends or girlfriends of the respondent. For males, their parents and less often their same-sex friends knew about their girlfriends. In the case of females, their friends of the same sex and siblings were more likely to know about their relationships than were their parents. Females in relationships were likely to conceal the identity of their friends from parents. For instance, a 19-year old girl who was in a relationship had to make sure that her aunt with whom she was staying did not get to know about her boy friend:

> *Interviewer: Did anybody know about your relationship?*
> *Respondent: "Hey do not go there" nobody in my house wants to know that you even have a guy (boy) friend. If you are a guy and you step in my house you will be in trouble, because the moment you get in and you are looking for me, my aunt will question you: 'Do you want to see her? For what?', and when you say she is a friend, what she will tell you is "can't you take a guy as your friend" My aunt is very strict. Even my friends of the same sex can't stay for long when they visit me. So if I want to see anybody I have to go to school first, because I can't have visitors at home.*

What this implies is that some guardians do not create environment for their wards to even introduce their friends to them. When this happens, the parents/guardians are unable to monitor the movements of their children/wards. That is, sometimes too much monitoring can lead to undesirable outcomes such as hiding the activity the adults are trying to prevent.

Table 4 shows sexual activity and contraceptive method use at last sex, especially use of the male condom. The majority of very young adolescents (12-14 year olds) report that they have never had sexual intercourse (98% or more). Even among unmarried 15-19 year olds, 76% of females and 85% of males have never had sex. Of those who ever had sex, most have had sex in the 12 months prior to the survey interview. Contraceptive method use among sexually-active unmarried adolescents still remains much lower than it should be: 54% of females and 50% of males used any kind of method at last sex, and the most commonly used method among unmarried adolescents is the condom (45% of sexually-active females and 48% of sexually-active males).

Multivariate analyses of monitoring, communication and social ties

The general view is that high levels of connectedness among adolescents through regular communication with positive reinforcement, a circle of friends and adult monitoring of activities will be related to positive sexual and reproductive health outcomes. Thus, all things being equal one would expect that a girl with parents or guardians who are aware of who her friends are, where she is at night and what she does with her free time will be less likely to be sexually active than a girl of a similar age who has parents or guardians who are not very aware of her activities and friends. It is also important to examine the separate effects of monitoring and communication on adolescent sexual activity and protective behaviour (i.e. using a condom for those who are sexually-active). These issues are captured in the logistic regression models shown in Table 5.

The full logistic regression models are shown separately for females and males. The first two columns are the results for whether an unmarried adolescent had sexual intercourse in the last 12 months. The last two columns are the results for whether an unmarried adolescent (or partner) used a male condom at last sex, among adolescents who had sex in the last 12 months. Adjusted odds ratios are shown: odds ratios greater than one mean that the likelihood of the outcome increases with the value of the predictor variable and, in the case of a categorical variable, relative to the reference category.

[Table 5 about here]

Monitoring, defined as how well parents or guardians know the friends and movements of their adolescent charges, has a negative association with unmarried adolescent sexual activity. The negative relationship between monitoring and recent sexual activity holds for both males and females and shows gradations in effect by level of monitoring.

In contrast, parental communication with adolescents about sex-related matters is not associated with sexual activity, with the one exception for female adolescents that those whose fathers or father-figures talked to them about sex-related matters are more likely to be sexually-active. As with prior studies, it is difficult to disentangle the causal direction between communication and behaviour. For example, when fathers eventually do get involved in talking to their children about sex-related matters, is it when the situation is "bad enough"—such as when an unmarried daughter is discovered to be sexually-active—to require their involvement? Given the relatively low levels of contact adolescents have with fathers on sexual and reproductive health issues and the fact that this association is observed for females but not males (for whom sex outside of marriage

is normatively tolerated), this explanation is plausible. Talking with friends does not have any significant association with recent sexual activity.

For those who are already sexually-active (the last two columns in Table 5), there are no significant associations of any of the monitoring or communication measures with condom use at last sex. Taken together with the findings on sexual activity, the evidence suggests that program efforts to get parents talking to their children about sex are not likely to have much effect in the way of their children's sexual behaviour. What matters is that parents keep a close eye on their children (know where they go out at night, how they spend their free time and who their friends are). This association was found to be the case for both males and females, confirming similar observations in the United States (DiClemete et al. 2001). Knowing who one's child or ward goes out/moves with indicates interest in the adolescent's well-being and can provide a psychological support for the young person. However, once adolescents are already sexually-active, parental monitoring and communication have little bearing at all on adolescents' use of the male condom (one of the most common methods used by adolescents).

The results on social ties indicate that for adolescent females, living with parents does not matter with respect to sexual activity (i.e., sex in the last 12 months), but for the males, living with both parents or a mother/mother-figure only was negatively associated with being sexually-active compared to those living with no parents/parent-figures. The lack of effect of living with parents on the sexual activity of females and the variation by gender may be due to more complex household living arrangements than are currently captured by these measures of coresidence with parents and parent-figures. Being in school was negatively associated with recent sexual activity, an observation which is consistent with the general dampening effect of formal education on the initiation of sexual activity in Ghana (see Awusabo-Asare et al., 2004 for review of the available literature). However, frequency of religious attendance and belonging to a social group or club had no statistically significant association with recent sexual activity. In terms of connections to peers, the larger the number of close friends an adolescent reported, the higher the likelihood that an adolescent was sexually-active and this association was observed for both females and males.

All but one of the measures of social connectedness was *not* significantly associated with whether or not a sexually-active adolescent used a male condom at last sex. The exception was that female adolescents who lived with a mother or mother-figure were much less likely to use a condom at last sex than their peers who lived with two parents or parent-figures. While few associations existed between social ties, monitoring or communication and condom use, condom knowledge (ever saw a formal condom demonstration), positive attitudes (do not think that condom use signals distrust of a sex partner) and self-efficacy were all positively associated with condom use. The effects, though, were not consistently significant for both males and females.

The effects of the control variables were for the most part in expected directions. The association between age and the likelihood of recent sexual activity was positive. Urban residence was not associated in a statistically significant way with sexual activity. Agyei et al. (2000) observed higher levels of sexual activity among females in urban than rural areas, but other studies have observed early sexual activity among females in rural than urban areas. There was no association between socioeconomic status (as proxied by where an adolescent's household fell in the distribution of household wealth) and sexual

activity or condom use with one exception that female adolescents in the highest wealth quintile had about half the odds of being sexually active as females in the lowest wealth quintile.

Conclusion

The ways that Ghanaian adolescents are socialized about sexual and reproductive health issues have undergone big changes. The aim of this paper was to examine the current state of unmarried adolescents' connectedness to parents, friends and social institutions like school and religion, the roles that these groups, particularly parents, play in providing sexual and health information to adolescents and the influence that they have on adolescent sexual activity and condom use. Both qualitative and nationally-representative survey data from 12-19 year olds were used in this study. The qualitative data showed clear gender differences in communication: daughters get messages about avoiding pregnancy while sons are told only to "be careful." While fathers tend to be autocratic, mothers are considered to be sympathetic but not very helpful with information about sexual issues. Other adults, such as grandparents, are viewed as being very helpful about sex-related matters. The survey data indicate that those who traditionally talked to adolescents are not doing so now and parents have, to a large extent, not filled that gap, especially for young men.

Multivariate analyses of the survey data show a negative relationship between monitoring and recent sexual activity for both males and females and the higher the level of monitoring, the lower the likelihood of recent sexual activity. Parental communication with adolescents about sex-related matters is not associated with sexual activity, with the one exception for female adolescents. Connections to religion (measured as frequency of attendance) or social group and club membership had no association with sexual activity or condom use. These findings provide little support for interventions that focus on increasing parent-child communication about sex as a way to delay the start of sexual activity. Instead, the findings provide support for the important role that parents and other adults can play in their children's lives by being more involved in how their children spend their time and with whom they associate. However, once adolescents are already sexually-active, parental monitoring and communication have little bearing at all on adolescents' use of the male condom (one of the most common methods used by adolescents). Instead, better knowledge, positive attitudes about condoms and a better sense of self-efficacy in using condoms (or getting one's partner to use them) are positively associated with protected intercourse. Once adolescents become sexually-active, the evidence suggests that the role for adults should be a supportive one to help adolescents get the information and methods they need to protect themselves from unwanted pregnancy and STIs, including HIV.

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TABLE 1. Parental coresidence, friendship networks and social ties among unmarried adolescents according to sex and age, Ghana, National Survey of Adolescents, 2004

Characteristic	Female			Male		
	12-14 (N=950)	15-19 (N=1145)	Total (N=2095)	12-14 (N=968)	15-19 (N=1239)	Total (N=2225)
Coresidence with biological parents or parent-figures						
Lives with both parents	42.4	40.7	41.5	48.5	41.8	44.7
Mother only	24.0	24.3	24.2	21.0	23.2	22.2
Father only	5.3	4.4	4.8	9.2	8.9	9.0
No parents	28.3	30.7	29.6	21.4	26.2	24.1
Average number of close female friends	3.1	2.9	3.0	1.4	2.0	1.7
Average number of close male friends	1.0	1.7	1.4	4.1	4.2	4.2
Sex composition of friendship networks						
No close friends	4.0	5.0	4.6	5.2	4.6	4.9
Only male	0.2	0.8	0.5	43.9	35.4	39.1
Only female	57.1	37.1	46.2	0.3	0.4	0.4
Both male and female	38.7	57.1	48.8	50.6	59.6	55.6
Currently attending school						
No	11.9	37.5	25.9	10.0	32.2	22.5
Yes	88.1	62.5	74.1	90.0	67.8	77.5
Frequency of religious service attendance						
Less than once a week	10.1	8.5	9.3	14.4	15.4	15.0
Once a week	53.7	47.2	50.1	56.0	47.6	51.3
More than once a week	36.2	44.3	40.6	29.6	36.9	33.7
Belongs to any social group or club						
No	74.0	62.4	67.7	84.0	75.6	79.3
Yes	26.0	37.6	32.3	16.0	24.4	20.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted.

TABLE 2. Types of people who talked about sex-related matters, contraceptive methods, STIs or HIV/AIDS with unmarried adolescents by sex and age, Ghana, National Survey of Adolescents, 2004†

Characteristic	Female			Male		
	12-14	15-19	Total	12-14	15-19	Total
Persons who have ever talked to respondent about sex-related matters	(N=950)	(N=1145)	(N=2095)	(N=968)	(N=1239)	(N=2225)
Any family member	39.9	50.7	45.8	21.7	33.4	28.2
Mother	29.2	35.8	32.8	14.2	17.0	15.8
Father	11.4	14.2	12.9	10.0	13.3	11.8
Aunt	6.5	11.4	9.2	0.8	3.7	2.4
Uncle	2.5	4.1	3.4	1.5	5.3	3.7
Grandmother	7.1	7.3	7.2	3.3	2.3	2.7
Grandfather	0.8	1.0	0.9	0.8	0.5	0.6
Any non-family member	40.8	55.4	48.8	34.6	55.0	46.0
Male friend	3.2	7.1	5.4	15.6	31.1	24.3
Female friend	14.9	24.4	20.1	1.3	5.9	3.9
Contraceptive methods (among those who know of at least 1 method)	(N=803)	(N=1085)	(N=1888)	(N=818)	(N=1192)	(N=2010)
Any family	17.3	17.2	17.3	14.9	12.5	13.5
Mother	7.1	8.4	7.8	3.7	5.2	4.6
Father	2.1	2.2	2.2	3.9	3.2	3.5
Any friends	20.0	24.8	22.7	18.7	26.8	23.5
STIs, apart from HIV/AIDS (among those who know of any STI)	(N=244)	(N=566)	(N=810)	(N=267)	(N=693)	(N=960)
Any family	13.9	13.1	13.3	9.7	9.5	9.6
Mother	12.0	8.2	9.4	4.9	5.3	5.2
Father	2.9	3.9	3.6	4.2	4.2	4.2
Any friends	7.0	11.7	10.3	7.9	18.0	15.2
HIV/AIDS (among those who know of HIV/AIDS)	(N=899)	(N=1116)	(N=2015)	(N=917)	(N=1226)	(N=2143)
Any family	23.0	22.7	22.8	16.5	16.2	16.3
Mother	12.7	12.6	12.7	6.8	7.8	7.4
Father	5.6	4.8	5.2	6.2	6.9	6.6
Any friends	15.2	17.5	16.5	15.8	22.1	19.4

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

TABLE 3. Parental monitoring reported by unmarried adolescents by sex and age, Ghana, National Survey of Adolescents, 2004

Characteristic	Female			Male		
	12-14 (N=950)	15-19 (N=1145)	Total (N=2095)	12-14 (N=968)	15-19 (N=1239)	Total (N=2225)
Parents/guardians know where respondent goes out at night						
Do not know	3.8	6.3	5.2	7.2	10.7	9.2
Sometimes know	16.0	19.5	17.9	27.5	31.5	29.7
Always know	80.2	74.2	76.9	65.3	57.8	61.1
Parents/guardians know what respondent does with free time						
Do not know	4.5	7.0	5.8	8.7	10.8	9.9
Sometimes know	19.3	23.0	21.3	31.7	38.2	35.3
Always know	76.2	70.1	72.8	59.6	51.0	54.8
Parents/guardians know who respondent's friends are						
Do not know	8.4	8.4	8.4	8.1	9.2	8.7
Sometimes know	18.8	22.4	20.8	32.4	36.9	34.9
Always know	72.8	69.2	70.8	59.5	53.9	56.4
Level of monitoring						
Low	4.1	6.5	5.4	7.3	11.4	9.6
Medium	37.6	39.7	38.7	54.7	57.1	56.0
High	55.0	51.5	53.1	38.0	31.4	34.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted.

TABLE 4. Sexual activity status and method use among unmarried adolescents by sex and age, Ghana, National Survey of Adolescents, 2004

Characteristic	Female			Male		
	12-14	15-19	Total	12-14	15-19	Total
Sexual activity status	(N=956)	(N=1137)	(N=2093)	(N=973)	(N=1237)	(N=2210)
Never had sex	98.3	75.5	86.0	98.7	85.0	91.0
Ever had sex, no sex in last 12 months	0.8	7.3	4.3	0.6	5.3	3.2
Had sex in last 12 months	0.8	17.1	9.7	0.7	9.8	5.8
Any method use at last sex (among those who had sex in last 12 months)	(N=9)	(N=188)	(N=197)	(N=7)	(N=123)	(N=130)
No method use	--	44.1	46.2	--	47.2	50.0
Used method	--	55.9	53.8	--	52.8	50.0
Any condom use at last sex (among those who had sex in last 12 months)	(N=9)	(N=188)	(N=197)	(N=7)	(N=123)	(N=130)
No condom use	--	53.7	55.3	--	49.6	52.3
Used condom	--	46.3	44.7	--	50.4	47.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

Table 5. Logistic regression models of having sexual intercourse in the last 12 months or using a condom at last sex (among those who had sex in the last 12 months) on social monitoring, communication and social ties among unmarried 12-19 year olds, Ghana, 2004 National Survey of Adolescents

	Had sex in last 12 months		Used a condom at last sex (if had sex in last 12 months)	
Variable	Females	Males	Females	Males
Monitoring				
Medium parental monitoring (ref=low parental monitoring)	0.39 ***	0.54 *	0.80	1.91
High	0.13 ***	0.24 ***	1.43	1.65
Communication				
Mother has talked about sex-related matters (ref=mother has not)	1.00	1.59	2.13	2.21
Father has talked about sex-related matters (ref=father has not)	1.79 *	0.52	0.95	0.69
Friends have talked about sex-related matters (ref=friends have not)	1.42	1.30	1.38	0.61
Social ties				
Live with both parents/parent-figures (ref=live with no parents/parent-figures)	0.72	0.58 *	0.64	1.09
Live with mother/mother-figure only	1.23	0.43 **	0.33 *	0.30
Live with father/father-figure only	1.19	1.50	0.80	0.71
Currently in school (ref=not in school)	0.28 ***	0.50 **	1.52	2.37
Attend religious services more than once a week (ref=attend less than once a week)	1.22	1.25	1.62	1.89
Attend religious services once a week	1.55	1.08	1.43	1.13
Belongs to a social club (ref=does not belong)	1.40	1.31	0.99	1.57
Number of close friends (0 to 12+)	1.08 **	1.15 ***	1.11	0.98
Controls				
Age (in years)	3.66 ***	3.43 ***	1.25	0.75
Urban residence (ref=rural residence)	1.38	0.95	0.41	2.09
Ever saw a condom demonstration (ref=never saw)			2.18 *	2.93
Condom means distrust partner (ref=disagree or don't know)			0.73	0.29 *
Embarrassed to ask for or buy condom (ref=disagree or don't know)			0.52	2.82
Not at all confident in using/getting partner to use a condom (ref=somewhat or very confident)			0.34 **	0.00
2nd wealth quintile (ref=lowest wealth quintile)	1.25	0.93	0.47	2.94
3rd wealth quintile	1.21	0.93	0.58	1.25
4th wealth quintile	0.98	0.81	0.47	8.91
Highest wealth quintile	0.41 *	0.55	0.97	1.02
Intercept	0.08 ***	0.03 ***	0.82	0.17
N (weighted)	2100	2206	190	123

Notes: Adjusted odds ratios (Exp[ß]) are presented.
* p < .05, ** p < .01, *** p < .001