HIV/AIDS AWARENESS AND BEHAVIOUR CHANGE AMONG ADOLESCENTS AND YOUNG PEOPLE IN GHANA

A qualitative study to understand the determinants of condom use in HIV/AIDS prevention among students of Odomaseman Senior High School in the Brong-Ahafo region of Ghana

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ABSTRACT

INTRODUCTION: Adolescents and young people have the highest risk of contracting HIV/ AIDS. In Ghana and most of Sub Saharan Africa a combination of being sexually active in young age and low condom use heightens the risk of acquiring HIV/ AIDS. Most young people are sexually experienced by age 15 and is estimated that 70 percent to 80 percent of all transmissions is through heterosexual intercourse. However condom use remains low despite the near universal awareness among this subpopulation. The study aims to explore knowledge and experiences of condom use in HIV/ AIDS prevention among adolescents and young people, and understand how sexually active adolescents and young people who use condoms consistently manage to circumvent the perceived individual and contextual influences associated with condom use to live protective sexual lives.

METHODOLOGY: Twenty - three in-depth interviews were conducted to explore participants' experiences and perceptions on sexual relationships and condom. Four focus group discussions in gender and age segregated groups were used to examine participants' knowledge about HIV/ AIDS and prevention methods, and how this awareness has impacted on their sexual behavior of sexually active young people. Their reasons for condom use or non-use in sexual relationships, any differences in male and female reasons, and how society views such relationship and thus influence condom use were also explored.

FINDINGS: Education of young people on HIV/ AIDS prevention happened through various means such as the media, home (family interaction), school, etc. However, adolescents and young people trusted and preferred sexuality education from their parents and significant adults in their lives; although most complained they did not get it; thus, giving way to be influenced through other means including their peers. Despite the awareness of condoms as an effective means of HIV/AIDS prevention, this did not necessarily translate into behavior change. Condom use was found to be linked with pregnancy prevention and casual sexual relationships. Parental influence, gender and power inequalities, as well as some sociocultural norms and belief were mentioned as the main determinants of condom use. Suggestions were made on how these influences could be circumvented to enable young people live sexually protective lives.

CONCLUSION: HIV prevention programs for young people should emphasize condom use instead of abstinence and should strengthen parental and community involvement components

KEYWORDS: *Adolescents, condom use, HIV/ AIDS, sexual behavior, young people*

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Kingsley Ntiamoah Arthur
Author

DEDICATION

This piece of work is dedicated to my family; especially, my wonderful moms, YES, moms!

Regina Afi & Regina

who constantly inspired me to press on till the goal is achieved.

Also to my amazing wife and friend,

Adel

for her firm support and love all this while.

OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CHPS	Community-based Health Planning and Services
GAC	Ghana AIDS Commission
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GETFUND	Ghana Education Trust Fund
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
MOE	Ministry of Education
MOH	Ministry of Health
NACP	National AIDS/STI Control Program
NDPC	National Development Planning Commission
NHIS	National Health Insurance Scheme
NSF	National Strategic Framework
PHC	Population and Housing Census
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother- to- Child Transmission
SHEP	School Health Education Program
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

LIST OF TABLES AND FIGURES

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION

COUNTRY PROFILE- Ghana

Geography

The Republic of Ghana is centrally located on the West African coast. It has a total land area of 238,537 square kilometers, and it is bordered by three French-speaking countries: Togo on the east, Burkina Faso on the north, and northwest, and Côte d'Ivoire on the west. The Gulf of Guinea lies to the south and stretches across the 560-kilometre coastline (fig. 1).

Ghana is a lowland country except for a range of highlands on the eastern border. The highest elevation is Mt. Afadjato, 884 meters above sea level, found in the Akuapem-Togo ranges, west of the Volta River. Ghana can be divided into three ecological zones: the low, sandy coastal plains, with several rivers and streams; the middle and western parts of the country, characterized by a heavy canopy of semi deciduous rainforests, with many streams and rivers; and a northern savannah, which is drained by the Black and White Volta Rivers. The Volta Lake, created by the hydroelectric dam in the East, is one of the largest artificial lakes in the world.

Ghana has a tropical climate with temperatures and rainfall patterns that vary according to distance from the coast and elevation.

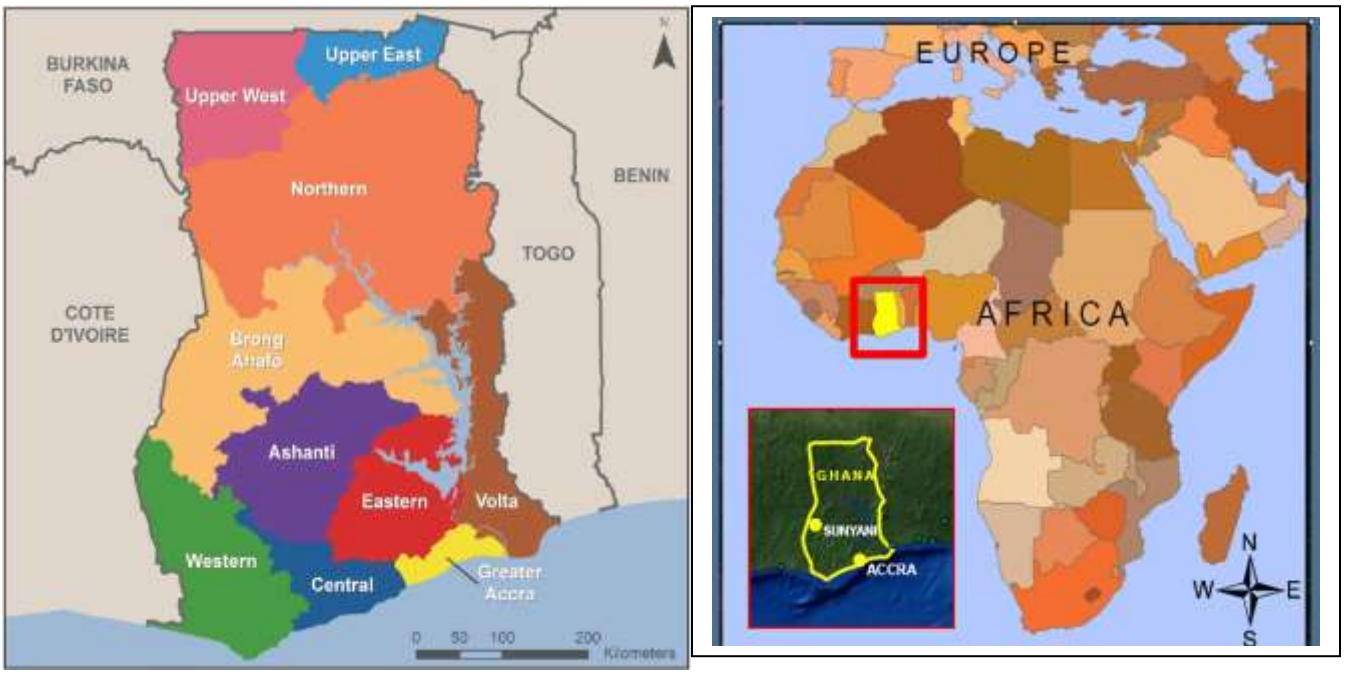

Fig. 1- Map of Ghana and Map of Africa Showing the Location of Sunyani in Ghana

Economy

The structure of the Ghanaian economy has seen minimal changes over the past two decades. The agriculture sector, previously the largest contributor to the Ghanaian economy, has been overtaken by the service and industry sectors. By 2014, the service sector was the fastest growing sector of the economy, contributing 52 percent of the gross domestic product (GDP), followed by the industry sector, at 27 percent, and the agriculture sector, at 22 percent.

About 45 percent of the economically active populations are engaged in agriculture, and 41 percent provide services. A high proportion of the employed population of Ghana works in the informal sector, the majority being self-employed.(1)

The leading export commodities of Ghana are cocoa, gold and timber. Recently, the economy has diversified to the export of non-traditional commodities such as pineapples, bananas, yams, and cashew nuts.

Many changes have occurred in the education sector over the past 15 years. Pre-school education has officially been incorporated into the basic education as a part of primary and junior high school. All primary schools are required to have nurseries or kindergartens. In the 2005/2006 academic year, the government absorbed school fees for all pupils enrolled in basic public schools, resulting in free education.(2) During the same period, a school feeding program was introduced on a pilot basis and has since been extended to all basic schools. While the program aims at improving the nutritional status of school pupils, a secondary effect has been to increase enrolment.

At the secondary level, the senior high school was introduced in the 2007/2008 academic year, expanding the system from three to four years, but this policy was reversed in 2009. The introduction of the Ghana Education Trust Fund (GETFUND), a public trust set up by an Act of Parliament in the year 2000, has brought many improvements to the education system. The fund provides educational infrastructure such as buildings to support the country's tertiary institutions and, as a result, has improved teaching and learning within these institutions.

Demographic profile

Ghana has completed five censuses since gaining independence in 1957. The first one was conducted in 1960 and reported a population of 6.7 million while in the 2010 PHC, 24.7 million were recorded. The average annual growth rate between 2000 and 2010 was 2.5 percent.

The population density has increased over the years from 29 persons per square kilometer (persons/km2) in 1960 to 103 persons/km2 in 2010. The proportion of the population living in

urban areas has more than doubled in the last five decades, expanding from 23 percent in 1960 to 51 percent in 2010. The sex ratio of 102.2 males per 100 females recorded in 1960 has declined to 95.2 males per 100 females in 2010. The proportion of the population under age 15 has also decreased from 45 percent in 1960 to 38 percent in 2010, while the proportion of the population age 65 years and older increased from 3 percent to 5 percent over the same period. An estimated 24.1 percent of the total population is between ages 15–24. Over the last five decades, life expectancy at birth has increased from 38 years to 60 years among males and from 43 years to 63 years among females (3, 4). Although mortality has decreased over the years, life expectancy at birth is currently estimated at 61.45 years in the general population. The decline in the maternal mortality rate from 4515 in 2008 to 3506 per 100,000 live births in 2010 is not sufficient. There have been significant reductions in neonatal mortality (from 41 to 30), infant mortality (from 77 to 50) and child mortality (from 155 to 80) per 1,000 live births between 2004 and 2008. The total fertility rate is currently 4.0 children per woman.

Population policy and reproductive health programs

The National Population Policy of Ghana was formulated in 1969 in recognition of the simultaneous high growth of population and fertility. The policy was revised in 1994 because of its modest impact after 25 years of implementation. The revision took into account emerging issues such as HIV/AIDS, population and the environment, and concerns about the elderly and children. It developed new strategies that would ensure the achievement of its goals and objectives. The revision of the population policy also entailed concerted effort to systematically integrate population variables in all areas of national development and program planning.(5)

Some selected targets of the revised population policy included the following:

- Reduce the total fertility rate (TFR) from 5.5 in 1993 to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020
- Achieve a contraceptive prevalence rate (CPR) with modern methods of 15 percent by the year 2000, 28 percent by 2010, and 50 percent by the year 2020
- Reduce the population growth rate from about 3 percent per annum to 1.5 percent per annum by the year 2020
- Increase life expectancy to age 70 years by the year 2020(5)

The attainment of these population targets is recognized as an integral component of the national strategy to accelerate economic development, eradicate poverty, and enhance the quality of life of all Ghanaians. In collaboration with the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), the World Bank, and other development partners, Ghana has implemented several projects aimed at reducing reproductive health problems among its population. Support from these agencies has targeted policy coordination, implementation, and service delivery. The government is committed to improving access and equity of access to essential health care services. The priority areas identified include HIV/AIDS and other sexually transmitted infections (STIs), malaria, tuberculosis, guinea worm disease, poliomyelitis, reproductive health, maternal and child health, accidents and emergencies, noncommunicable diseases, oral health and eye care, and specialized services.

Emphasis is also being placed on regenerative health and preventive as well as community-based health care services. This has necessitated the introduction of the Community-based Health Planning and Services (CHPS) program in which trained nurses are stationed in selected communities to provide health care services to members of the communities.

In response to the HIV/AIDS epidemic, the government of Ghana set up the National AIDS Commission to oversee the implementation of HIV/AIDS programs using a multi-sectorial approach and to ensure that HIV/AIDS prevention education, treatment, care and support reach every corner of the country. The Ghana Health Service (GHS) also set up the National AIDS Control program (NACP) to offer HIV/AIDS prevention and education services. The combined efforts of all stakeholders ensured the implementation of the Ghana HIV/AIDS Strategic Framework: 2001-2005.(6)

The Roll Back Malaria, tuberculosis (TB-DOTS), and integrated management of childhood illnesses (IMCI) are also priority areas under the country's health care system. Other health interventions instituted as part of the government's efforts to make health care accessible and affordable to all include the introduction of the National Health Insurance Scheme (NHIS) and a free maternal care program.(7)

Sustainable accessibility and availability of improved water and sanitation are essential to the health of a population. Therefore, extensive efforts are being made in Ghana to ensure universal access to safe drinking water and improved sanitation facilities by the year 2025 (8). The Ghana WASH Project, under the auspices of the Ministry of Local Government and Rural

Development, is a USAID-funded initiative. The goal of the project is to improve water and sanitation facilities and to increase hygiene education among rural and peri-urban communities to prevent the spread of diseases like diarrhea, dysentery, cholera, and, recently, Ebola. The Ghana WASH Project is supported by a number of agencies, including Relief International, the Adventist Development Relief Agency, and Winrock International.

HIV EPIDEMIC IN GHANA

Since the first 42 cases of AIDS were recorded in Ghana in 1986, a cumulative total of 225, 4788 people living with HIV was estimated at the end of 2011. Results from the Ghana Demographic and Health Survey in 2003 indicated that 2 percent of adults aged 15–49 were HIV positive (2.7 percent of women and 1.5 percent of men). HIV prevalence in Ghana has been estimated based on sentinel surveillance of pregnant women attending antenatal clinics since 2003. An estimation and projection package (EPP) modeling done in 2008 estimated the national HIV prevalence among adults to be 1.9 percent (range of 1.7 percent to 2.2 percent), with urban and rural prevalence estimated at 2.4 percent and 1.7 percent, respectively. The trend in the national median HIV prevalence since 2003 shows three peaks: 2003 (3.6 percent), 2006 (3.2 percent) and 2009 (2.9 percent). A linear trend analysis shows that HIV prevalence since 2003 has decreased and stood at 2.1 percent as of 2011. Currently, the national adult HIV prevalence has stabilized at 2 percent, declining from 2.7 percent in 2005. To estimate the distribution of new infections and to identify those populations at highest risk for HIV infection in Ghana, a Modes of Transmission (MOT) study applying the UNAIDS model was conducted in 2014 and its findings indicate that the majority of infections (73 percent) occur among stable heterosexual couples and persons involved in casual heterosexual sex together with their regular partners.(9)

Although Ghana is classified as having a low level generalized HIV epidemic there are significant variations of the epidemic and is notably higher among key population segments—men who have sex with men (MSM), female sex workers, prisoners, and people suffering from STIs and TB. HIV is more prevalent in urban (2.4 percent) than in rural (1.7 percent) areas. Eastern Region has the highest (2.8 percent) followed by Western (2.7 percent), Greater Accra (2.5 percent), Brong Ahafo (2.2 percent), Central (2.1 percent), and Volta (2.1 percent); all above the national average of 2 percent. The Northern Region (0.3 percent) has the

lowest HIV prevalence, followed by Upper West 0.4 percent) Upper East (0.6 percent) and Ashanti Region (1.9 percent) all below the national prevalence.

Furthermore, young people (15-24 years) are considered a vulnerable group for HIV infection as they are sexually active and are often involved in unprotected sexual intercourse.(10) Young people who are not in school are particularly vulnerable to HIV infections, as services providers do not often target them with HIV prevention information and services. Condom use among young men with two or more sexual partners decreased from 42.0 percent in 2008 to 34.2 percent in 2014. Compared with adults, HIV testing is low among young persons. In 2014 only 10.6 percent of young men 15-24 years have ever tested for HIV compared with 22.4 percent of men aged 15-49 years. This data notwithstanding, the prevalence among young people 15-24 years is 1 percent; however, Central Region (2.9 percent) and Brong Ahafo Region (1.1 percent) are the regions with prevalence above 1 percent; all other regions have prevalence below 1 percent.

The HIV gender ratio of 3 to 1 (female to male) is higher than found in most population based studies in Africa. The high gender ratio implies that women are more particularly vulnerable to HIV infection than men. Men and adolescent boys have poor health seeking behavior and are less involved in the HIV and sexual and reproductive health (SRH) responses than women and adolescent girls. About 60 percent of people living with AIDS, 56 percent of new HIV infections, and 51 percent of AIDS related deaths are female.(10)
In Ghana, encouraging pregnant women to know their HIV serostatus in order to reduce the risk of transmission of the virus from mother to child is a key component of Prevention of Mother-To-Child Transmission (PMTCT) service delivery. It also serves as the entry point of care for HIV-positive mothers and is a key prevention intervention being provided at all PMTCT centers across the country. The median ANC HIV prevalence has shown a downward trend from year 2000 to 2015, moving from as high as 3.6 percent in 2003 to 2 percent in 2015.(9)
The key drivers of the HIV epidemic in Ghana have been identified as:

Sex-based drivers

• Low personal risk perception of acquiring HIV: Most people especially men and young adolescents have a low personal perception of their risk of contracting HIV. The low illusion prevents people seeking to know their HIV status.

• Multiple concurrent sexual partnerships without accompanying correct and consistent condom use: That men and women engage in sexual activity with more than one partner at the same time is common in the country.
• Transactional and inter-generational sex: This exposes many women especially young women and adolescent girls to HIV infection. Condom use and alternate means of livelihood will reduce the risk of HIV exposure.

Health System Drivers

Ineffective and inefficient services for sexually transmitted infections (STIs): STIs are important co-factors for the transmission and acquisition of HIV and therefore ineffective treatment of STIs is key driver for the spread of HIV. Inadequate access to and poor quality of healthcare services: Effective HIV prevention and treatment programs as part of a good health system reduce the risk of transmitting and acquiring HIV. Many components of Ghana's health systems are weak leading to delivery of poor quality services. Strengthening health systems including collaboration between the TB and HIV programs will contribute to reducing HIV acquisition and transmission.

Gender-based drivers

Entrenched gender inequalities and inequities: Ghana is a male-dominated society. Examples of gender-based inequalities and inequities including harmful gender norms and gender-based violence abound and are key drivers of the epidemic as they effectively hinder women and adolescent girls from accessing HIV prevention and treatment services. Therefore gender equality and gender-sensitive approaches must be integral parts of the policies and actions that drive the HIV response. This involves engaging both men and adolescent boys, and women and adolescent girls.

Poverty-based drivers

Chronic and debilitating poverty: Severe and prolonged poverty is a significant barrier to poor people accessing HIV prevention and treatment services. Poverty sometimes forces people, especially women and girls, to adapt survival strategies that increase their vulnerability to HIV infection. Linkages with poverty reduction and social protection programs will contribute to reducing poverty as a significant driver of the epidemic.

National Response to HIV Epidemic

Ghana's national response to HIV has made significant progress towards achieving Universal Access to HIV services through the implementation of robust and a vibrant National HIV and

AIDS Strategic Framework (NSF). NSF 1 covered the period 2001-2005, and NSF II covered the period 2006-2010. In line with efforts to continue and sustain this progress, The Ghana AIDS Commission (GAC), in collaboration with key partners and stakeholders, developed and is implementing a National Strategic Plan on HIV and AIDS 2011-2015 (NSP 2011-2015) which is directing the implementation of the national HIV and AIDS response.(11) Implementing this strategy takes into account the unique challenges that it faces in addressing the HIV epidemic. Although Ghana is among countries with a low HIV prevalence, efforts for responding to the epidemic need to be sustained and scaled up to maintain and even lower the prevalence. It is for this reason that the NSP set ambitious targets which aim at achieving universal access as well as the Millennium Development Goals (MDGs). Overall, the focus of the 2011-2015 strategy is to reduce by half the new HIV infections by the end of its fifth year of implementation; with a virtual elimination of mother to child transmission of HIV, as well as sustaining and scaling up the proportion of people living with HIV (PLHIV) who are on treatment, leveraging treatment as a prevention strategy.(11)

The National HIV Prevalence and AIDS Estimates Reports show the national HIV response is making modest progress. In 2012, about 236,000 people were living with HIV. The number of new HIV infections reduced from 12,077 in 2011 to 7,991 in 2012; adults contributed 89 percent, children contributed 11 percent, and young people 15-24 years of age contributed 28 percent (2,236 of 7,991) of new HIV infections in 2012.

HIV Education for young people

The school environment provides an ideal opportunity to provide HIV and sexuality education to young people. For more than two decades now, the education sector through the Ministry of Education (MoE), the Ghana Education Service (GES) and the National Council for Tertiary Education (NCTE) have been playing important roles as critical stakeholders in the national HIV response with regards to integrating HIV activities into its core business that benefit its staff and young people in school. The MoE has developed and is implementing the Education HIV Sector Policy. The GES has introduced HIV education into the curriculum of teacher training colleges in the country, implemented a fairly successful HIV Alert School Project over the last decade, and has been piloting the enhanced School Health and Education Programmed (e-SHEP). The HIV Alert School Project is a nationwide HIV prevention education program for basic schools,

which is delivered through curricula and co-curricular activities using pupils/students as peer educators and teachers as training of trainers.
However, inadequate funding is adversely affecting the coverage and quality of the education sector response programs to HIV.

Prevention among young people

The HIV situation among young Ghanaians aged 15-24years provides a proxy for HIV new infections. According to the GDHS 2014 results, among the youth age 15-24 that have had sexual intercourse in the past year, 16 percent of young women and 3 percent of young men have been tested for HIV in the past year and received their results prior to the 2014 GDHS. Overall, about 1 percent of Ghanaian youth age 15-24 are HIV positive. HIV prevalence is higher among young women (1.5 percent) than among young men (0.2 percent). HIV prevalence among young women is highest among women age 23-24 years (4.7 percent) and lowest among women age 15-17 years (0.3 percent). Condom use is one of the most effective and efficient strategies for combating the spread of HIV. Furthermore, social acceptability of condoms is key to determining the success of condoms in preventing sexual transmission of HIV and other STIs, as well as preventing unintended pregnancy. However, educating young people about condoms is sometimes considered controversial; some oppose educating young people about condoms because they think it promotes early sexual experimentation; others favor teaching only abstinence until marriage.

STUDY BACKGROUND

Nairobi, 17 February 2015— **"**While major advances have been made in almost every area of the response to HIV, progress for adolescents and young people is falling behind".
This was acknowledged by a meeting of world leaders in Nairobi, Kenya in the global response to end the AIDS epidemic to launch "All In", a new platform initiated through a partnership between UNAIDS, UNICEF and other partners to address this inequity by encouraging more young people in the effort. AIDS has become the leading cause of death for adolescents in Africa and the second leading cause of death among adolescents globally. Just one in four children and adolescents under the age of 15 has access to life-saving antiretroviral treatment. Deaths are declining in all age groups, except among 10–19 year olds.

The initiative focuses on four key action areas: engaging, mobilizing and empowering adolescents as leaders and actors of social change; improving data collection to better inform programming; encouraging innovative approaches to reach adolescents with essential HIV services adapted to their needs; and placing adolescent HIV firmly on political agendas to spur concrete action and mobilize resources.

HIV/ AIDS is considered a major international health challenge facing both developing and developed nations and responsible for high levels of morbidity and mortality- especially in developing countries.(12) Despite reported lowering prevalence rates and the number of new infections globally, HIV/ AIDS is still a threat to children's rights in sub Saharan Africa and a major obstacle to the achievement of universal basic education.(13) Although HIV/ AIDS affects all the social sectors of the population, the epidemic among young people is the fastest growing partly due to young people's vulnerability and of low use of preventive services. Young people- typically those under 25 years have the highest risk of contracting STIs including HIV/ AIDS, among this group are adolescents.(14)

In spite of this, adolescents are seen as a 'window of hope' because they have great potential for positive change of attitudes and behaviors. Focusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries.(15) Again, this was recognized at a global level by the 2001 UN General Assembly Special Session on HIV/AIDS who endorsed then that "By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 percent and by 25 percent globally by 2010".

The need for urgent response to the HIV situation among adolescents cannot be overemphasized. As in most countries in Sub Saharan Africa, adolescents and young people in Ghana are increasingly exposed to the risk of HIV infection. Although AIDS cases have been identified in all age groups, the age group most afflicted is 20 to 39 years, constituting 70 percent of the total number of cases(16) most of whom are likely to have contracted the human immunodeficiency virus (HIV) in adolescence. According to the Ghana Health Sentinel Survey, 2008, HIV prevalence of 1.9 percent among young people aged 15 to 24 years still remained above the national average of 1.7 percent.

By far, the most frequent means of transmission of HIV in Ghana is heterosexual contact.(17) The HIV virus is mainly spread through sexual intercourse and the main hope to prevent infection remains modification of sexual behaviors including correct and consistent condom use. It is estimated that 70 to 80 percent of all those infected with HIV in Africa contracted it through sexual intercourse with an infected person.(18) The literature on HIV/AIDS and sexual behavior in sub-Saharan Africa confirm that most young people in Africa are sexually active and tend to initiate sex at a fairly early age, ranging from 14. 4 to 16.1 years for males and 15.1 to 16.6 years for females; they have multiple sexual partners; relationships do not last long and they rarely take protective measures.(19-21) For instance, in Ghana, the age when many young Ghanaians engage in their first sexual intercourse corresponds with the time when they are in high school or of high school age.(22) Based on recent available data, 6 percent of youth had their first sexual intercourse before the age of 15, while 37 percent had their first sexual intercourse before the age of 18.(23)

For sexually active adolescents, consistent use of condoms during sexual intercourse is the most effective behavioral measure to prevent HIV infection. Although 82 percent of young people aged 15 to 30 years in Ghana are sexually active, the prevalence of condom use in this age group is only 15 percent.(24)

Several studies have demonstrated that HIV/ AIDS knowledge is associated with condom use. Low level of knowledge about the transmission and prevention of HIV/AIDS among adolescents was a predictor of non-use of condoms.(25-27) However, several other studies have indicated that despite the increasing levels of HIV/AIDS knowledge, adolescents do not use condoms consistently.(14, 22)

Researchers have also identified several perceptions as important determinants of condom use among adolescents. These include perceived susceptibility to AIDS, perceived benefits and barriers of condom use, perceived self-efficacy to use or have a partner use a condom, and perceived social support for condom use. Perceived susceptibility to AIDS has been found to be significantly related to intention to use condoms among adolescents.(28) Some studies have further demonstrated that adolescents who perceived peer norms as supporting condom use were more likely to report consistent condom use.(28, 29)

In Ghana there is a high level of awareness among adolescents and young people with regards to unprotected sex as a major risk for HIV infection and the use of condom as the most effective means of prevention; however this has failed to translate to positive behavior change. Studies also show that, although awareness of AIDS and risk reduction measures like condom use is high, this knowledge is not transformed into positive attitudes and behaviors like consistent condom use.(30) Adolescents and young people have increasingly become sexually active but continually engage in unprotected sexual intercourse putting them at greater risk for HIV infection. These vulnerable adolescents and young people have sex with their peers with some of them engaging in sexual practices with multiple partners including older ones. Abstinence which is a key element of HIV/ AIDS prevention education in schools and strongly supported by religious groups has shown little efficacy in changing behavior, and withheld lifesaving information on use and effectiveness of condom in HIV prevention. Condoms offer safe, economically cheap and practically effective means of preventing both unwanted pregnancies and sexually transmitted infections including HIV/AIDS when used consistently and properly.

Traditionally, HIV prevention programs among young people in Ghana have focused on individual and interpersonal approaches to behavior change. While individual and group level interventions have been quite effective, behavior occurs within a context.

It is therefore evident that, many HIV/ AIDS prevention programs are primarily designed to improve knowledge and awareness about HIV/ AIDS and are often based on the premise that increased knowledge among young people will lead to changes in their sexual behavior; however, reviewed literature points to little or no association between HIV/ AIDS knowledge and sexual behavior. On the other hand, social and cultural factors, attitudes and practices have been shown to be the major determinants of young people's risky sexual behavior. Furthermore, it is believed that condom use will depend on the type of sexual partner, this may hold among adults; however it remains unclear if young people also act in this way.

Extensive quantitative studies have been carried out which shows that condom use among adolescents and young people remains low despite the high level of knowledge among this subpopulation; this suggests that other factors including social and cultural may influence young people's decisions to use or not to use condoms during sexual intercourse. Whatever the reasons are, this study responds to the gap by utilizing a qualitative approach to establish an in depth

perspective of adolescents' own interpretations and perceptions of the situation. There is also the need to develop additional theoretically grounded interventions that address the range of ecological factors that influence adolescents and young people who are at risk for HIV infection

Furthermore, several studies reviewed have looked at factors militating against condom use among adolescents; however, it is worth noting that not all adolescents conform to these social norms that shape their behavior. In response, this study goes beyond the usual trend and aims to understand how some adolescents and young people confront these dominant cultural and social norms and live protective sexual lives. In this way, findings from the study will serve as a guide for the development and scale-up of comprehensive and culturally relevant interventions which target these multiple ecological factors and could help achieve better results in preventing the spread of HIV.

RESEARCH OBJECTIVES AND RESEARCH QUESTIONS

RESEARCH OBJECTIVES

Main Objective

The main objective of this study is to explore the perceptions and experiences of condom use in HIV/AIDS prevention among adolescents and young people between the ages of 14 and 20 years in Ghana.

The Specific Objectives sought to:

- Explore knowledge and practice of condom use in HIV/ AIDS prevention among adolescents and young people in Ghana
- Explore perceptions of relationship and sex among adolescents and young people in Ghana
- Identify the reasons why sexually active adolescents and young people who protect themselves do so, and their experiences.
- Investigate the perceived individual and contextual beliefs and barriers to sexually active adolescents and young people who do not use condoms.

RESEARCH QUESTIONS

Specific research question

- What do adolescents and young people in Ghana know about condom use in HIV/ AIDS prevention?
- What are the available sources of information on condoms and HIV/ AIDS prevention for adolescents and young people and which do they prefer?
- How do adolescents and young people perceive or interpret relationships and sex?
- What are the reasons for condom use among sexually active adolescents and young people, and their experiences?
- What are the perceived social and cultural norms about sex and how do they militate against condom use among sexually active adolescents and young people?

SCOPE OF THE STUDY

HIV/ AIDS transmission occurs in various varied media, which includes but not limited to: exchange of blood and blood products for example through blood transfusion, using or sharing contaminated needles and sharp objects. Transmission can also occur from an infected mother to child through child birth or breastfeeding and also having unprotected sex with an infected person; in which case it can be transmitted within opposite or same sex sexual relationships. Although participants were in known and mentioned these various media of transmission, the study does not cover all these, but focused on prevention of sexually transmitted HIV/ AIDS through the use of condoms among adolescents and young people.

CHAPTER 2 - LITERATURE REVIEW

The purpose of the study was primarily to understand adolescents' and young people's sexuality with regards to their knowledge and experiences of condom use in HIV/ AIDS prevention, as well as their perceptions and experiences with relationships and sex. This Chapter therefore presents a review of related literature on adolescents and young people's sexuality in order to have a broader view of the issue to support the current study.

HIV/AIDS Burden among Adolescents and Young People

Sexually transmitted infections (STIs) are a major international health issue responsible for high morbidity and mortality. Globally, it is estimated 35 million people are currently living with HIV, Sub -Saharan Africa is the most affected region with 25 million people living with HIV/AIDS account almost for 70 percent of global total of new HIV infections.(31) Young people aged 15 to 24 represent about 40 percent of all new cases of HIV/ AIDS among persons aged 15 to 49; considered to be the group with the highest prevalence.(32) Studies points to evidence that young people have a higher and higher infection rates of HIV/ AIDS than in previous generations.(33) A World Health Organization (WHO) systematic review estimated that 50 percent of HIV transmission occurs among youth aged 15–24 years(34), possibly because young people lack adequate life skills to protect themselves from unplanned pregnancies and STIs.(35)

Adolescence is the period between 10 and 19 years of age. The term 'young adult' indicates the post-adolescent period and overlaps with adolescence. The age range implied by the terms 'youth' or 'young adult' by WHO is 15–24 years (14). However, for the purpose of this review both terms may be used interchangeably to refer to young people aged 14 to 20 years; our population of interest. This period is characterized by efforts to consolidate knowledge of oneself, and to integrate the images of the self into a personal identity. Information on the outcome of behaviour of others and information on how the outside world evaluates one's own behaviour are essential for the development of a consistent set of values, beliefs and behaviors, which together shape this unique identity. Therefore, adolescents typically tend to experiment with diverse roles in numerous relationships with adults and peers.(36)

Adolescents' and Young People's Sexual Risk Behaviors

Although social issues such as poverty and inequality can result in an increased incidence of STIs among communities,(37) young people (typically those under 25 years) have a high

incidence of STIs(14) They are known as a population at risk of HIV infection mostly because they consider themselves, immune from infection, exploring their sexual identities and often are experimenting; their behaviour tends to be impulsive and greatly influenced by peer pressure, often feel invulnerable and have trouble seeing long-term consequences.(38) In addition young people tend to be insufficiently aware of the health risks of physical intimacy, and they often lack information on how to prevent such risks. Consequently, they are in danger of contracting sexually transmitted infections (STIs), which can have serious consequences because of their young age.(39) Thus, experimenting with relationships and intimate behavior has increasingly become a normal pattern of their development. The young adolescent, however, does not yet have a consistent set of norms or a behavioral repertoire, which makes it difficult to attain satisfactory sexual experiences. As a result, young adolescents' sexual encounters are often unplanned, sporadic, and sometimes the result of social pressure or coercion.(40)

The risky sexual practices among young people may include having multiple sexual partners, early sexual debut, engaging in unprotected sexual intercourse, and engaging in sex with older partners.(41,42,43) A 2003 survey indicated that the median age of first intercourse was 16.9 years for boys and 17.4 years for girls.(44) The same study found that the percentage of teenagers under the age of 14 years engaging in sexual intercourse had decreased to 6 percent among girls and 8 percent among boys. Nearly one million teenaged girls, however, become pregnant each year in the United States.(45) This represents a 28 percent decrease in the pregnancy rate since the 1990s. A related concern is that four million teens contract some form of sexually transmitted disease (STD) each year, the highest ranking in the Western world.(46)

Previous reports have shown that youth's risk taking sexual behavior and their vulnerability to HIV and other sexually transmitted infections (STIs) are significantly related.(47) Risky sexual behaviors developed during youth may also influence sexual behavior in adult life, thus increasing the cumulative risk of acquiring and transmitting an STI.(48)

Condom Use among Adolescents and Young People

Efforts to address the rapid spread of STIs have largely focused on promoting the use of the male condom as a protective 'safer sex' measure. However, despite widespread and multi-targeted public campaigning promoting safer sex through condom use, its use is still largely inconsistent and the incidence of STIs continues to increase.(31).

Despite the epidemic proportions of STIs and extensive publicity campaigns, condom use is reported to be generally inconsistent, particularly among young people.(49) Less than half of an Australian sample of sexually active respondents, aged 16–59 years, reported using a condom in the preceding 12-month period.(50). In their examination of knowledge of STIs among young people (15–21 years), James et al. found that condom use was inconsistent despite awareness that condoms were effective in preventing transmission of STIs.(51) Similarly, another study found that consistent condom use only occurred in just over half a sample of sexually active young people (aged 14–20 years).(52) From the findings of these studies, it is evident that, although some young people may have adequate knowledge about STIs, their perceptions of themselves as being at low risk increase their vulnerability to STI acquisition.

Clearly, despite the availability of condoms, there remain significant barriers to their use. Furthermore, it is well documented that, for a variety of reasons, men of all ages do not like to use them.(14,53) There is some suggestion in the literature that condoms are more strongly associated with contraception rather than safer sex,(53-55) and this association could mean that young people may stop using condoms when contraceptives such as the OCP are used.(56) The development and formation of romantic and sexual relations begin in the time span between adolescence and young adulthood. Although romantic love among young people can have various meanings, it is generally characterized as having attributes such as trust, attraction, happiness and friendship.(57,58) Within the context of romantic love, sexual relations can be guided by gender scripts, which equate sexual activity with trust, intimacy and commitment for young women, and with physical pleasure, particularly for young men. Safer sex and condom use can be hindered because condom use may imply mistrust, and unsafe sex is often seen as a declaration of one's love. Within the romantic love discourse it is difficult to conceive that the person who holds the affection of another could possibly be a source of sexual infection.(59)

In a related study of condom use and relationship characteristics among 13–24 year olds with STIs, it was found that condom use was dependent on relationship type, with condom use decreasing with: age, having a child, cohabitation, increased frequency of intercourse within a partnership and perceptions of a relationship as positive.(60) Generally, condoms are seen as something that does not contribute positively to an intimate relationship, but that the condom is an object that symbolically taints it. The condom is often associated with casual sexual encounters and infidelity, and thus can imply mistrust within a partnership.(61) Mistrust is not in

keeping with the ideas and beliefs young people hold about romantic love. However, what is concerning is that it has been posited that the average time-frame for young women's relationships to progress from being treated as new to being considered established and therefore marks the beginning of unsafe sex is 21 days.(62) With trust long being promoted as the basis for a healthy and loving relationship, women may be reluctant to initiate discussion about a partner's previous sexual exploits and safer sex, as it may be interpreted by their partner as mistrustful. Furthermore, women may be reluctant to raise the subject of safer sex because of their own previous sexual history, fearing judgment by their partner that parallels societal disapproval and labeling of sexually active women as promiscuous.

Skidmore and Hayter(63) found that unprotected sexual encounters were influenced by the physical appearance of potential sexual partners and factors such as perceived knowledge and trust. However, subjective assessments determining a sexual partner's risk are often erroneous and can conflict with the sexual partner's actual- lived background. Stoner et al.(64) also found that individuals who had contracted an STI had underestimated the sexual risk of a partner. Hoffman and Cohen (65) further concluded that assessment of an individual's sexual riskiness was based on personal looks and characteristics, perceived trust, and disclosed information rather than what is factual. These bases for assessment, as the authors suggested, reinforced sexual risk behavioral because people assumed that their subjective assessment of partner risk was correct, particularly when previous avoidance of STIs had occurred despite engagement in unprotected sexual activity. Although young people, typically those under 25 years, have a high incidence of STIs, (14) young people perceive themselves as being relatively invulnerable to STI acquisition. Owing to this perceived invulnerability, and the general concept of invincibility among young people, it is common for them to think that STIs happen to others rather than to themselves, and they may frequently engage in sexual high-risk behaviors.(66,67).

A study conducted by Stulhofer et al. found that positive sexual attitudes among males and females and condom use during the first sexual intercourse were stronger predictors for condom use during their last sexual intercourse.(68) Cohen emphasized that the use of condoms is a critical component of safe sex behavior and one of the most effective ways to prevent HIV infection.(69) It was shown that using condom during the first sexual intercourse event was associated with decreased STD infections.(70) Thus, it is clear that sexual attitudes can influence safe sexual behavior among adolescents.

Females are more likely to have unprotected intercourse than males. It is argue that adolescent females may feel that it is their partner's responsibility to decide whether a condom will be used. They may also believe that they lack the skills to negotiate safer sex practices, and may fear termination of the relationship or coercion in case they do not agree to have unprotected sex.(71) Owing to the power inequality in sexual relationships, women remain ill-equipped to advocate their own sexual health; adolescent girls, in particular, reportedly find it easier to refuse sex than to initiate condom use (14,71). The reluctance associated with condom use is complex and embedded in issues of gender and power relationships.

Attitudes to the use of condoms also differ between the genders. Grady et al.(72) found that both men and women ranked the condom highest as a way of preventing STIs and the OCP was ranked the most effectual for birth-control. Although pregnancy prevention was ranked the most important characteristic of contraception among the males and females, men ranked prevention of STIs higher than women. Similarly, the findings of a Russian study showed that the importance of condom use for females was pregnancy prevention, whereas for men it was STI prevention.(73) These findings could reflect the fact that women bear the major responsibility for the consequences of unwanted or unplanned pregnancy, the ramifications of which may be perceived as more long-lasting and life-changing than contracting a STI.

The issue of perceived sexual pleasure is central to the use of condoms regardless of whether the purpose of use is to protect against STIs, prevent pregnancy, or both. It has been reported that males place greater value than women on sexual pleasure,(72) with men asserting that condom use interferes with sexual pleasure and intimacy.(53,63,74) Thus, men have some resistance to condom use, and may refuse to use condoms.(50)

Male resistance to condom use places the responsibility on young women to insist on their use, a stance that may pose difficulties for some women. Condom negotiation requires women to have high self-efficacy, perceived autonomy within the encounter, and acceptance of sexuality and effective communication skills.(50,75) Women of all ages may find it difficult to successfully negotiate the use of condoms; however, young women and adolescents may find it even more difficult because of their age and probable inexperience in such negotiation.(14) Strongly entrenched social and cultural norms that reinforce male dominance and female passivity within sexual encounters are likely to hinder women's ability to negotiate safer sexual practices. This

power imbalance and inequality limits female assertiveness.(76) It has been reported that young women feel more positive towards condoms and are more committed to their use than men.(77) However, condom use is influenced by egalitarian partnerships with women's use of condoms being hindered by repressive relationship dynamics and gender attitudes.(78) That is, in relationships in which women are typically viewed as subordinate to the male, women lack the power to assert condom use. Furthermore, successfully negotiating condom use can be hindered by women perceiving a negative reaction from partners, including fear of emotional or physical abuse.(75)

HIV Prevention among Young People in Ghana

Similarly, Young people in sub-Saharan Africa (SSA) face a higher risk of HIV/ AIDS as they transition from adolescence to adulthood. For instance, in Ghana a combination of being sexually active in adolescence and low condom use among sexually active young people heightens the risk of acquiring HIV/ AIDS and other sexually transmitted infections.(23) In 2011, an estimated 1.9 percent of Ghanaian youth, aged 15 to 19 years, were living with HIV, an increase of 1.1 percent from 2010.(79) In addition young Ghanaians, aged 15 to 19, have the second highest prevalence of STI in the country, with 22 percent reported having STIs or STI symptoms.(23)

To a large extent the most frequent means of transmission of the HIV virus in Ghana is heterosexual intercourse contact.(80) It is estimated that 70 to 80 percent of all those infected with the HIV virus in Africa contracted it through sexual intercourse with an infected person.(81) Prevention education is recognised as the primary means of decreasing the rate of new HIV infections among young people(24) and the quest for improved educational approaches is still a challenge. Traditionally, prevention of HIV/AIDS among young people has until recently focused primarily on individual-level HIV risk factors. These programs are commonly designed to increase adolescents' knowledge of HIV/AIDS; promote delay in sexual debut; encourage the use of condoms with non-marital partners. However models that rely on such rational choice behaviours ignore broader social, economic and cultural factors that operate outside an individual's ability to weigh costs and benefits but have substantial influence on sexual behaviours of young people.

For sexually active adolescents, consistent use of condoms during sexual intercourse is the most effective behavioural measure to prevent HIV infection. Although 82 percent of young people

aged 15 to 30 years in Ghana are sexually active,(24) reports indicate that the prevalence of condom use in this age group is only 15 percent.(82)

HIV/ AIDS Awareness and Behavior Change

Research suggest that although young people may be knowledgeable about HIV, knowledge does not necessarily equate with behavioral changes, nor does it influence risk perception of HIV.(22,51) Despite high knowledge of condoms and HIV/AIDS, condom use among sexually active young Ghanaians remains low. A study to examine knowledge of HIV among young people 15 to 21 found that condom use was inconsistent despite awareness that condoms were effective in preventing transmission of HIV.(51) A similar study in the Netherlands found that consistent condom use only occurred in just over half a sample of sexually active young people aged 14 to 20 years.(52) Thus in general, literature reveals that awareness among adolescents is high but some knowledge gaps still exist, as to why this high awareness levels, almost universal (up to 98 percent) among Ghanaian youth,(79) is yet to translate into appropriate behaviour.

Psychological research on determinants of sexual behavior has mostly applied a decision-making framework.(83). It includes the application of theoretical models, such as the Health Belief Model,(84) the Theory of Reasoned Action,(85) and the Theory of Planned Behavior.(86). Within this framework, one assumes that individuals will adopt a healthy behavior (in this case, the use of condoms), once they are convinced that the benefits will outweigh the drawbacks. Thus, when the estimated benefits of using condoms (e.g., reduced chance of acquiring STI) are higher than the expected disadvantages (e.g., reduced satisfaction), the chances that precautions are taken increases. Attitude, beliefs and motivations with regard to health protection and disease prevention are therefore expected to explain whether or not protected sex is practiced. To date, research based on this framework has had some success. In particular, the Theory of Planned Behavior has been fairly successful in explaining condom use.(87) However, the decision making framework does not take into account that behavior may fulfill a variety of individual goals unrelated to health protection or disease avoidance. For example, a more relevant goal may be personal development or a wish to belong and to be accepted by others.(88)

While individual and group level interventions have been quite effective, behaviour occurs within a context. Literature suggests that young people's sexual behaviour and attitudes towards condoms may also be influenced by a range of social and cultural factors.(89,90) Kippax

suggests that HIV transmission and therefore prevention is profoundly social, as are the responses of individuals, communities and governments to it.(89) Thus effective HIV prevention involves modifying social practices, including sexual practices, which are regulated by local and particular social and cultural understandings and norms. Studies conducted in Cameroon(90) and South Africa(91) shows that a supportive social environment was associated with higher use of condoms among young people. Furthermore, evidence from other studies suggest that socio-cultural factors are the most common barriers to obtaining male condoms among sexually-experienced adolescents in Burkina Faso.(92)

It is evident that, strong cultural norms are especially restrictive for sexually active young women. Young women who carried condoms on them risked being labelled promiscuous. In addition to this, the inability of both male and female partners to negotiate for condom use within relationships, especially within established relationships, has also been shown to be as result of the society's construction of sexuality.(91) Furthermore, recent studies have demonstrated that young people who perceived peer norms as supporting condom use were more likely to report consistent condom use. Further evidence also suggests that Ghanaian youth are more likely to use condoms if they believe that their peers support and approve of condom use.(81,91,93)

The use and non-use of condoms by young people cannot be divorced from the economic context in which they live their lives. MacPhail et. al(91) concluded that poverty was a powerful agent in preventing young people from purchasing condoms. In addition, a complex relationship between poverty, gender relations and male 'need' for sex was identified as resulting in little condom use among South African youth. Male and female groups identified sex as a driving force for males to engage in relationships and money as one of the dominant reasons for females to have relationships. The same study outlined the commercialization of youth sex in the southern African context, claiming that women frequently engage in sexual relationships with the expectation of monetary remuneration. Krugu et al. found that, young people's relationship needs were 'beyond love,' explaining that being supported financially to cater for basic needs was a main reason for young people in Ghana- especially girls accepting to be in sexual relationships.(94)

Another factor that influence adolescent condom use is the attitude of adult relatives to its use. While there is concern among adults about the spread of HIV among adolescents, adult relatives do not support the use of condoms but rather prefer to encourage abstinence through punishment. MacPhail et. al found that young South African males often do not use condoms due to their parents' disapproval of adolescent sex.(91) The study pointed out that most people lived at home with their families and therefore their opportunities to have sex were usually constrained by their parents. When the opportunity arises to have sex, many don't bother with condoms as they are considered a waste of precious time during which adults are absent from home. The study further emphasizes that, not all adolescents and young people conform to these norms. As this study also seeks to find, some adolescents and young people who define their sexuality outside of the norms constructed by society thereby, challenging the traditional/normative social constructions of relationships and sexuality.

Some research(95) has suggested that parent-teen discussions influence adolescents' sexual attitudes and behavior; however, factors associated with such discussions are not well understood. Others contend that parent–teen connectedness (support, closeness, and warmth) is related to lower adolescent pregnancy risk; evidence is greatest for this effect through delaying and reducing adolescent sexual intercourse.(96) According to Baldwin & Baranoski, Sexuality education of adolescent children happens through family interactions that occur long before the child reaches teenage years.(97) Not all adolescents have family interaction regarding sexual education in the home; however, some of the available evidence supports the notion that adolescents want more interaction with their parents about sexuality.(98) Adolescents who reported more sexuality education by their parents also had better communication within the home, and were more likely to be satisfied with family interactions.(97) Some adolescents reported their parents served as rolemodels by instilling values and beliefs about sexuality education. These adolescents indicated they learned from their parents by indirect actions, such as observing parents dating or a parent's behavior in public places.(98) This type of education could later influence the decision-making process about sexual intercourse.

Research further demonstrates that 65 percent of 15–17-year-olds are getting information on birth control and protection from advertisements through television, magazine articles, and internet sites.(99) A majority of teens ranked entertainment media as their top source of information on sexuality and sexual health. Given these compelling statistics, it appears that

many parents are losing a “window of opportunity” to provide their children with accurate information related to sexuality.

Sexuality education is occurring in all areas of adolescents’ lives from television to the school and also peers. Studies have shown, however, that the preferred sexuality education comes through family interactions and should be established long before the child reaches his/her teenage years.(97) Some studies show that greater parent/adolescent communication about sexuality is associated with a decrease in adolescent sexual behavior.(96) Furthermore, increased parent/child communication decreases risk behaviors by encouraging the delay of first intercourse, increasing condom usage, and decreasing the number of sexual partners.(100) Unfortunately, 61 percent of teenagers are more likely to obtain information from their friends about sexual matters than from their own parents. Adolescents who do not talk with their parents about sexual issues are more likely to allow peer norms to guide their sexual behavior.(101) The implicit message from parents who do not engage in the conversations may be that they do not care or are too uncomfortable addressing sexuality. Although children generally prefer to discuss relationships and sexuality with parents, certain circumstances prevent this conversation.(102)

Many parents prolong initiating the conversation about sex because they fear that once the topic is raised, teenagers will be left with the impression that implicit permission has been granted to be sexually active.(103) Even though the discussions are delayed, parents that do discuss sexuality with their children may be demonstrating more comfort talking about sexuality. If the discussions about sexuality are not initiated until adolescence, the child may perceive the parent–child sexuality conversations as intrusive, embarrassing or unimportant.(104) Rather, if the discussions begin in early to middle childhood, such conversations may be seen as more normative and may communicate more clearly that the parent is a resource.

According to Kirkman et al; mothers tend to initiate sexual education discussions with their children because mothers communicate better with both sons and daughters when compared to fathers.(105) It may be that women have better communication skills in intimate relationships when compared to men. Furthermore, mothers spend more time with their children, are more proficient communicators, and tend to be the parent who displays more intimacy with children. In contrast, fathers often hold the belief that sexuality education with children is a responsibility that falls in the mother’s parenting domain.(106) Adolescents who are satisfied with their

mother–child relationship, are less likely to be sexually involved.(100) Similarly, research has demonstrated that maternal discussions about condom usage in the year prior to first sexual experience are strongly associated with teens using protection during intercourse.(96) It seems that mothers who demonstrate confidence in discussing sex with their children generally expect more positive outcomes from these discussions.(107)

However, mindful of the fact that young people do not always constitute a homogenous grouping, and that there will always be a range of variations in the extent to which young peoples' behavior serves to reproduce or resist dominant social norms. As this study seek to identify young people with counter-normative behaviors and views, an investigation into the interaction of factors that operate to affect their sexual health behavior will help health care providers develop a more comprehensive sex education program for adolescents and young people. Such factors may include individual-level perceptions of health and vulnerability, community-level factors such as peer and parental pressure, and wider social influences including the social construction of male and female sexuality and gendered power relations, as well as economic constraints.

CHAPTER 3 - RESEARCH METHODOLOGY

This chapter presents the study methodology and consists of a description of the research design and the underlying basis for the choice of methods and research instruments used to understand adolescents and young people's sexual and condom use behavior. It also includes a description of the study context, participant characteristics and recruitment strategy, data processing and analysis approach, techniques employed to ensure trustworthiness of the study, as well as some ethical considerations during the research process.

RESEARCH DESIGN

The debate over relative merits of qualitative and quantitative methodologies rages on but many researchers are insisting that there is a great complimentary between them. While some kinds of data are best collected with one or the other method, most information is best collected by a combination of the two approaches. The overarching premise is that the integration of two or more approaches should provide some added benefit with regard to research objectives that a single approach could not offer. The decision of whether or not to integrate multiple approaches depends on a combination of the research objectives, the resources and time available, and the audience for the study's findings.(108)

In the study of human behavior, much of the initial description takes the form of observations and information documented qualitatively. The use of qualitative data has become more common and has recently grown in acceptance within the scientific community, especially in the area of public health which to a large extent is due to new questions about relationships between human behaviors and public health problems including HIV/ AIDS. It is also effective in identifying intangible factors such as social norms, socioeconomic status, gender roles, ethnicity, and religion whose role in research may not be readily apparent.(109)

Qualitative research aims to describe social phenomena and behavior through the means of rich contextual data. According to Yilmaz(110) qualitative methods are a useful tool for exploring complex behaviors, attitudes, and interactions which the quantitative methods fail to do. It is employed in understanding phenomena of interest from a broader perspective with the aim of describing, interpreting and contextualizing it. Unlike much quantitative methods, qualitative explorative methods are concerned with answering questions such as what the phenomena of

interest is, how does the phenomena vary in different situations and why the difference.(111) The value of such a perspective has gained acceptance and favor in social behavioral health related research.

Although findings from qualitative data can be extended to people with characteristics similar to the study population, gaining a rich and complex understanding of specific social context or phenomenon is most often of more importance than findings that can be generalized.(108)

With the emergence of HIV/ AIDS and other public health problems, traditional quantitative data collection methods have become recognized as insufficient to meet informational requirements about human health and behavior. The increased use of qualitative methods thus reflects an urgency to understand HIV/AIDS risk behaviors and their contexts and to develop effective prevention interventions for curbing the epidemic. Furthermore, the use of quantitative methods in the evaluation of HIV prevention programs provides answers limited to whether an intervention has worked rather than promoting an understanding of why the intervention has worked. In addition, in many instances when working within the field of HIV, researchers are still attempting to understand rather than to measure. Quantitative methods do not allow researchers to consider the processes at work but rather limit them to the final outcome.(91)

In the qualitative approach the researcher normally adopts inductive reasoning; qualitative data analysis gradually performs from the first contact between the researcher and respondents. Through interactions with informants, the researcher collects and interprets the data based on his or her understanding of the context in which it is collected. This enables the researcher to gain an in-depth understanding of the issue under investigation.(110)

This study is aimed at understanding the condom use experiences of sexually active adolescents and young people and these experiences can be better understood, by employing the phenomenological approach which provides an understanding of phenomena from the actors own perspective and describes the world as experienced by the subjects, with the assumption that reality is what people perceive it to be.(112)

CONCEPTUAL FRAMEWORK

Several studies recognize the influence of a variety of individual and structural factors that impact adolescents' and young people's reproductive health related behavioral intentions.(113) Mann and Tarantola further pointed out that, prevention of sexually transmitted infections, including HIV/AIDS and other reproductive health consequences among adolescents required an

understanding of how these factors interact in order to design appropriate intervention programs and policy.(114) It is therefore, important to place adolescents' and young people's sexual behavior within a framework to provide a better understanding and facilitate a more detailed explanation of the phenomenon and its possible causes.

Some theoretical models, mainly from the behavioral sciences, have been used to predict human behaviors which mostly attempt to provide explanations of why people behave as they do.(83,84,85,86,87) Within this framework, one assumes that individuals will adopt a healthy behavior (i.e. condom use), when they believe that there is more benefits to be gained compared to the down side. Thus, when the estimated benefits of using condoms (i.e. reducing HIV risk) are higher than the expected drawbacks (i.e. reducing sexual pleasure) the chances that precautions are taken increases. Attitude, beliefs and motivations with regard to health protection and disease prevention are therefore expected to explain whether or not protected sex is practiced.

It is however important to mention the social environment has a great impact on the individual's actions, some of which are induced by the rules, norms, and cultural practices of society they find themselves. It is further suggested that HIV transmission and therefore prevention is profoundly social, as are the responses of individuals, communities and governments to it. Thus effective HIV prevention involves modifying social practices, including sexual practices, which are regulated by local and particular social and cultural understandings and norms.(89) Thus, Bronfenbrenner's work provides an alternative insight not applicable when using other possible theories.

Bronfenbrenner's Ecological Systems theory,(115) lately renamed the bioecological systems theory (see fig. 2 below) underlines the child´s own biology as the primary microenvironment that is the fuel for development. It however lays stress on the quality and context of the child´s surroundings. Bronfenbrenner maintains that because the child develops, the interaction with the environments acquires a complex nature. The chance for complexity appears since the physical and cognitive structures of a child grows and matures. The theory dwells on human development and follows one´s growth into a fully competent member of the society. Thus, it is a developmental psychology theory. It has also been called the theory of socialization.(116)

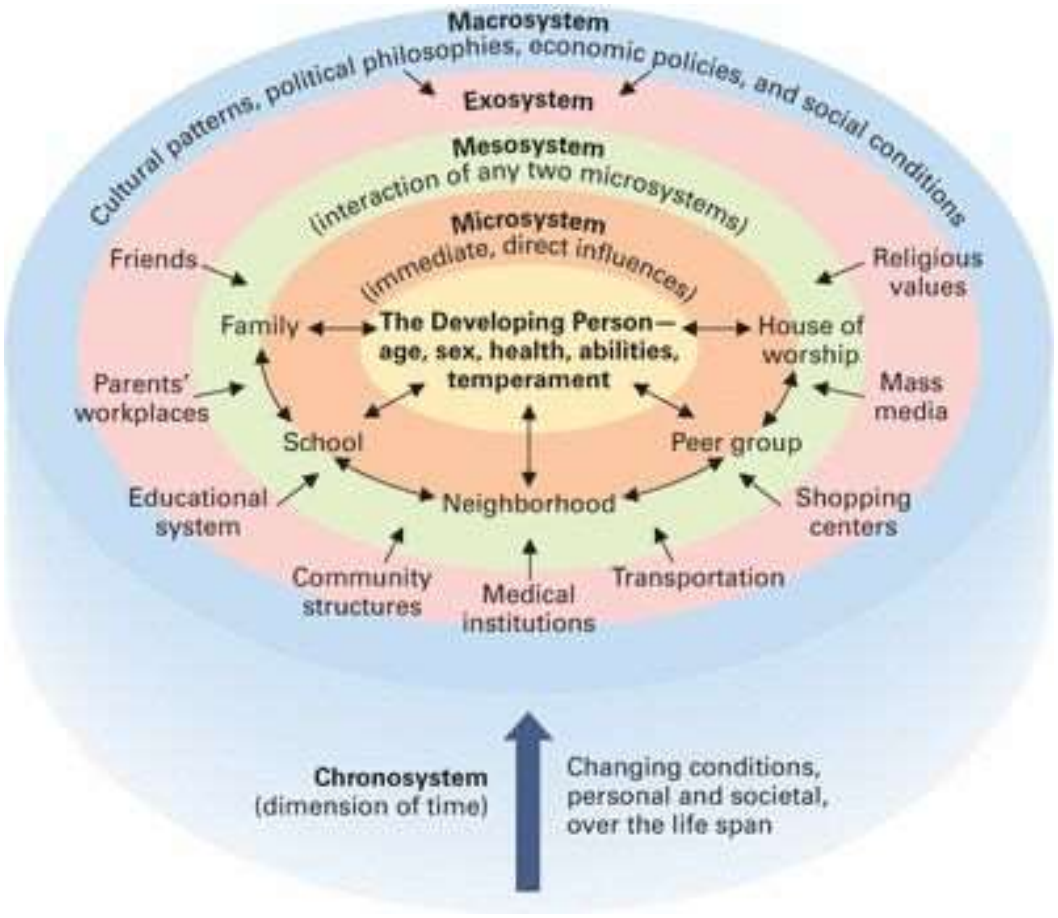

Fig. 2 - Bioecological Systems Model of Human Development

According to Bronfenbrenner, development and socialization are influenced by the different width rounds or circles of the environment with which a person is in active inter-relation. This includes three significant assumptions:(115,116)

1) The person is an active player, exerting influence on his/her environment,

2) The environment is compelling person to adapt to its conditions and restrictions and

3) The environment is understood to consist of different size entities that are placed one inside another, of their reciprocal relationships and of microsystem, mesosystem, exosystem, and macrosystem.

In an attempt to explain the theory, Härkönen(117) describes the levels of influence and their inter – relationships as follows;

The microsystem is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical and material features, and containing other persons with distinctive characteristics of temperament, personality, and systems of belief. The microsystem is closest environment for a child and includes the structures with which the child maintains direct contacts.(118) At this level the relations between persons happen in two ways – from the parent and towards the child. For example, a child´s parents have an influence of his/her beliefs and behavior, but the child can as well influence the parents´ beliefs and behavior. Bronfenbrenner calls this bi-directional influence and he points out how such relationships exist on the levels of all environments. The interaction within the layers of the structures and the interaction of the structures between the layers is the key to this theory. In a microsystem the bi-directional interactions are at their strongest and they have a most powerful influence on the child. Still, the interactions on the outer levels can nevertheless have an influence on inner structures. A microsystem is made up by the developing person´s closest surroundings like home, the day care group, the kids in the courtyard, classmates at school, or close relatives.(116) Other examples may include the neighborhood or the religious setting.(117)

The mesosystem, comprises the linkages and processes taking place between two or more settings containing the developing person e.g., the relations between home and school, school and workplace etc. In other words, a mesosystem is a system of microsystems. This layer produces the connections between the child's microsystems, i.e. connections between the child´s teacher and the parents or the child´s church and the neighborhood. Saarinen et.al. explained the mesosystem by saying that it consists of the relationships that the child´s and a young person´s Microsystems have between themselves.(116) The important ones are first of all the relation between home and mother and child clinic, home and kindergarten, as well as home and school interaction. It is important to see if the influencing factors of socialization have coinciding or opposing directions, in other words, do the different Microsystems support each other or does the developing person perceive them as clashing pressures, are there in different microsystems expectations or obligations for different ways of behavior.

The exosystem, encompasses the linkage and processes taking place between two or more settings, at least one of which does not ordinarily contain the developing person, but in which events occur that influence processes within the immediate settings that does contain that person (e.g. for a child, relation between the home and the parent's work place; for a parent, the relations between the school and the neighborhood group)

The macrosystem consists of the overarching pattern of microsystem, mesosystem, and exosystem characteristic of a given culture, subculture, or other broader social context, with particular reference to the developmentally-instigative belief systems, resources, hazards, life styles, opportunity structures, life course options, and patterns of social interchange that are embedded in each of these systems. The macrosystem can be thought of as a societal blueprint for a particular culture, subculture, or other broader social context. Bronfenbrenner(115) reiterates that the behavioral and conceptual models that are characteristic of the macrosystem are transferred from one generation to another by the means of different cultural institutions like family, school, congregation, workplace and administration that intermediate the processes of socialization.

Berk(118) writes that the macrosystem is the outmost layer for the child. It has no distinct framework but it holds inside it the cultural values, traditions and laws. The macrosystem influence penetrates through all other layers. For example, if in a culture it is believed that bringing up children is the parents´ task then evidently this culture will not offer much help to the parents in their educational efforts. Saarinen et.al.(116) pointed out that the impact of the macrosystem will often be noticed only after making comparison between children and young people, growing up in different societies. Puroila and Karila(119) have concluded that under the notion of macrosystem Bronfenbrenner might have meant not only the society but cultures and subcultures as well.

The chronosystem is a description of the evolution, development or stream of development of the external systems in time. The chronosystem models can cover either a short or long period of time.(115) The time change has been shown in the models by using the terms like change, development, history, time and course of one´s life. Any system, like this one, includes roles and rules that can have a strong influence on development.(120)

In summary, Bronfenbrenner's Bioecological Systems Theory asserts that human development occurs at different levels of social interaction and within multiple environmental systems. These developmental processes have a bi-directional effect, and occur between individuals and their environments with the interconnectedness of each system and their consequent interaction with the individuals. Although Bronfenbrenner understood interpersonal dynamics such as sexual behavior to occur in the microsystem (the most immediate environments or settings), other ecological systems are also thought to impact these sexual behaviors (i.e. exosystem, macrosystem).(121)

The bioecological theory of human development, initially termed an ecological approach, was originally proposed to explain how human development occurs, focusing largely on the impact of context. By the word *ecology*, Bronfenbrenner clearly viewed development as emerging from the interaction of individual and context. Subsequent reformulations of his original ideas resulted as he came to stress the role played by the individual; the impact of time; and most important of all, proximal processes. Bioecological theory in its current form specifies that researchers should study the settings in which a developing individual spends time and the relations with others in the same settings, the personal characteristics of the individual (and those with whom he or she typically interacts), both development over time and the historical time in which these individuals live, and the mechanisms that drive development (proximal processes). It is thus held that, children are embedded within various sociocultural systems that interact either to support or hinder their development and thus influence their behavior.(115)

The BST in combination with others such as Bowlby's and Ainsworth's attachment theory(122) as well as Bourdieu's concepts of habitus and field(123) are thus very important and useful frameworks for understanding the individual and contextual factors that influence behavior change i.e. condom use among sexually active adolescents and young people in Ghana.

STUDY CONTEXT

The study was conducted at Odomaseman Senior High School, a flagship second cycle educational institution located in Odomase. Odomaseman senior high school is located along the Odomase - Kwatire road near the Sunyani West district education directorate. The co-educational institution which was established in 1985 has a student population of about 1079 out of which 468 are boarders, made up of almost equal enrollment numbers for both boys and girls.

Odomase is the capital of the Sunyani West district in the Brong - Ahafo region of the Republic of Ghana. The Brong - Ahafo Region is one of the ten administrative regions in Ghana. The region has 22 administrative districts with the Sunyani west district being one of them. The region has a total population of about 2.3 million inhabitants and accounts for about 9.4 percent of the national population. With a land area of 39,554 km^2, it is the second largest region by land area and has a population density of about 58.4 persons/ km^2. With a land area of about 1,059.33 km^2 and a population of about 85,272 inhabitants, the Sunyani West district accounts for about 3.7 percent of the total population of the region. Females constitute 51.5 percent and males represent 49.5 percent. About 71 percent (70.8) of the population reside in urban localities. The district has a sex ratio (number males per 100 females) of 94.3. The youthful population (population less than 15 years) in the district accounts for 38.3 percent of the population. Residents of this district are mostly employed in agricultural, fisheries and the forestry occupations with about 29.3 percent not economically active and 5.4 percent unemployed.(1)

The regional HIV prevalence is about 2.2 percent, one of five regions with prevalence above the national average. It also has the second highest prevalence of 1.1percent among young people; HIV prevalence among Ghanaian youth is highest in Central region (2.9 percent), followed by youth in Brong Ahafo region (1.1percent), while all other regions have a prevalence of less than 1 percent.(9)

PARTICIPANT RECRUITMENT

Participants for the study were male and female students of Odomaseman Senior High School aged 14 to 20 years; and were recruited with the assistance of the contact person who is a teacher in the school by purposeful sampling. This method of recruitment was necessary due to the time and resources available and therefore, it was imperative that the study was conducted in the most efficient manner. Furthermore, it allowed for the identification and selection of participants who are knowledgeable about the phenomenon of interest and may have had some experiences in that regard. In addition, it was assumed that the teacher knew the students better and could assist in identification and selection of participants who could communicate better and are willing to share their experiences and opinions in an articulate, expressive, and reflective manner. In all, thirty – two participants were identified; however, only twenty – three were recruited; thirteen females and ten males based on the age requirement for the study and the desire to recruit equal numbers of males as female participants.

DATA COLLECTION

In achieving the already stated objectives for the study a range of qualitative methodologies were used to answer the research questions posed. A comprehensive understanding of all the aspect of data collection is important to carry out a quality research that uses qualitative methodology. There are a variety of data collection method used in qualitative methodology; however for the purpose of this study, the researcher employed two main types namely; in depth interviews and focus group discussions. Interview guides (see appendix C) were developed for both in-depth interview and focus group discussions and were pre-tested with a group of Norwegian high school student of similar characteristics as the study participants. Although contextually different, this was purposely done to ensure clarity and appropriateness of questions due to the sensitive nature of the topic.

In depth Interviews

In-depth interviews are utilized when researcher wants to find out detailed information about a person's perception, based on behavior or experience, on opinion or value, on feeling, on knowledge, and on sensory experience and those asking about demographic or background details and can explore new issues in depth.(111) They may be used to provide a focus on subjective human experience of other data offering a more complete picture of an issue. In health and social care research, in depth interview is particularly useful where the research questions involve one of the situations where people's experiences and views are sought on real life sensitive topics where flexibility is needed to avoid causing distress.(124) A typical example is when the potential participants may not be comfortable talking openly in a group, or when you want to distinguish individual perspectives and opinions about a particular issue of interest. It is also recommended when the researcher has developed enough understanding of a setting and his or her topic of interest to have a clear agenda for the discussion with the participant, but still remains open to having his or her understanding of the area of inquiry open to revision by respondents.

For our study, in depth interviews using semi structured, open ended interview guides (see appendix C) was used to obtain meaning and get participants' own perspective and experiences of the phenomenon. The interview guide consisted of questions grouped into different themes based on the theoretical framework and related to the research questions. This was mainly employed to collect some socio-demographic data of interest to the study and also assess

participants' knowledge of HIV and condoms. Participants were also asked about their sexual experiences as well as their condoms use experiences. This helped in identifying sexually active adolescents including those with counter normative behaviors who practiced consistent condom use as shown in fig. 3 and fig. 4 below. The initial plan was to recruit only those with counter normative behavior in the FGD; however the plan was change to include all participants due to some ethical dilemmas explained in the ethical considerations section. Interviews were conducted by the principal researcher in English, since that is the official language of instruction in Ghanaian schools and were held in the science laboratory which is secluded thereby enhancing privacy of our conversations. In addition to taking notes, all interviews were audio recorded if participants agreed and were later transcribed verbatim and translated where necessary. Before each interview, time was taken to establish a connection with participants by introducing myself and talking about topics which were not in any way related to the issue of enquiry. This was done to lighten the encounter in order to create a relationship where the participants felt very comfortable sharing their experiences with me. After each interview, participants were also asked for their consent to participate in the FGD which took place on a later date. Out of twenty - three participants only two declined to participate in the FGD.

Code/Name	Age (Yrs)	Marital Status	Parity	Residence	Relationship status	Sex	Consistent condom use
B1- Kwadwo	20	Single	0	Boarder	No	No	-
B2- Kwabena	17	Single	0	Day	Yes	No	-
B3- Kwaku	16	Single	0	Day	No	No	-
B4- Yaw	17	Single	0	Boarder	Yes	Yes	No
B5- Kofi	18	Single	0	Day	Yes	Yes	No
B6- Kwame	20	Single	0	Boarder	Yes	Yes	Yes
B7- Kwasi	15	Single	0	Day	No	No	-
B8- Fiifi	19	Single	0	Boarder	No	No	-
B9- Ato	16	Single	0	Boarder	No	No	-
B10- Jojo	20	Single	0	Boarder	Yes	Yes	No

Fig. 3 - Characteristics of Participants (Males)*

Code/Name	Age (yrs)	Marital Status	Parity	Residence	Relationship	Sex	Consistent condom use
A1- Adwoa	19	Single	0	Day	No	Yes	-
A2- Abena	18	Single	0	Day	Yes	Yes	No
A3- Akua	18	Single	0	Day	Yes	Yes	No
A4- Yaa	17	Single	0	Day	No	No	No
A5- Afua	20	Single	0	Day	Yes	Yes	No
A6- Ama	17	Single	0	Day	Yes	No	-
A7- Akos	17	Single	0	Boarder	Yes	Yes	Yes
A8- Esi	20	Single	1	Boarder	Yes	Yes	No
A9- Araba	17	Single	0	Boarder	No	No	-
A10- Awura	15	Single	0	Boarder	No	Yes	-
A11- Adzo	18	Single	0	Boarder	Yes	Yes	No
A12- Baaba	17	Single	0	Boarder	Yes	Yes	No
A13- Naana	18	Single	0	Boarder	Yes	Yes	Yes

Fig. 4 - Characteristic of Participants (Females)*

Names are imaginary Ghanaian names and do not in any way identify the participants

Focus Group Discussions

Focus Group Discussion is another important method of data collection which was used in this qualitative research. According to Kitzinger, FGD is relevant for finding out knowledge and experiences of people and also useful for exploring what people think, how they think and why they think that way.(125)

FGD are effective when seeking a broad range of opinions on a topic and they provide the opportunity for participants to probe each other's reasons for holding a specific view. This is also appropriate for discussing taboo topics like condom use among adolescents. For this research, FGD s provided a vivid description of how contextual factors, such as social and cultural norms influence adolescents and young people's sexual behavior and was important in gaining a complete understanding of the interview data. Participants discussed what they knew or have heard about HIV and prevention methods, why adolescents and young people have relationships and also sex, reasons for condom use or non-use among them, and any differences in male and female reasons. Participants were also asked to describe contextual influences on their sexual behavior and how these societal and cultural norms impact their condom use behavior. The FGDs were conducted in gender and age segregated groups; in all, four group discussions were conducted with a maximum of six participants in each group as shown in Fig. 5 below. Focus group discussions used semi – structured guides with discussion themes based on the theoretical framework and related to the research objectives. Discussion themes were verbalized as general, non-personal issues which allowed participants to discuss freely defining and describing the situation and influences using their own terms. Participants occasionally probed each other's views held which sometimes resulted in some disagreements and participants talked simultaneously making it difficult to follow. In such instances they were reminded of the importance of their contributions and therefore the need to speak one after another for their views to be acknowledged.

For the final part of the FGDs, questions required participants to share their ideas on how these contextual influences could be confronted in developing HIV/ AIDS and condom use interventions which will be beneficial to adolescents and young people. To conclude, each FGD ended with a feedback session to know informants' view of its usefulness and also a free questions session. Because the study setting was an educational institution, all discussions were held in English which is the language of instruction in Ghanaian schools. All FGDs were

facilitated by the principal researcher and were held in the science laboratory which is secluded thereby enhancing privacy of the discussions. In addition to taking notes; all discussions were audio recorded and later transcribed and translated where necessary. Before each FGD, participants were taken through the order of engagement and some guidelines were laid to ensure a successful outcome. All participants agreed for the discussions to be audio taped.

GROUPS	GROUP AA1 Females (14-17yrs)	GROUP AA2 Females (18-20yrs)	GROUP BB1 Males (14-17yrs)	GROUP BB2 Male (18-20yrs)
PARTICIPANTS	Ama	Adwoa	Ato	Kwadwo
	Adzo	Abena	Kwabena	Kofi
	Baaba	Akua	Kwaku	Kwame
	Araba	Afua	Kwasi	Fiifi
	Awura	Esi	Yaw	Kuuku
		Naana		

Fig. 5 - Groupings for Focus Group Discussion*

Names are imaginary Ghanaian names and do not in any way identify the participants

DATA PROCESSING AND ANALYSIS

Interviews and Group discussions were audio recorded, with permission of participants, and with the help of the field notes these were transcribed verbatim. Since interviews and discussions were conducted in the English language there were no translations made, except for the few expressions and terms participants used in expressing their experiences. All transcribed data were then imported into HyperResearch; qualitative data management software which was used in organizing data in an easily accessible manner and further assisted in generating codes from the data. Data was then analyzed using a phenomenological inductive approach guided by the data and the guiding theoretical framework- The Bioecological Systems Theory. This approach differs from others in that, it is specifically focused on describing what the participants have in common as they experience a particular phenomenon, and it is an inductive analytic approach that allows the patterns, themes and categories of analysis to emerge from the data.(126) It involved listening to all interviews several times and critically reading all transcripts in order to increase familiarity with data and in the process, identifies patterns and expressions that emerged that were relevant to the research objectives. These were assigned codes based on their meanings and connecting codes were further organized under categories which were representative of the

primary systems of the theoretical framework which have been demonstrated to influence sexual behavior among adolescents and young people.

REFLECTIVITY

Reflexivity is an important concept that is necessary to enhance accuracy or credibility of qualitative research outcomes. It is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. As a concept of acknowledging the researcher as the primary research instrument, it is assumed that perspective or position of the researcher shapes all research. It further holds that the researcher's background affects what is been investigated, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the understanding, framing and communication of conclusions. Among researchers, it is assumed that bias in a research study is undesirable; however, Malterud(127) writes that: "*Preconceptions are not the same as bias, unless the researcher fails to mention them*"

Furthermore, awareness of misperceptions through reflexivity enables the researcher to design specific questions for the participants that help inform and clarify understanding of the outcomes. It is therefore important to acknowledge that, my experience in working with adolescents and young people in health education and HIV prevention programs may have influenced my decision to conduct the study, methodology employed and therefore, the outcome of the study. Prior to enrolling in the program, I worked with the Sunyani West district directorate of the Ghana Education Service as the schools health education program coordinator. I work with a team of dedicated professional which among other things coordinated specific implementation methods of successful comprehensive health and STD/HIV peer education programs. My previous knowledge and experience helped me to gain prior insight of the situation and also assisted in the process of acquiring the permission from the education service under whose jurisdiction the study was conducted. Furthermore, being a Ghanaian, knowledge of the Ghanaian society informed me about the general culture of the people and what was required of me of a researcher. However, there were some things that I may have overlooked or underestimated which may have been interesting to the study. Moreover, different communities in the country have specific cultural practices which I may not be privy to due to the fact that I am not an indigene of Odomase community.

For these reasons field notes were kept throughout the data collection and analysis process on details of how processes or methodical decisions and unexpected situations that occurred may have influenced the results or outcome of the interview or results. Entries included notes on the researcher's perceptions of the participants and recollections of how the participants behaved and spoke during the interviews. This helped in drawing my attention to preconceptions, and how they impact on the credibility of the research outcomes, and was useful on what should be guarded against regarding subjectivity during the data analysis process

TRUSTWORTHINESS

In ensuring the trustworthiness of a qualitative study researchers argue for different standards for judging the quality of research. Guba and Lincoln suggested four criteria for judging the quality of qualitative research, which according to them better reflected the underlying assumptions involved in most qualitative research. These are **credibility**, **transferability**, **dependability**, and **confirmability**.(128)

Credibility involves establishing the accuracy of qualitative research or the extent to which the research is believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are ideally, the only ones who can legitimately judge the credibility of the results. It is also associated with the accuracy of the research process, consistency in the written product and accuracy in the data analysis. Through the use of multiple methods, i.e. method triangulation, contributions from the participants in our FGDs confirmed the responses from the in depth interviews with the same participants. Even though FGDs were held with the same group of participants, the aim was to identify the contextual influences on their experiences which confirmed their individual experiences. In addition, the researcher ensured transparency in the research and the data analysis process

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. To increase the transferability of the study, participants were selected based on the objectives of the study, as described above; through the recruitment process, it was ensured that participant selected would be able to provide a vivid description of

the phenomenon as experienced in the community. Thus information received from participants gave a perfect picture of the situation. The researcher further contributed to the transferability by giving a thick description of the situation based on the contextual factors that influenced their experiences.

Dependability is essentially concerned with the principle of replication; whether the same results would be obtained if the research is conducted by a different researcher with a different set of informants. However in qualitative research, understanding is constructed through the interaction between the researcher and participants, thus making it near impossible to replicate the study. To enhance dependability of the study, the researcher tried to draw attention to the context within which research was carried out by describing the changes that occur in the setting and how these changes may have affected the way the research was approached or the outcome.

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. It also deals with the evidence that the informants' expressions and the interpretation of the research are rooted in the informants' truthful meanings; thus verifies the aim of the study. Confirmability of the study may have been compromise due to the sensitive nature of the topic; participants may have given socially accepted responses and may have given information based on their notion of what the researcher would like to hear instead of their truthful experiences. In order to improve confirmability, the researcher ensured each interview or discussion began on a friendly note and tried to create an atmosphere of familiarity for participants to have trust to share their truthful experiences.

ETHICAL CONSIDERATIONS

Despite the potential for the study to contribute to improvement in HIV prevention programs for adolescents and young people, it required that the researcher considers some ethical issues related to health research involving this population due to their vulnerability. The Council for international organization of medical sciences (CIOM) guideline on conducting research with child participant classifies children as vulnerable due to their relative or absolute incapability of protecting their own interest. They may have insufficient power, intelligence, resources, strength and other needed attributes to protect their own interests and may be susceptible to coercion or undue influence to participate in a study. (129)Due to nature and the sensitivity of the topic of inquiry, the key ethical issues considered in enrolling participants for the study included;

confidentiality; and most importantly, informed consent and the role of parents or people with parental responsibility. Another consideration had to do with the recruitment of participants for the FGDs; participants were asked for their consent to participate in the FGDs after each interview. The initial plan was to recruit only sexually active participants; however the plan was changed upon some reflective thoughts. Out of 23 participants interviewed, two female participants who I was hoping to include in the FGDs declined to participate. In addition, recruiting only sexually active participants could raise suspicion on the criteria for selection and could have undermined confidentiality which was key to the study.

Approval of Study

In keeping up with the above and regulations for conducting research with human participants, the study was submitted to the Regional Committee for Medical Research Ethic (REK) here in Norway and received exemption. (See appendix D) The study was thus reported to the Norwegian Social Science Data Service (NSD) and was granted approval for the study to be carried out. (See appendix E) In Ghana where the study was conducted, the study was also submitted to the Ghana Health Service – Ethical Review Committee (GHS-ERC) which reviewed and granted approval for the study to be conducted. (See appendix F) Further approval was sought from the Sunyani West District Directorate of the Ghana Education Service, under whose jurisdiction the study was to be conducted. (See appendix G.) Permission was also granted by the headmistress of Odomaseman Senior High School to engage her students for the research. This was however not construed as substitute for participant consent, and further steps were taken for participant to consent to their participation.

Consent Process

All participants recruited for the study were given detailed information about the study in clear and plain language which was understood by all of them. Information given included, the relevance of the study, their roles as respondents, as well as the procedures involve and the projected time for the process. Before the interviews were carried out, each participant's written consent was obtained and was also informed of their rights to withdraw their participation at any point in time without giving any reasons for their withdrawal. (See appendix A)

In addition, discussion about who should take responsibility for granting parental permission for participants less than 18 years was held with the headmistress and the contact person who was a teacher in the school. In the end, it was agreed that, since these participants were in school and

the study was being conducted in the school, the teachers bore the responsibility of the students and therefore had responsibility of the students. However, it was ensured that, participants' wish was superior to that of the consenting teacher and all such participants were also made to personally sign the child assent form.

Data Handling

In order to ensure confidentiality, all data collected from the fieldwork were protected by means of very safe and secure mechanisms. First, all participants were given pseudonyms in order to make it impossible to link participants to the data. In addition, all audio recordings, interview transcripts, field notes as well as researcher's note of participant's names and matching pseudonyms were kept securely under lock and key. Finally, data stored electronically were kept in an isolated computer with strict password which was only accessible to the principal researcher. There are also plans to destroy all data collected throughout the fieldwork once the project has been completed and submitted; both printed and electronic data.

Study Dissemination

Results from the study will be submitted in partial fulfillment of the requirements leading to the award of a Master of Philosophy degree in International Community from the Department of Community Medicine of University of Oslo. In addition to that, copies of the study will be made available to the Ghana Health Service, Ghana Education Service and other stakeholders responsible for the implementation of HIV prevention programs for adolescents and young people in Ghana. There are further plans to publish articles from this study in scientific journals and hopefully present them in conferences.

CHAPTER 4 - RESEARH FINDINGS

Participants in the study covered a variety of topics and areas related to adolescents' and young people's relationships, sexual behavior and HIV/ AIDS prevention. This chapter organizes research findings into three main sections. The first section presents young people's knowledge and awareness of HIV/AIDS and the preventive methods available to them. It also describes available sources of information and their preferred source of information about HIV/ AIDS and condoms. The second section explores adolescent and young people's sexuality through their perception and experiences on relationships, reasons for entering relationships, the types of relationships, their sexual practices and therefore their reasons for having sex. Finally, their perceptions and experiences on condom use practice is also described. Their reasons for using condoms in sexual relationships are of prime importance to this study; including any societal or cultural norms and beliefs which work to militate against condom use in these sexual relationships.

Knowledge and Awareness of HIV/AIDS and Condoms

Findings of the current study suggest that, despite some few misconceptions, adolescents and young people are very knowledgeable about HIV/AIDS and its associated risk factors. Awareness among participants is at an impressively high level with most of the participants exhibiting great knowledge of the causative factor, modes of transmission and prevention of infection. Respondents knew HIV is caused by a virus and mainly transmitted sexually although there may be other modes of transmission; one of the participants went on to describe in detailed as captured below:

- *HIV/AIDS is a sexually transmitted disease; actually there has been no cure for it. So the HIV/AIDS affects the body's immune system and the condition is such that, it has two phases. The first phase is when you get the HIV virus and as the condition progresses and you don't go for the test, it becomes chronic and you move from HIV to AIDS; for the HIV, it's not all that dangerous like the AIDS, so at this stage the virus don't multiply themselves in larger quantities and therefore can be managed or treated if detected earlier*

  Kwabena; 17 years, male

Another participant puts it this way:

- *HIV is the virus or the causative agent, once it gets into the blood it weakens the body's immune system. Although it cannot be cured, it can be managed; otherwise it develops to AIDS after sometime and opens the body to other infections like TB and others.*
  Awura; 15 years, female

With regards to HIV transmission, almost all participants stated that HIV is transmitted mainly through having unprotected sex with an infected person. Participants also mentioned infection through transfusion of contaminated blood, sharing razors and needles and also mother to child transmission. When asked in an interview what she knew about HIV transmission, a respondent answered:

- *I learnt that there are many ways to transmit HIV; an example is if you have unprotected sex and the person has HIV, you can also get it. Also, if someone has HIV and he or she uses a sharp object and you also use it afterwards, you can get infected if it cuts you. HIV can also transmit from a mother to the child; when a mother breastfeeds the child, the child can be infected with HIV.*
  Baaba; 17 years, female

This was stressed by another participant who also said:

- *About HIV/AIDS, I know it is real and a dreadful disease; it can be contracted through having unprotected sexual intercourse with an infected person, using infected sharp objects like sharing needles and razor blades with infected person or through blood transfusion and also from mother to child during childbirth.*
  Ato; 16 years, male

Even though this study is primarily concerned with sexual transmission of HIV, participants described a variety of transmission modes including non-conventional ones such as kissing and sharing toothbrush when both partners have bleeding sores in their mouths as given in the account below:

- *For someone to get HIV, unless the person not having it gets in contact with someone who has HIV through deep kiss, you can also get the HIV through sharing a toothbrush*

with someone who has HIV: maybe the person is having a cut in the mouth, you can contract HIV/AIDS and also through sexual intercourse, you can also get HIV.
Abena; 18 years, female

When asked about prevention of infection, most participants stressed abstinence as the primary method of prevention. Younger participants were more likely to mention abstinence compared to their older counterparts; below is the view shared by one such participant when asked about prevention

- *For me, I have decided to abstain from sex until I get married, but for those who cannot abstain, it is important for them to use condoms or stay with one partner they can trust.*
  Kwasi; 15years, male

The above quote also demonstrates participants' awareness of the important role condoms play in the prevention of infection and the risk associated with having sexual intercourse with multiple sexual partners. This was echoed by Kwaku, in his comment below;

- *Hmmm…That one (having sex with multiple partners) is even more dangerous than not using a condom and it can easily lead to spreading the disease, because you don't know which of the girls you had sex with has HIV. You pick it from that person and you give it to the next person you have sex with.*
  Kwaku; 16 years, male

Impressively, this awareness seems to have impacted greatly on their perception of people living with the condition, and have had a great influence among participants on stigma towards people living with HIV/AIDS. Participants talked about how they dreaded getting close to any person perceived to be living with HIV in times past and how the knowledge they have acquired influenced what their relationship with one will be like even though most of the participants are yet to know any person living with HIV personally. Afua, in one of our in depth interviews tells me that, personally, she has not met anyone with HIV/AIDS, but anyone can contract HIV, even children; therefore we should not show a negative attitude to people with HIV/AIDS but rather show them love and help them manage their condition; however, before getting educated, I was so scared of HIV/AIDS and thought one could contract it by just getting close to an infected person.

Sources of Information on HIV/AIDS and Condoms

Participants described various sources of information on HIV/ AIDS and condoms available to them including, the school (teachers), parents and guardians, peers and the electronic media e.g. radio, television and the internet. The church has also played some role in getting information about HIV prevention to participants; however, abstinence unsurprisingly, was the key message participants received from the church. One participant sums it up by saying

- *It is against my religion to engage in sexual practices until you are married, and if you are found to be doing that, it may have a serious consequence on yourself.*
  Kwadwo; 20 years, male

Contrarily, in an interesting development, some participants commended their churches for having received some information about condom as prevention from infection. Yaw, in explaining how the church has been instrumental in informing them about HIV/AIDS prevention said;

- *We learnt about HIV/AIDS in my church. In my church we have the youth ministry called the AYS, and we had this man coming to talk to us about HIV/AIDS and how HIV came to being and also how to prevent infection.*
  Yaw; 17 years, male

When asked about (on the use of) condoms for prevention, he continued;

- *The man said you can use condoms to protect yourself from getting HIV and even educated us on how to use it correctly. He said there is nothing wrong with a teenager like me to have sex, but it is important to protect myself for me to prevent pregnancy or HIV before having sex or that relationship.*

Majority of these participants have gone through the HIV Alert school program and have received information on HIV during their peer education sessions, although some of them confessed they didn't actually understand what was discussed. In addition, most participants mentioned the media as their main source of information on HIV/AIDS prevention and condoms. Other participants favored information from their friends, while just a few of them mentioned teachers in the school or parents. This therefore, seems that many parents have abandoned their

educative roles in providing accurate and reliable information on sexuality and HIV prevention to their children, leaving them exposed to varied opinions on an important aspect of adolescent development such as sexuality. Most of the time, information from their peers are based on opinions and what they perceive to be convenient for them and may sometimes be misleading

Adzo, 18 years old participant shared her experience as recorded below:

- *For condoms, my parents never discuss with me, but I have a friend who usually discusses condoms with me. She once said that, although condoms are good for preventing HIV, you sometimes feel some pains around the abdominal region after using it.*
  Adzo; 18 years, female

Awura, a 15 year old girl, narrated to me how the important influence of her mother who works as a health personnel has helped in educating her about HIV prevention and condom use. She was actually the only participant who had a thorough knowledge of the female condom as well as the male condom and could describe how it is used correctly.
Another participant, in our FGD complained about materials broadcasted in the media; specifically, she talked about the content of a television advertisement of a particular brand of condom, which as she puts it;

"It's really bad and I don't think children should be made to see this".
Naana; 18 years, female

This was supported by all participants in that FGD; some participants explained the content of this advertisement may influence young people into sexual experimentation.
Clearly, these comments from our participants raise another issue of importance, which is the quality and accuracy of information available to these young people. Some participants pointed out that, they trusted information from their parents/ guardians and teachers and wished they had frequent discussions on sex and HIV with them.

- *As for myself, I think what my teachers, my parents and even my grandmother told me; I think that is more convenient than what my friends told me.*
  Kwaku; 16 years, male

The teacher's role cannot be underestimated when it comes to providing quality and accurate information to these young people. Some participants confirmed their trust in their teachers, aside their parents to provide them with facts; however, they complained that, some teachers' ability to educate them is hindered by their level of comfort due to the community's attitude towards such issues and the notion that, teaching them will rather promote sexual activities among them. In contrast a participant argued that:

- *We do always take the advice the teachers give to us, because sometimes it is important to teach the young person how to prevent or protect him or herself rather than stopping her. I feel by teaching the young person you expose him or her to the good and the bad and thus guide him or her to make a better choice.* ***Araba; 17 years, female***

Experiences and Perceptions of Sexual Relationships

- During that age I think it is a stage in any individual's life where you develop feelings for those things and so you begin taking some risks- ***Kwabena; 17 years, male***

Participants' perception and experiences on sexual relationships were reported in our study and the above statement puts adolescents' and young people's views into perspective. With the exception of some few of them, most participants have been in sexual relationships or are still in relationships with some of them having been in two or more relationships already. It was also reported among participant that such relationship are seen as normal in the community and anyone who goes contrary is labeled with names such as; "Kolo", "John" "Nino", among others. Some explanations were given by participants as their reasons for engaging in sexual relationships. Chiefly among these reasons were; financial incentives, peer influence, and parental influence.

Financial Incentives

Financial incentives were mentioned as the major reasons why young people enter sexual relationships. It was revealed that, some young people from poor homes are force into relationships because they have limited or no source of financial support. When they come to school and they see what their friends have got, they feel they can get more from their boyfriends so they enter into such relationships.

One participant in our focus group discussion pointed out that;

- *We the young ones sometimes go into sexual relationships due to the hardships in the family*
  Afua; 20 years, female

She explained that, *at some stage, the society sees you or takes you as an adult and therefore there are certain things the individual is expected to provide for herself. So in order to be able to meet these needs you have to go into a relationship with a partner who can help you, because at that point you may not be working or in any employment.*

Although, some boys may go into relationships for financial gains, female participants were more likely to mention financial gains as reason for entering relationship. This was confirmed by the male participants in their FGD

- *In the case of the girls, financial difficulty leads them into relationships with men who can take care of their financial needs, because they may be from poor backgrounds.*
  Kwasi; 15 years, male

With regards to the situation with boys, Kuuku, a 19 year old boy tells me that,

- *"Yes, some boys also go into relationships because of the money they will get from the girls. When the girls are coming to school, they have more money than the boys do."*

Following a little probe on where the girls get the monies from, he revealed that *"Some of them get it from their parents, but most of them get it from their boyfriends and mostly their "sugar daddies". So if you see this girl is "Loaded" [rich], you try to go into a relationship with her so that you can also get something from her"*.

Peer influence

"Use what you have to get what you want" – ***Araba; 17 years, female***

In addition to financial reasons, participants mentioned peer influence as another significant reason why young people go into sexual relationships. The above statement describes what young people- especially girls get influenced with by their friends. According to participants, young people are easily influenced by their peers into sexual relationships because they are also doing it. This according to participants usually happens since they are most often in the company of their peers and so learn from each other.

It was revealed in our focus group discussions by Kofi who said:

- *This happens when friends move together and one of them is having a relationship, the other person will also be attracted or influenced into getting a sexual relationship even if he is not interested.*
  Kofi; 18 years, male

It was also reported that, such relationships among young people happens when there is the fear of name callings should they refuse to accept to also engage in sexual relationships. Kwadwo revealed that, if you have a friend, and your friend has a certain relationship with a girl, that friend will influence you to also get into a relationship; most often with a girl who is a friend to his girlfriend.

He continued and stated that

- *If you reject the offer, your friend will make fun of you and say things that will get you to accept the offer. Things like, "Your eyes not open", "in this modern Ghana, if you don't have a girl, then you don't know what's going on" [you are not trendy]*
  Kwadwo; 20 years, male

It is worth noting that, male participants were more likely to report peer influence as reason for engaging in relationships. Kofi, mentioned above narrated to me in our in-depth interview that, he entered into his first sexual relationship at the age of about 13 years. He was introduced to this girl who I will call "Mary" by a friend who was also in a relationship with an older sister of Mary who I will call "Aku". Kofi's friend who was quite older, usually sent him to call Aku from her home since Kofi was quite close to their family. Eventually he influenced Kofi to also start a sexual relationship with Mary, even though Kofi initially did not have any such intentions.

Female participant also confirmed peer influence as a major reason for their male counterparts to go into sexual relationships. Adzo, an eighteen (18) years old girl, shared a phenomenon in her neighborhood where young guys meet at a place they termed "Parliament" on a daily basis. At this parliament all they do is play games and engage in conversations; mostly about, sports, politics, girls and sex. She continued that if a girl passed by they try to influence the younger ones among them to call the girl and if you refused or turned them down, they conclude that you are "not man enough" to be amongst them. Some of them sometimes go to the extent of calling

their girlfriends into their meetings for all gathered to appreciate them as men. Thus, some of the young boys get influenced to get girlfriends; just to prove to their friends that they can also have girlfriends for the name callings to stop.

Girls also reported peer influence as a reason for entering sexual relationships; however, it was found to be linked with financial incentives. Peer influence among girls was more skewed towards supposed financial gains as reported by their friends. This according to Akua happens

- *When I see my friends wearing all kind of fashionable clothing, they look so nice and attractive to me. When you also want to look like them and you ask them, some friends can influence you badly to get into relationships- especially with older men.; convincing you about all sorts of benefits you can get from the relationship*
  Akua; 18 years, female

Baaba also expressed her view on the same situation as recorded below

- *Even in instances where you don't have a boyfriend, you may want to ask a friend to help you out since your parents did not get it for you; that friend will eventually influence you since she is always helping you out, but you don't know where she is getting the money from. If she is getting it from her relationships, she will tell you that you're grown up now so you have to "look sharp". They will tell you to "use what you have to get what you want,"*
  Baaba, 17 years, female

This she explains means that you should be reasonable and sacrifice yourself by engaging in sex to get the money you are looking for.

Awura's view supported the above when she disclosed that

- *Some friends will give you advice to get into a relationship, telling you all sorts of benefits you can get from your relationship like money, clothing, phones etc. Sometimes they compare you to other girls who are doing it and are always looking fashionable. They will sometimes tell you that if you don't get into a relationship like they are doing, they will no longer be friends with you.*
  Awura; 15 years, female

Some participants, in explaining the connection between their financial circumstances and peer influence argued that, young people will sometimes go into sexual relationship because there is the need to please their friends in order to continually gain their approval. This according to them may include financial gains

Kuuku illustrated that;

- *I may have a friend who may be from a rich background and already in a relationship, while I may not be from an equally rich background. As far as he is my friend, he may be the one who always buys for me; therefore, I have no choice than to do whatever he tells me. In such a situation, you will be tempted to get a relationship too because, if you do not do it, you risk losing his friendship and the benefits associated.*
  Kuuku; 19 years, male

However, Kwame disagreed with his colleagues but rather believed that even though, the influence from your friends may be great, you can always say no, and still remain friends with them until you realize yourself that you are ready for a relationship. This he argues that the role of parents in advising their children determines whether one accepts or decline influences from peers

He justified his point when he said;

- *What my friends are saying is true, but some of us our parents advise us when coming to school, that we should consider our backgrounds and not involve ourselves with friends who will influence us badly. Therefore, with that one, I disagree with my friend that, because my friend will not buy for me again, I will do what he tells me to do and turn down my parents' advice.*
  Kwame; 20 years, male

According to him, one cannot rely entirely on friends to help financially especially when helping forces you to do something against your values. You may have other friends who you can borrow from but will not influence you negatively, or teachers you can talk to about your situation, so that you do not put yourself at the mercy of these friends who will influence you negatively.

Parental influence

"*Some parents don't monitor their children and allow their children to go wayward; when their children go out, they don't bother to know or ask where he or she has been or which friends (s)he has been with; so once the child gets to know that their parents don't care about his/ her movement, (s)he gains the advantage to indulge in sexual relationships"*

Yaw; 17 years, male

Parental control or influence was mentioned as an important determinant for young people to engage in sexual relationships or not. Participants discussed the various ways parental influence guards adolescents and young people from engaging in sexual relationship as well as how it encourages sexual relationships even at that age. This included parents' relationship status and socioeconomic standing and most importantly- how they relate with their children.

Broken homes, for example was mentioned as a factor that affects parental influence on adolescents and young peoples who go into sexual relationships. In an example, Esi commented that;

- *When the mother is unemployed and has to take care of the children all by herself, the children will be force to find their own means of survival since the mother doesn't have any means of earning money to enable her take care of the children. The children especially the girls will go into sexual relationships, most of the time with adult partners who will be able to assist them financially.*

  Esi; 20 years, female

In our in depth interview, Esi mentioned above, shared her experience as a child from a broken home with me. According to her, her parents got divorced when she was a kid and therefore had to live with her mother's sister, because her mother who died later, did not have any means of income. She lived here with her mother's sister until she completed her junior high school and she decided to visit her father. Unknowing to her, this caused the displeasure of her auntie who refused to continue to take care of her. In the end she had to go and live with her cousin in another town because she could not live with her father who lived in a village far away from the town. While living with her cousin, she was introduced into a sexual relationship with a man whom the cousin claimed to be a colleague at work, and unfortunately had a child with this man at the age of sixteen (16) years.

In addition, participants further explained that, where mother and father live separately after a divorce, separation between parents encourages promiscuity among young people. According to Kwaku:

- *This happens when the child seeks permission from the parent whom she lives with to visit the other parent, instead she goes to the boyfriend while both parents are unaware exactly where she is at that point in time.*
  Kwaku; 16 years, male

It was also reported that a child who yearns for attention or care may seek for the needed care or attention from a boyfriend or girlfriend if it is not forthcoming from the parents. Araba in our focus group discussion with the girls stated that

- *Another point with broken homes is that when the children need attention and the parents are not around to provide it, the child thinks it is the boyfriend or girlfriend who will provide him or her with the needed attention.*
  Araba; 17 years, female

In support of the above statement, Akua also shared her experience as a girl who lives with her mother's friend in Sunyani because of school; her mother lives in Kumasi, a different city in Ghana whiles her father lives outside the country. She confessed that, even though she sometimes speaks to her parents on phone, the absence of or the lack of physical intimacy she will feel if she were living with her parents sometimes forces her to go out with friends to explore and experience it for herself.

To this, Naana questioned; if your parents are not around they will by all means send you money or some family member will be available to provide their financial support for your upkeep

In response Akua said; No! It's about the money in this case; it's about attention, emotionally; you want to be with someone who can listen to you at all times

"For example, we girls are sometimes attention-seekers and if we are not getting this attention or physical contact from parents, it can lead to young girls going into sexual relationships to get that physical connection or attention from somewhere else- in this case her boyfriend"

The above scenario explain the important role adolescent - parents connectedness plays in the adolescent developmental process; especially when it comes to issues of sexuality. This was echoed by another participant who gave a scenario where adolescent – parent attachment was non-existent.

- *Some parents live together where there is no broken home, but the parents don't open up for the children to talk to them about anything; therefore you dare not talk about relationships or sex with them, so such a young individual will no doubt go out to friends and ask them about relationships, and that's where the peer influence comes in. The child will be told by these friends to try it and see the pleasures for herself if these friends are also in such relationships.*
  Awura; 15 years, female

Araba is a seventeen (17) year old female participant who lives with both parents; she told me in our in-depth interview how her parents provide her with everything and are always protective and welcoming to listen to her concerns. Because of this relationship with parents she feels safe to discuss everything with them, especially her mother. Despite several influences from her friends she continued that

- *It will be a wrong choice to take what my friends tell me instead of all the advices my parents give me.*
  Araba; 17 years, female

This confirmed Kwame's initial assertion that, though the influence from peers may be great, the capacity to make better choices develops through interaction with caring parents, and their advices becomes part of the individual so that it enables adolescents and young people to take care of themselves - also in new and different situations, like sex.

The effect of parents' socioeconomic economic status on their influence as a determinant for adolescents and young people to go into sexual relationships was also expounded. It was pointed out that

- *Some parents are always complaining about financial resources and due to that they can't provide adequately for their children; however these same parents when they get the money don't bother about the welfare of their children but rather use the money for*

unnecessary purchases such as funeral cloth and other unnecessary things and allow their children to go into sexual relationships.

Ama; 17 years, female

Despite young people's trust in their parents to protect them, some participants revealed that some parents sometimes influence their children (especially girls) negatively to engage in sexual relationships. Most of the time these relationships are promoted with adult partners who are wealthy men in the community or are these parents' superior at work and can give them monetary or other favors in return. This further highlighted the effects of socioeconomic status on parental influence and was explained by Adwoa in our FGD as recorded below;

- *Some parents who stay with their children alright but sometimes try to convince their young girls to go into a relationship with adult men due to the material things he can provide for the girl. I have also seen a similar situation where the girl asked her mother for supplies for school, and the mother responded that* ***"Bro. Kwasi kae sɛ ɔpɛ wo no, w'ante anaa?"*** *which means: didn't you hear Bro. Kwasi when he said he loves you/ want to have a relationship with you?*

  Adwoa; 19 years, female

I was so amazed to hear one female participants reveal that

- *A single parent (mother) can ask her daughter to go out and have sex with a man and bring money home due to the financial difficulties they may be facing*

  Baaba; 17 years, female

Clearly, mothers are more likely to be involved in this phenomenon than fathers; this was also confirmed by another participant who shared her views that;

- *The fathers are stricter and so they wouldn't do that, even the mothers who do that will not make the fathers know what they are doing.*

  Naana; 18 years, female

She continued;

- *I personally know a woman in my neighborhood, anytime her daughter asks her for something, she will then say* ***"na wo nfɛfoɔ no ɛkɔ no wo deɛ wo nhue"?*** *Which is*

translated to mean: when others of your age are going, don't you see them? In effect the mother is telling the daughter to go and get a man who can provide for her since the other girls in the community are doing it.

Naana; 18 years, female

It was also reported that some parents who live in the village send their children to look for jobs in the city or town due to their poor socioeconomic status. According to Adzo,

- *The problem here is, the mother expect the child to bring money home without knowing what work the child is doing or where the money is coming from. All she is interested in is, when the money is coming but not where the money is coming from or what the child does to get that money.*

  Adzo; 18 years, female

In support of what Adzo said, Abena explained that "some parents will use their children especially girls as cocoa" (referring to cocoa as a cash crop and able to generate income). She commented that "I know a woman in my community who was always getting favors from boys and men because she has a sixteen (16) year old daughter. The woman herself knows that it is because of her daughter that is why she is getting all those favors and sometimes brags about it that, it she has a beautiful daughter that is why she is getting all those benefits and that it is always better to give birth to a daughter than a son". In response Baaba added that such a mother will lose control over the daughter; to which Abena confirmed and said that,

- *Now the girl is bringing all sorts of boys and men home and has rebelled against her mother because she complained about it.*

  Abena; 18 years, female

Other interesting reasons such as reported below were also mentioned;

Some participants reported that young people go in to relationships out of curiosity; the reason is that,

- *We hear a lot about relationships from our communities and see a lot also on television and in movies, so we are curious to know more and have a relationship to have an experience of how it feels like being in a relationship –* ***Ama; 17 years, female***

Kwaku's contribution supported this when he said; at that stage, especially when you have older siblings who are also in relationships, you want to know more about relationships and experience for yourself why people go into relationships

Adolescents and young people's curiosity to experience sexual relationships was also found to be partly attributed to what they see in their community and what they are exposed to through multimedia. For example;

- *When we watch television and movies, the way relationships are portrayed; you see a couple and how they behave, how they move together and play makes you think it is always good like that so you also want to try it.*
  Fiifi; 19 years, male

Another participant also disclosed that

- *Some people are in the habit of watching things that are not pleasant to the eye; an example is those who are in a habit of watching pornography. When they watch these things, they get aroused and they want to try it.* - ***Yaw; 17 years, male***

Some participants also reported that going into sexual relationships was seen to elevate one's social status and how friends see you. For example Ama explained that;

- *Some people want to feel higher than their friends so they go into relationships. An example is where I have a boyfriend and my friend also has her boyfriend; but my boyfriend is richer and nicer than my friend's boyfriend. In such a situation I will feel more "bossy" than my friend.*
  Ama; 17 years, female

Kwasi's view also supported Ama's point when he also confirmed that boys will also go for sexual relationships on similar grounds. He clarified that;

- *Some of the boys go for sexual relationships just for others to see that the girls prefect is my girlfriend or the most beautiful girl in the school is my girlfriend*
  Kwasi; 17 years, male

Types of sexual relationships

The data available seem to suggest that, for female participants, sex as an act was not an important reason for entering relationships. Before asking for their reasons for engaging in relationships, I asked in our FGD: Is sex a reason for going into relationships? In unison, all the female participants shouted No! It was affirmed by the female participants that most of the sexual encounters were initiated by the males. According to Afua;

- *It is every girls pride to remain a virgin until marriage. However, once you get into a relationship and the boy starts demanding for sex, even though you may not want to do it, you will have to give in, or do something to please your boyfriend to keep the relationship going or to show him that you love him. That is where you get trapped.*

  Naana; 18 years, female

Male participants however gave mixed responses to the same question; with some of them corroborating with their experiences and what other friends have told them while others also disputed the claim. Kofi explained that;

- *There can never be a relationship without sex; if you love me then show me something.*

  Kofi; 18 years, male

Among the twenty – three participants interviewed for the study, early sexual initiations was reported by a large number of them with sexual experiences ranging from coerced to consensual and were often unplanned and unprotected. Awura in one of our in depth interview gave an account of how a trusted adult in his mid - twenties whom she was left in his care while her mother was away working, defiled her when she was just nine years. She continued that, at that time she didn't even understand what was going on until she was introduce to sexuality education by her mother and in school. Another participant also revealed how a brother's friend who had come to visit, sexually abused her while she was asleep in the same room with them when she was just ten years.

With the exception of the above cases, most sexually active participants interviewed perceived sex as a natural part of life and gave diverse reasons for having sex, which include financial incentives, peer influence as well parental influence, as stated above in the previous section. Among participants and young people in the community, sexual relationships were considered to be a normal practice. These relationships were usually characterized by casual unions with peers

as well as unions with older partners. Some participants revealed that although some young people- especially girls may be in relationships with younger partners, they may also have older partners who according to them are always at hand to provide them with their needs.

In explaining the situation, Kwame gave details of what happens among them in the school when he said;

- *You will find a boy and a girl in a secluded area having some romantic time or trying to have sex; we call this "Katale". It basically means, you want to have sex, but there is no bed, nothing to be used, but, because you can't go to the dormitory, you just find yourself in some secluded area or even in the classroom at night and do your own thing where no one will see you.*
  Kwame; 20 years, male

A female participant disclosed that:

- *Here in the school, if you have a boyfriend who is also a student, they call it* ***"chop box-to-chop box"****. They usually do not value such relationships because; they believe that boyfriend who is also in school with you is incapable of taking care of you.*
  Adwoa; 19 years, female

To support the above statement, Afua revealed that

- *I know some friends who are in sexual relationships with men older and of a higher educational background than they are. These "****sugar daddies"*** *as we call them are usually rich and can provide anything they may need for them*
  Afua; 20 years, female

Another participant gave me more insight to the phenomenon: She told me that;

- *There is also the situation where some young girls may be in relationships with two people at the same time: one younger partner usually of the same age group, and the second, an older man who is rich and can take care of her needs. This older partner- usually called* ***"Mr. Otua" (the payer)*** *provides everything for the girl and is most of the time not as sexually strong as the younger partner- usually called* ***"Mr. Odi" (the eater)*** *who provides the good sex she needs, even though he does not have money to meet her*

*needs and is usually considered **"the serious boyfriend"***

Naana; 18 years, female

The situation with boys was not any different from the girls; however participants pointed out that the phenomenon occurred more commonly with the young girls

- *It is the same with the boy; in their situation, it is the older women who go in for the boys because of their money and the need for sexual satisfaction. The boys like to have the younger girls, but the "sugar mummies" go after the boys because they have the money to splash on them, and the money they (boys) see carries them away.*

  Awura; 15 years, female

Sexual Communication

Sexual communication is another critical element that influences adolescents and young people's sexual behavior. Participants reported that, talking about sex or condoms openly, society frowns on it, because sex is seen as something that is supposed to be private and reserved for married adults. Therefore, if you talk openly about it, you are seen as a bad child. Even though one may not be engaged in sexual activities, as soon as you are seen just talking about it, you are seen to be sexually promiscuous. One participant disclosed that

- *Once we were talking about sex and condoms in class, some of my mates who heard us quickly jumped to condemn us; branding us as bad girls. For me, I think it is educative to ourselves, so I was surprised that this people did not know the importance of discussing it and only saw us bad girls and branded us as bad influence.*

  Akua; 18 years, female

Parents' relationship or communication with their children was also found to have a significant influence on young people's sexual behavior; it was found that participants who had their parents talking to them about sex earlier in life were more likely to embody those values

- *My parents always advise me not to have any sexual intercourse with any lady and I am also a believer in that, so I had that conscience not to have sex or involve myself in any sexual activity as a small boy so I stayed away from that thing.*

  Ato; 16 years, male

However, most participants complained that it is difficult to talk to their parents about such issues. This according to them may be due to factors which may include; embarrassment of parents and young people, parents time constraints among others. Adwoa in our focus group discussion pointed out that;

- *They feel shy to talk to us about sex because they think we are not old enough and even if they talk to us, they only talk to us about not getting pregnant. As for HIV/AIDS or condoms, they do not even mention it at all.*
  Adwoa; 19 years, female

It was further reported that, parents who do, do not initiate sexual communication with their children earlier enough because they feel talking to them about sex at that age is a sign of endorsing their engagement in sexual relationship. It was noted that some parents will only start advising their children when they find out they are engaging in such practices. This according to Esi is not the best,

- *Some parents, especially mothers' will only start advising you when they see you doing it. That is when it will occur to her that she should advise you about having sex and protection, but I think that is not the best; it is important for parents' to educate their children earlier in their life to know the consequences of their actions and how to protect themselves even before they reach adolescence*
  Esi; 20 years, female

It was also stated that some parents upon finding their children in sexual relationships rather prefer to punish or beat them up instead of advising or educating them on how to protect themselves. This according to Abena does little if anything to change her behavior about her boyfriend or her sexual relationship; she asserts that,

- *I would rather go and enjoy myself than to quit with my boyfriend, because I know that when return, you are only going to beat me, and the next day, I go again.*
  Abena; 18 years, female

This lack of adolescent – parent communication/ interaction, according to participants is what sometimes forces them to seek advice from friends who will in turn influence their sexual behavior due to their vulnerability.

Condom use in sexual relationships

Researcher: Now, let us talk about condoms; as for me, I like condoms so much ☺

Akua: You do?

Researcher: Yes, in fact, I love condoms☺☺

Esi: For me, I do not like it: "eating banana with the cover"

Akua: How can you eat banana with the peels on it?

Condom use practices and experiences among sexually active participants was the main focus of this study; however, responses received from our participants indicated that, despite the belief and awareness among participants that condom use is the right thing to do in order to prevent contracting HIV/ AIDS, condom use among these adolescents and young people in sexual relationship was generally not encouraging. The above discourse gives a telling picture of participants' view of condom use in sexual relationship. In addition, Kuuku, in one of our focus group discussions with the male participants asked; *"how can you take a shower with an umbrella"?* Clearly, the use of condoms was seen by participants as unnatural and the notion of "raw sex" came up several times in our discourse. This seems to suggest that most participants considered unprotected sex as the natural way of having sexual intercourse. Thus, exposes them to the risk for HIV/ AIDS infection.

Pregnancy Prevention

A small number of participants reported consistent condom use; however, most of these participants mentioned pregnancy prevention as the major reason for using condoms. This according to them was because, looking at their status as young people and students for that matter, while the female participants were concerned about dropping out of school should they get pregnant, the males on the other hand were concerned about taking care of a mother and a child in the face of limited resources available.

- *For me I will use a condom because, looking at my status, I am a student and my parents are taking care of me, so if I should impregnate a girl today, I don't know what I would do. I cannot even get anything to cater for the girl and the baby. Therefore, I will use the condom, because I want to prevent pregnancy.*

  Fiifi; 18 years, male

The statement below also represents the female participants' view of the situation

- *Nowadays, the girls are more concerned about preventing pregnancy, especially since they are still in school; so those who even use condoms use it because the want to prevent pregnancy and not any disease. Forget about disease.*
  Akua; 18 years, female

Undoubtedly, sexually active participants used condoms for contraceptive purposes and therefore resorted to other forms of contraception.

- *Some friends told me that, when you are in a relationship and you know your partner's menstrual cycle, you can decide not to use the condom and go "Raw", because you know when she is safe and when you know she may get pregnant, and then you can use the condom.*
  - Kwadwo; 20 years, male

The Oral Contraceptive pill (OCP), and the withdrawal method were both mention as common alternatives for condom use.

- *Nowadays, there are these contraceptive pills and other methods in abundance, which I can use. They are even not expensive. Therefore, I will have sex without a condom because there is a variety of methods to prevent pregnancy, but for the presence of STIs.*
  Afua; 20 years, female

However, Kwame had a word of caution for his colleagues

- *One of my friends said that, because he is a student and cannot afford to take care of the girl if she gets pregnant, he would use the condom. Let me tell you that, there are other people who are gainfully employed and are very well to do, but they still use the condom. That should tell him that, there is more to using the condom than just to prevent pregnancy.*
  Kwame; 20 years, male

Sexual pleasure

Sexual pleasure was cited by participants as another reason for not using condoms. According to some of them, the condom interferes with pleasure and makes it difficult for them to enjoy sex.

Male participants especially complained about how long it takes them orgasm when they use condom. Baaba explains that;

- *Some people say that, using condoms is not as good as doing it "Raw". When you have sex with the condom, the feeling is not the same as having sex without the condom. There is no pleasure at all.*
  Baaba; 17 years, female

According to Esi,

- *If not for HIV/AIDS, but for just pregnancy, I prefer to use the OCP to prevent pregnancy and go "raw" because I want to enjoy the sex instead of bothering myself with the condom*
  Esi; 20 years, female

This was further confirmed by another male participant in our focus group discussion.

- F*or me, in using the condom, if not for HIV, using condoms is not the best. To prevent pregnancy, you can do that in a variety of ways without using the condom: you can use the safe period calculation, "coitus interuptus", the pills, and many other methods. Therefore, if I had a choice, I would not use the condom, so that I can enjoy the sex better.*
  Kuuku; 19 years, male

Naana was however, of a different view

- *Sometimes, when you talk to your friends that you use condoms during sexual intercourse, some of them do not buy that idea. You often hear them saying things like "How can you eat candy with its wrapper on"? Meaning, if you use the condom, you will not enjoy the sex as much as doing it "raw". In some cases, they will suggest to you some drugs, which according to them, will protect you from getting pregnant and tell you to forget about condoms. But to me, I think it is better to use the condom and stay alive than to enjoy the sex and put yourself at risk of getting HIV.*
  Naana; 18 years, female

Duration and Type of Sexual Relationship

Both female and male participants believed that there is no need to use condoms in established relationships. Most of them were of the view that, condoms are only necessary when you have not known your partner for a long time. Thus condom use can be discontinued once the relationship is considered established.

- *I think that, as far as you have just met and don't know the person much, you have to use the condom for some time, so that when you have been in the relationship for a long time, then you can chose not to use the condom.*
  Baaba; 17 years, female

It was also stated that condoms were only necessary for casual sexual encounters

- *If I should propose to a girl today and the next day, she wants sex, I will use a condom because; I do not know her well yet. I do not know if she has any disease or not, so I will think of using the condom so that if she has any disease, I will be protected. Some boys also go for casual sex with prostitutes, so in that instance, because you do not want to contract any disease if she has it, you will have no choice than to use the condom.*
  Kofi; 18 years, male

But Adwoa in her submission believes otherwise.

- *Not exactly so. Once you do not know if the person has HIV/AIDS or not, it is important to use a condom always: whether you have just met the person for a "one night stand" or you have known him forever. The only way you are sure the person does not have HIV/AIDS is to go to the hospital and test. Period!*
  Adwoa; 19 years, female

Some female participants complained about the negative response they get from their partners when they raise the issue of condom during sex.

- *In some cases, if you tell your boyfriend to use a condom when having sex, he will tell you that because you do not love him, that is why you are telling him to use the condom, Therefore, because the girl wants to show him that she loves him, she agrees to his request to do it "raw"*

Abena; 18 years, female

Seemingly, "raw sex" as they call it, was synonymous to love among participants. The statement below from a female participant explains that;

- *Some boys will use condoms because, they say they do not love the girl and don't want to leave anything of theirs with the girl (in this case his sperms), e.g. in the case of having sex with a prostitute, but if they have sex with their girlfriends they love, they do it "raw"*
  Esi; 20 years, female

Sexual relationships involving young people and adult partners were also found to have negative implications on condom use which was influenced by the power imbalance within the relation. Receiving monetary and other favors from your partner puts one in a disadvantaged position with regards to safe sex negotiation. Girls in particular found it difficult most of the time to negotiate for condom use, especially if they have received any monetary favors or gifts; therefore they do anything they are asked to do.

- *My friend once told me that because she does not want to lose the money she gets from her "sugar daddy", she does not question anything he tells her to do. When it comes to having sex, the partner does not like to use the condom so, he gives her some pills to take so that she does not get pregnant.*
  Adzo; 18 years, female

Another participant stated that;

- *They can also get the sex, any time they want it, because she will definitely give you money, and so as soon as she calls you, you are ready for her because she will give you anything you ask from her.*
  Yaw; 17 years, male

Trust was another factor mentioned that influence adolescents'' and young people's decision to use condoms during sex. One participant explained that

- *Someone will use a condom when she suspects that her partner is having multiple sexual relationships and she does not trust him. In addition, if you are not married to him, there is a greater chance that your partner may be seeing girls, so you may want to use the*

condom while you are still unmarried.

Ama; 17 years, female

Communication within the relationship was also found to influence positively on condom use behavior. According to Fiifi, condom use will depend on the request of his partner. This clearly shows that girls' ability to negotiate condom use in sexual relationships may impact greatly on safer sex practices, though most female participants disagreed on that point. It was discussed among the female participants that male partners were responsible for condom use or nonuse; however Naana in our in-depth interview shared with me how she has influenced consistent condom use in her sexual relationship.

- *I have always told my boyfriend that, he should always have a condom whenever he wants to sleep with me; otherwise "no condom, no sex"*

  Naana; 18 years, female

Sociocultural Norms and beliefs

The use of condoms among adolescents and young people was also found to be linked with some societal and cultural norms and beliefs within the community. According to participants, the society's views about sex and condoms influences their ability to keep or use condoms. It was reported that, within their community, sex was seen as a reserve for married adults and therefore, at their age, they are not expected to talk about sex or engage in sexual practices. Due to that, adolescents and young people do it on the blind side of other people- especially preventing adults from knowing about it.

- *Some people are in relationships and are having sex, but they do not want the people to know about it because of the way the public sees such relationships. So if we are talking about such things like sex, they do not want to be seen talking about it.*

  Kwame; 20 years, male

It was pointed out that, some parents or significant adults may know about the fact that, their children are having sexual relationships; however, they continue to live in a state of denial until something pops up i.e. a child gets pregnant or they find a condom on the child. Abena cleared her point out when she said

- *I believe they are always suspecting us because of some attitudes that may show up, but*

they do not have the courage to talk to us about it and just hope that it is not true. They only get to know when something like pregnancy pops up.

Abena; 18 years, female

Participants lamented about some parents' reactions when they found condoms on them and implicated it for being a fundamental element in their decision to keep and use a condom. In keeping with the above, society's view about sex meant that young people who were found with condoms were question and in some cases punished by their parents

- *In some cases, if a parent finds a condom in the child's bag or purse, even though you may not be engaged in sex, they feel disappointed and conclude that you are sleeping around with boys. They will be very angry, unless you give them a better explanation for keeping the condom*

  Abena; 18 years, female

Researcher: *You talked of giving "a better explanation" for keeping condoms on you; almost everybody knows what condoms are, so what better explanation are you thinking of giving your parents?*

Akua: *I will tell her we did an experiment in school and the teacher gave it to all of us.*

Abena: *My mother will follow me to the school, come, and ask the teacher if I told her that.*

Adwoa: *You can also tell her that, some people from the hospital came to the school to talk to you about HIV/AIDS and gave them to every student.*

Naana: *Some parents will be angry and even accuse the teacher or the person who gave them to you of teaching you immoral things; assuming that is even true.*

Researcher: *So you mean, if your mother should find a condom on you, and you explain to her that, it was given to you at school in a sex education class, she will be angry with the teachers who gave it to you.*

Naana: *Yes, unless the teacher gives a better explanation why he gave you that. As for my mother, she will follow me to the school to ask. Woe unto you if it is not true.*

NB: The above discourse took place between the researcher and young girls aged 18 to 20 years. For younger people, the least said about the situation the better. It further highlights

parental influence on what is being taught in HIV/AIDS prevention programs for young people in school.

Another issue of concern for participants was the discomfort and embarrassment they have to go through when they want to get a condom. The experience of buying a condom while someone is watching was mentioned as a very embarrassing situation, which most young people are likely to avoid. The experience was described as been worse if you know the person watching and the person also knows you.

- *I will just buy something else and go home; meanwhile the girl is also waiting for me at home.*
  Yaw, 17 years, male

Availability and Quality of Condoms

Availability of condoms was cited by some participants as also contributing to their decision to use condoms. According to them, it happens sometimes when you are in a rush or in the heat of the moment to get sex, and suddenly find out you do not have condoms. In line with that Adzo narrated that

- *A friend once told me that she went to her boyfriend, and before sex, she asked if he had a condom, he responded no, I forgot to buy some, and I have to walk some distance to get some from the drug store. In such cases, since it is not available at the time they needed it, they cannot wait to get the condom, so they decided to go "Raw" for that day.*
  Adzo; 18 years, female

Some other participants bemoaned the poor quality of some condoms as another reason for not using condoms. Because pregnancy prevention was their main reason for condom use, they wouldn't want to risk using a substandard condom which can break and render the condom ineffective

- *I do not think condoms are even 100% sure; it is 50/50 because, it is a rubber and can tear or burst at any time; that is why I will want to use the OCP.*
  Fiifi;18 years, male

Some misconceptions and superstitions about condoms and HIV/AIDS further influenced participants' attitudes towards condom use; an example was mentioned by Kwame.

- *Some people claim that condoms contains germ; but I think, there are original condoms which are of good quality and duplicate ones which may not be of good quality. Some time back I heard that, there were some duplicate or inferior condoms in the system, which when you use will cause some swellings and reactions in your body. Those ones I believe were brought into the system from the "Boko Haram" in Nigeria to justify their views about condoms, and it affected many people* – ***Kwame; 20 years, male***

Adzo also mentioned that, some people believed that, HIV/AIDS is caused by some evil forces and therefore you will only get HIV/AIDS if you are meant to get it and this influence their decision to use the condom.

In keeping up with our objectives, some participants suggested some ways these elements influencing condom use among this subpopulation can be circumvented;

Kwame in one of our focus group discussions explained what he does to ensure a sexually protective lifestyle. He stated to the admiration of the other participants that; he lives in a town somewhere in the western region where his girlfriend also lives. So when school vacates, before he goes back, he buys his condoms from Sunyani where nobody knows him and takes it home. With that he is able to avoid the embarrassment he has to go through when he wants to buy condoms.

Adwoa also believes that, finding a condom in your child's bag or purse; you should rather encourage them for living a protective life than to punish them. She further suggested that, parents and significant adults should be sensitized not to see condom use or keeping condoms by young people as a sign of immoral behavior or taboo, but rather should be encouraged, so that young people will always be conscious of using condoms during sex.

Many of such suggestion were given by participants and these would be considered further in our discussion.

CHAPTER 5 - DISCUSSION

The study aimed to understand adolescents' and young people's sexuality with regards to their knowledge and experiences of condom use in HIV/ AIDS prevention and how this awareness impact on their sexual behavior. It had the primary objective of exploring perceptions and experiences of condom use in HIV/AIDS prevention among adolescents and young people between the aged 14 and 20 years in Ghana. In our bid to better understand the above, their perceptions on sexual relationships were also considered since condom use cannot be divorced from sexual relationships. This chapter presents a discussion of the key research findings, in relation to other relevant studies to give a better understanding of the individual and major contextual factors that support behavior change (i.e. condom use) among this subpopulation; it follows up with addressing some limitations of this study and concludes with recommendations for implementation and further suggest implications for future research.

Before a detailed interpretation of the results and their implications, it is essential to begin with a summary of the key research findings. The findings from the study provided insight into adolescents' and young people's knowledge about HIV/AIDS and condoms and how this knowledge impacted on their sexual behavior. Their perceptions and experiences about relationships and sex, their condom use practices in sexual relationships, as well as the individual and sociocultural influences on its use were also explored. In support of previous studies reviewed, participants exhibited a higher degree of awareness about sexual transmission of HIV/ AIDS and acknowledge condoms as the most effective means to prevent transmission. In addition, education of young people on HIV/ AIDS prevention happened through various means such as the media, home (family interaction), school, and also through their wider interactions within community. However, it was found that adolescents and young people trusted and preferred sexuality education from their parents and significant adults in their lives; although most complained they did not get it; thus, giving way to be influenced through other means including their peers.

The results on how this knowledge gained impacted on their sexual behavior were consistent with what other studies have already found; it emerged that awareness of condoms as an effective means of HIV/AIDS prevention did not necessarily translate into behavior change.(22,51)

Notwithstanding this high degree of awareness, a greater number of these adolescents and young people continued to engage in unprotected sex, putting them at risk of infection. Some of them occasionally made use of condoms but this was linked to casual sexual encounters. Only a handful of them practiced condom use consistently; however, it was found that pregnancy prevention was the major reason in most cases. Suggestions were given on how these sociocultural norms and beliefs about sex and condoms in the community which presented as barriers to adolescents' and young people's condom use behavior could be circumvented to enable them live sexually protective lives.

For the purpose of interpreting and understanding the results of this study, the guiding theoretical framework which was adapted in discussing the findings is the Bioecological Systems Theory (BST) as proposed by the American psychologist, Urie Bronfenbrenner. The theory began as the ecology of human development and evolved as a bioecological model to include a process, person, context, time (PPCT) framework and a concept of interaction known as proximal processes.(115) The BST was used in conjunction with other theories such as Bowlby and Ainsworth's attachment theory(122) as well as Bourdieu's theory of habitus and field(123) to understand the individual and contextual factors that influence behavior change i.e. condom use among sexually active adolescents and young people in Ghana.

The underlying premise here is that behavior change occurs at multiple levels of influence within the individual's immediate environment, community, as well as the larger social system and sociocultural contexts. The bioecological approach to behavior change assumes that one cannot understand a person's behavior exclusive of the environment in which he or she lives and interacts. It is held that behavior change is most likely to occur when multiple levels of individual and environmental influences are addressed by an intervention program. The bioecological approach explains how individual factors, interpersonal relationships, community level factors and sociocultural factor(130) through a complex mechanism of interaction among them lead to behavior change. Findings from the study identified a range of factors at multiple systemic levels as mentioned above, which influenced adolescents' and young people's condom use behavior.

INDIVIDUAL LEVEL INFLUENCE ON CONDOM USE

According to the BST, behavior change occurs as a result of an interaction between an individual and his or her environment over a period of time; this process acknowledges the individual as central to this interaction. Individual factors such as age, gender, attitudes towards HIV and condoms, knowledge and awareness of HIV or condom use as effective in preventing infection, as well as personal vulnerability to infection had an influence on adolescent condom use behavior; however, knowledge and awareness or just providing adolescents with information has been found to have little or no correlation with behavior change.(22,51) In support of previous studies, participants who believed that anyone was at risk of HIV infection were more likely to use condom than participants who said HIV was a disease of others. Although its use may not be on a consistent basis, some participants confessed that, their fear of contracting HIV informed their decision to use condom. It was also evident that these participants' decision to use condom was influenced by the appearance of the potential partner as found by Skidmore and Hayter.(63) Furthermore adolescents' who initiated sex at an early age were less likely to have used condom compared to their older counterparts. When asked about how their first sexual experience happened; majority of them said "it just happen", which demonstrates that adolescent sexual experiences are usually unplanned and unexpected as indicated by Krugu et. al(94) A possible explanation for this as observed by Adih et al.(80) is that in Ghana, where contraceptive services traditionally cater to adults, younger people may find it more difficult to obtain condoms; they may not have the money to buy condoms.

However, such adolescent decision making framework has been criticized for being solely focused on the individual rational choice in decision making and its failure to accommodate the broader social, economic and cultural factors that operate outside an individual's ability and have influence on sexual behaviours of young people.(131) Participants' gender, although an individual characteristic, also has social connotations and presented as a key determinant of condom use among young people; whereas male participants were more concerned about sexual pleasure, female participants were found to have a better attitude towards condom use; Notwithstanding their positive attitude towards condom use, they lack the skills to negotiate its use in their sexual relationships. This according to the findings of this study is because females bear the ultimate responsibility for pregnancy and sometimes end up dropping out of school due to the shame and stigma associated. It was however mentioned by one male participant that he

will not use a condom if the partner agrees to it. This may be interpreted to mean that adolescent girls' ability to negotiate condom use may also be accepted by their male partners. As pointed out by Powell,(123) the negotiation of sexual consent and therefore condom use involves a complex interplay of individual agency and embodied gendered practice. Futhermore, female participant who were confident to initite condom use discussions with their partners succeeded in ensuring condom use consistently in their their sexual relationships. Nevertheless, the experiences told by these adolescents' is that the use of condoms is not a simple behavioral response but, rather, the result of complex social and interpersonal events that reflect a multifactorial decision-making process influenced by the individual, developmental, social and structural forces as noted by Becker.(132)

CONTEXTUAL INFLUENCES ON CONDOM USE

Social and sexual networks as indicated by BST are comprised of interpersonal relationships including family, friends, neighbors and others that directly influence behaviors in multiple ways. This includes the webs of human relationships which are dyadic, familial, social, sexual, through which social as well as sexual exchange occurs and social norms are played out"(133) HIV risks behaviors are found to be associated with social influence, social engagement, as well as access to information, intimate contact and social networks

Accordingly, adolescents and young people's sexual behavior and decision to use condom was found to be influenced by structural factors as described by participants through their interactions with partners, peers, and most importantly, familial interactions especially with parents. Some sociocultural norms and practices were also mentioned to influence their sexual behavior.

Gender, Power and Sexuality

Both female and male participants confirmed the strong influence of their partners on their decisions to use condom. Female participants were of the view that condom use decision was the responsibility of their partners; this according to Harrison et al. is due to the existing power bias between males and females in relationships.(71) Findings from this study suggest that females may have perceptions significantly different from males concerning relationships. Consistent with literature, females seek attachment and intimacy and will therefore do anything to sustain the relationship. It was further revealed that, females who raised the issue of condom use risked been abandoned or abused. Adolescent girls in particular are perceived to have little power to

negotiate condom use or the decision to have sex especially with older partners. In our study, female participants revealed that refusing sex or suggesting condom use was interpreted by their partners as lack of trust and may result in termination of the relationship. In demonstrating the usefulness of attachment theory framework to understand women's sexual risk behavior, it has been posited that anxiously attached women reported consenting to unwanted sex for different reasons than women who were less anxious in their relationships. Women high in attachment anxiety reported consenting to unwanted sex in order to avoid conflict or to prevent a partner from losing interest in the relationship.(134) The findings further showed that fear of rejection translated into behavior and more specifically, condom use behavior partially motivated by desires to prevent the dissolution of an important intimate relationship. On the other hand, this kind of attachment may be argued to be as a result of female adolescents' economic deficiencies. Most participants from the study revealed that, entering and remaining in such relationships may not be a preferred choice, however due to the economic benefit and the low socioeconomic status of family, they have no choice than to keep the relationship going. One participant expressed vividly as follows; "*In the case of the girls, financial difficulty leads them into relationships with men who can take care of their financial needs, because they may be from poor backgrounds."* This is a general situation in Ghana where the community under study is no exception where men are always dominating in decision making and wield economic power.

In spite of this, Harrison cautions that, instead of a one-sided focus on male power and female subservience, it is necessary to show how both males and females conceptualize relationships, and express love and desires within the social organization of gender which provides an important framework through which they construct their sexualities.(71)

A major influence is the issue of transactional sex which came up for discussion several times in the study; adolescents and young people were found to be involved in sexual practices for economics reason for survival purposes due to extreme poverty within their family settings. Participants noted that both male and female adolescents were involved in this practice; however it was reported to be more common among females. Female adolescents were more likely to engage in sexual relationship for survival purposes with adult partners because it is believed that younger partners were not financially sound to cater for their needs. In addition they may also have relationships with younger partners which they see as "serious relationships". This notwithstanding both types of relationships exerted some influence on female adolescents' condom use behavior with regard to their ability to negotiate for condom use. For example, in

sexual relationships with adult partner for survival purposes, they were limited in their ability to negotiate for condom use; the power imbalance within this kind of relationships meant that female adolescents did the bidding of their adult partners and as one participant put; "*since you are going for the money, you cannot give instructions*". On the other hand, female adolescents' perception of their relationships with younger partners as being serious also influenced their ability to negotiate condom use. Due to the notion of trust in this kind of relationships, raising the issue of condom use indicated mistrust or suspicion and may result in unpleasant consequences on the relationship. Therefore, even though female adolescents may have the agency and a positive attitude towards condom use; their ability to negotiate for its use is restricted by these factors. Similar findings were discussed by (135); and reported that such power dynamics within such relatioships influenced females but not males. In contrast our findings indicated that male adolescents may experience such gendered influences on their sexual behavior; study participants pointed out that adolescents males who were in sexual relationships with older partners were also under the influence of their partners with regard to condom use; and were also restrained from talking to younger girls due to the circumstances such as their socioeconomic status and the power imbalance within the such relationships. There is therefore the need to show how both males and females conceptualize relationships, and express love and desires within the social organization of gender which provides an important framework through which they construct their sexualities.(71)

Adolescent – parent Attachment

An important interpersonal level influence on adolescents' and young people's condom use behavior is their relationship with their parents. Adolescent – parent relationship was a significant predictor of their condom use behavior. The BST posits that, the family is the closest, most intense, most durable, and influential part of the mesosystem, therefore, the influences of the family extend to all aspects of the child's development including sexual.(122) Perceived parental support was found to be an essential determinant of most participants' decision-making and sexual behavior. It was found that participant who had their parents educating them about sex earlier in life were more likely to embody those values such as abstinence or condom use. It reported by a participant as below; "*My parents always advise me not to have any sexual intercourse with any lady and I am also a believer in that, so I had that conscience not to have sex or involve myself in any sexual activity as a small boy so I stayed away from that thing".*

Mothers were seen as a primary source of financial and logistical needs. They were also reported to serve as trustworthy sources of information and guidance for some participants. Consistent with literature, mothers played more educative roles for adolescents and tend to initiate sexual education with their children than fathers. This has been explained to be because mothers spend more time with children, are more proficient communicators and happens to be the parent who displays more intimacy with children.(101) Prevention programs should therefore be initiated at the family level to ensure participation of both parents effectively impact adolescents' and young people's sexual behavior.

Furthermore, findings demonstrate that participants who had discussion about sexuality with their mothers were significantly more likely to be influenced in their sexual behavior and to use condoms consistently if they supported condom use. It is worth mentioning that, among the twenty – three participants for the study, female condoms were not something they knew much about; however only one participant knew about it in addition to the male condoms and could practically explain how it is use. This was because she had an accommodating mother who frequently talked to her about sexual issues; thus, findings stress the importance of such discussions between young people and the parents. However, as mentioned earlier, the joint effort of both parents would yield greater results.

It has also been theorized that, parents' effect on their children's sexual behavior goes beyond just communication and connectedness or relationship quality. Miller et al.(136) considers timing of discussions, as well as parental regulation of behavior and parental control to be important predictor variables. Adolescents and young people were found to engage in sexual activities at an early age, therefore if sexual communications are not initiated until adolescence, this may be perceived as intrusive, embarrassing or unimportant and may not have any influence on the child's behavior. Instead, if the discussions begin earlier before adolescence, discussions may be seen as normative and may communicate clearly that the parent is a resource and will minimize initiations that are merely in response to the child's sexual behavior as noted by participants.

Sexuality could also be seen as a new field where young people get into. And for those having parents accepting sex the young people are able to transfer their social capital of caring habitus into this new field; while those having parents who do not accept it, are precluded from necessary capital to protect themselves. Such capacity for self-care develops through interaction

with caring parents, and is embodied so that it enables adolescents and young people to take care of them self - also in new and different situations, like sex and therefore condom use.

A unique finding of the study was that of the financial influence or influence of parents' socioeconomic status on parental influence; rarely found in the literature, yet a topic that emerged in many of the interviews. Researches on the effects of parental influence on adolescents and young people's behavior have tended to be skewed toward positive behavior outcomes; however findings pointed to the possibility of resulting in negative outcomes. Generally, it was mentioned that, for whatever reason- financial gains or lack of control over their children; parental influence was also found to impact negatively on adolescents' sexual behavior. Some mothers influenced their children negatively into sexual relationships due to their socioeconomic deficiencies. This was supported Bronfenbrenner and Evans(137) assertion; which indicated that the adolescent-parent attachment process does not always result in positive behavioral out comes, but could also lead to dysfunctional outcomes.

Socialcultural Norms and Beliefs

HIV is transmitted by specific practices among individuals and groups that occur in a social context. According to Kippax,(89) practices are socially produced behaviors that are organized and patterned by culture. From our findings, community level influences on sexual behavior are recognized as the perceived norms, attitudes, beliefs and interpretations regarding the sociocultural acceptance of adolescents' and young people's sexuality and its consequences. In the Ghanaian context, there is significant pressure from the community for adolescents to behave in a set manner which is deemed "appropriate behavior" for their age and therefore any deviation from this, is socially unacceptable and comes with a consequence. Sexual activities are regarded as the preserve of married adults hence, unacceptable among adolescents. This means that, for sexually active adolescents, keeping their relationships secret allowed them to meet the expectations of the community.

"Some people are in relationships and are having sex, but they do not want the people to know about it because of the way the public sees such relationships. So if we are talking about such things like sex, they do not want to be seen talking about it."

This has been found to have a negative influence on their condom use behavior. Adolescent and young people found it difficult to keep or use condom, as this will be interpreted as promiscuity.

Furthermore, the act of acquiring condoms under the gaze of another person especially an adult was seen as embarrassing. This prevented participants who were willing to use condoms from purchasing them. Participants suggested the introduction of condom vending machines which seem to be an important structural adjustment to improve adolescent's sexual behavior.

CONCLUSION

The findings of this study yield timely, informative, and enlightening insight into a topic that has impacted adolescents and young people's lives globally. As this research and the literature demonstrate, Adolescents and young people get sexual education through various means which include the media, family, school, and peers; however, this has not translated into behavior change. In addition to individual level influence, contextual factors were found to have a significant influence on adolescents and young people's condom use behavior. Of key importance is the role of the parent adolescent relationship in ensuring that capacity for self-care develops through interaction with caring parents, and is embodied so that it enables them to take care of them self - also in new and different situations, like sex. Family dynamics clearly play a significant role; however this is implied that parents can have some influence on, but they cannot determine whether or not adolescents have intercourse or use condoms. What parents do, however, makes these outcomes more or less likely.

RECOMMENDATIONS

HIV/ AIDS prevention educational program in school have mainly relied on providing knowledge to participants and based on abstinence only messages; thus, depriving them of key information about effectiveness of condom use in HIV prevention. This knowledge provided is yet to translate into behavior change; adolescents and young people continually engage in sexual relationship without condoms. In light of the BST the following recommendation were suggested;

From the study, some participants pointed out the dual benefit of using condoms in pregnancy prevention and HIV prevention and suggested the need to draw HIV prevention programs concurrent with pregnancy prevention to encourage condom use among young people. These participants argued that even though their primary objective for using the condom was to prevent pregnancy, they also benefited indirectly in protecting them against HIV although that may not have been their conscious reason.

Prevention strategies should be designed to promote positive attitudes, beliefs, and behaviors that ultimately support condom use. Specific approaches may include education and life skills training. Furthermore, at the community level social norms and social marketing campaigns can be used to ensure a supportive community for adolescents and young people to explore their sexuality and promote healthy relationships. In addition, prevention programs must emphasize the responsibility of men to insist on condom use, and at the same time assisting young women to negotiate condom use more effectively. Also important is to emphasize condom use as an act of social concern and responsibility, instead of associating it to promiscuity.

Programs should include training components that empower adolescents especially girls through skills that enable them to generate income in order to minimize the incidence of transactional sex among adolescents and may also include mentoring and peer programs designed to improve adolescents and young people's problem solving skills, and promote healthy relationships.

Finally, findings suggest that parents were not the primary source of information and sexual communication although several studies have pointed to their important influence on adolescents' sexual behavior. There is therefore the need for parents to assume a more vital role earlier in their children's life and also involving them in sexual education programs in schools.

STUDY STRENGTH AND LIMITATIONS

The decision to employ FGD in collection data proved to be a key strength of the study. It gave room to participants to describe the contextual factors influencing their sexual risk and condom use behaviors through their own perspectives and lived experiences and utilizing their own terms and conceptualizations to suggest ideas for effective HIV prevention and condom use interventions for young people. Furthermore, although FGD was mostly used to collect information on the social influence on participants' sexual behavior and suggestions for effective prevention programs, it performed a dual function of collecting the above mentioned information, and further proved to be a validation tool for responses from the in-depth interviews.

Notwithstanding the above stated strengths of the study, some limitations are noteworthy and therefore findings of the study should be interpreted in line with these. Even though steps were taken to ensure a friendly atmosphere as possible so participants felt comfortable to discuss their

sexual experiences, some participants were likely to have given responses which are socially acceptable due to the sensitive nature of the topic.

In addition, FGD were conducted in age and sex segregated groups; however the first discussion to be held with female participant below 18 years included an 18 year old participant since there were only 4 female participants below 18 years. Her presence in that group had an influence on another participant who could not express herself and could not contribute much to the discussion. This participant had shown signs during the in-depth interview she had a lot of information for the FGD, However due to the limitation above, was hindered in the FGD. Steps were therefore taken in subsequent discussions to avoid a repeat of such occurrence.

Finally, in conducting research study on a broad and complex social and health issue such as adolescent sexuality and HIV, some simplifications made may have resulted in exclusion of some salient information which would have been important to the outcome of the study.

Further research needed employing more advanced analysis of these dataset, as well as the need for action research in the community under study and other related communities engaging citizen thus, both adolescents and parents.

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APPENDIX A: Information Sheet/ Informed consent document

Invitation to participate in a research

Study title: HIV/ AIDS awareness and behaviour change: A qualitative study to understand the reasons for condom use among young people in Ghana

Background and purpose

You are kindly invited to participate in a research study that aims to understand the reasons for condom use in HIV/ AIDS prevention among young people in Ghana. This research is taking place in connection with the International Community Health master program at the University of Oslo's Faculty of Medicine, Department of Community Medicine.

As part of the study, the researcher will explore the knowledge and practice of condom use in HIV/ AIDS prevention among young people; the reasons why sexually active people who protect themselves do so, and their experiences; and also investigate their perception of the individual and contextual beliefs and barriers to sexually active people who do not use condoms

You have been invited to participate in this study based on your status as an adolescents student and because you currently reside in the Brong Ahafo region of Ghana- the region of interest.

In depth interviews will be used to explore experiences, perception and views of adolescents on condom use in HIV/ AIDS prevention and obtain meaning of participants' own perspective of the situation while Focus group discussions will be used to explore their general knowledge about HIV/ AIDS and prevention methods, why young people have relationships and also sex? Any differences in male and female reasons, reasons for condom use or non-use among participants and how society views it will also be explored.

Your participation in this study will go a long way to help policy makers in the region and Ghana on the whole to refocus and improve already existing HIV/ AIDS education intervention programs and also develop new and effective ones.

Please be informed that participation in this study is voluntary and you can withdraw at any time during the study without giving any reasons for your withdrawal. Taking part on withdrawal from the study will not put you in any disadvantage in terms of your rights and your entitlements.

Be assured that no private or personal information will collected during the study and any information provided will be treated with confidentiality and will only be used for the purpose of

the current study.

The study has been reviewed and sanctioned by the Norwegian Research Ethics Board; The University of Oslo; as well as the Ghana Health Services' Ethical Review Committee and the Ghana Education Service.

You are welcomed to ask any question concerning the study

Much thanks!

The researcher can be contacted as follows:

Kingsley Ntiamoah Arthur

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(+47) 48643290

(+233)244535346

Declaration of Consent for Participation in the research

I am willing to participate in the study after receiving information about the research.

(Signed by the research participant, date)

I confirm that I have given adequate information about the research to particpant.

(Signed by the researcher, date)

APPENDIX B: Information Sheet/ Parental Permission document

Request for your child to participate in a research

Study title: HIV/ AIDS awareness and behaviour change: A qualitative study to understand the reasons for condom use among young people in Ghana

Background and purpose

Your child is kindly requested to participate in a research study that aims to understand the reasons for condom use among young people in Ghana. This research is taking place in connection with the International Community Health master program at the University of Oslo's Faculty of Medicine, Department of Community Medicine.

As part of the study, the researcher will explore the knowledge and practice of condom use young people; the reasons why sexually active people who protect themselves do so; their experiences; and also investigate their perception of the individual and contextual beliefs and barriers to sexually active people who do not use condoms

Your child has been invited to participate in this study based on her/ his status as an adolescents student and because (s)he currently resides in the Brong Ahafo region of Ghana- the region of interest.

In depth interviews will be used to explore experiences, perception and views of participants on condom use and obtain meaning of participant's own perspective of the HIV/ AIDS situation while Focus group discussions will be used to explore general knowledge about HIV/ AIDS and prevention methods, why adolescent and young people have relationships and also sex? Any differences in male and female reasons, reasons for condom use or non-use among adolescents and how society views it will also be explored.

Your child's participations in this study will go a long way to help policy makers in the region and Ghana on the whole to refocus and improve already existing HIV/ AIDS education intervention programs and also develop new and effective ones.

Please be informed that your child's participation in this study is voluntary and (s)he can be withdrawn at any time during the study without giving any reasons for withdrawal. Taking part on withdrawal from the study will not put your child in any disadvantage in terms of her/ his

rights and entitlements. Be assured that no private or personal information will collected during the study and any information provided will be treated with confidentiality and will only be used for the purpose of the current study. It is however important to note that your consent is subject to the child's agreement/ assent to participate.

The study has been reviewed and sanctioned by the Norwegian Research Ethics Board; The University of Oslo; as well as the Ghana Health Services' Ethical Review Committee and The Sunyani West district Education Directorate of the Ghana Education Service.

You are welcomed to ask any question concerning the study

Much thanks!

The researcher can be contacted as follows:

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(+47) 48643290
(+233)244535346

Declaration of parental consent for Participation in the research

I am consenting to my child's aparticipation in the research after receiving information about the research.

(Signed by the research participant, date)

I confirm that I have given adequate information about the research to particpant's parent.

(Signed by the researcher, date)

APPENDIX C: Interview Guides

Study title: HIV/ AIDS awareness and behaviour change among young people: A qualitative study to understand the reasons for condom use in HIV/ AIDS prevention among in-school young people in Ghana

In depth interview guide

Qualitative interview guide

- **Background Information**
  - How old are you?
  - Are you married?
  - Have had a child before?
  - Who do you live with?
  - For how long have you been living here?
  - What do you usually do during the day and after school?
- **Information and communication on HIV/ AID and condom use**
  - Has anyone talked to you about HIV/AIDS and condom use? (Probe for who, where and when)
    - Can you tell me about who talked to you and what you talked about?
    - In what ways did you find these talks helpful?
  - Are there people you feel you can go for information about HIV/ AIDS and condoms? (probe for adequacy)
- **Relationships**
  - When did you have your first boyfriend/ girlfriend?
  - Tell me about your boyfriend/ girlfriend (probe for more description on age , schooling)

- How did you come to know each other?
- Did anyone know about your relationship? (probe for who and how they reacted to it)
- What happened to the relationship? **(Continuing?)**
- How long did the relationship last? (if the relationship ended probe for what happened and if there was any other boyfriend/ girlfriend during or after that relationship)
- **If never had a relationship**
  - What are some of the reasons why you have never had a boyfriend/ girlfriend?
  - Have you ever felt like having one?
  - What efforts have you made to get one? How did it work?
- When are you thinking of getting your first boyfriend/ girlfriend?

❖ **Sexual Experiences and Condom use**

- Tell me about the first time you had sexual intercourse (probe for how it happened, and any protection used)
- How did you feel about it then? How about now?
- When was your current or last sexual intercourse? (Probe for description of partner; boyfriend/ girlfriend? Age? Schooling? And condom use or non-use
- What were the things you could talk about?
- What were the things you could not talk about? Why?
- What kind of decision did you make? What kinds of decisions were made by him/ her?
- How about decision to protect yourselves against HIV/ AIDS and other STIs
  - What did you decide to do? How did you reach that decision? Did you both agree or disagree?

- Did you ever think you were at risk of HIV/ AIDS or any other STI when you had sex with him/ her? (probe for consequences of condom use or non-use)
- **If never had sexual intercourse, probe for fear of HIV/ AIDS, or any other issues**
  - Has anyone pressured you to have sexual intercourse? Who? In what ways?
  - How did you feel about not having sexual intercourse?
  - When are you thinking of having your first sexual intercourse? Why then?

❖ **Perceptions and risk**

- What comes to your mind if you hear about HIV/ AIDS? Why do you think that way?
- What do you think about people who have HIV/ AIDS?
- Do you personally know someone with HIV/ AIDS?
- How much of a problem do you think HIV is for you and in the community?
- What do you understand to be risky sexual behaviours? (probe on unprotected sex, multiple sexual partners)
  - Why do you think these are risky behaviours?
  - What do you think will happen to someone who does these things?
- What kinds of sexual behaviours do you think are not risky? Why do you think these are not risky?
- What do you think you can do to prevent HIV/ AIDS?

Focus group discussion guide

Focus group Discussions topics

Discussions will begin with some general questions that would put the informants at ease and comfortable to participate. Topics to be discussed include

- What are the reasons why young people like you enter into relationships? Probe for any differences in reasons for males and for females?
  - Why do young people therefore have sex? Probe for any differences in male and female reasons? Also probe for reason related to societal norms
- Now let's talk about condoms ☺
  - What do you know about condoms? Probe for knowledge on correct use, any misconception and how and where do u get your condoms?
  - Why would you use a condom when you want to have sexual intercourse with anybody? Probe for reasons of HIV/ AIDS prevention
  - Tell me what would make you have sexual intercourse without a condom (probe for reasons related to sociocultural norms and beliefs)
  - How would you describe your experiences when you want to get or use a condom
    - What do you think the consequences are?
- How is HIV/ AIDS a problem in this community?(Probe for perception of personal vulnerability)

APPENDIX D - Ethical Clearance From REK in Norway

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Advisor:	Telephone:	Our date:	Our reference:
REK sør-øst	Jakob Elster	22845514	11.09.2015	2015/1243 REK sør-øst B
			Your date:	
			16.06.2015	

Heidi Kvalvaag
University of Oslo

2015/1243 Kondombruk blant ungdom i Ghana, for å forebygge HIV/AIDS

Project title: HIV / AIDS awareness and behavior change among young people: A qualitative study to understand the reasons for condom use in HIV / AIDS prevention among Senior High School students in Ghana.

We are writing in reference to your Application for Preliminary Approval for the above-mentioned Research Project. The Regional Committee for Medical and Health Research Ethics, Section B, South East Norway, reviewed your Application during its meeting on the 19th of August 2015. The Project was assessed in accordance to the Norwegian Research Ethics Act § 4 (2006), and the Health Research Act § 10 (2008), for Regional Committees for Medical and Health Research Ethics.

Institution responsible for Research: University of Oslo
Project Manager: Heidi Kvalvaag

The Project Manager's description of the project
Despite high knowledge of condoms and HIV/AIDS, condom use among sexually active young Ghanaians remains low. Although young people may be knowledgeable about HIV, this does not necessarily equate to behavioral changes; sexual behavior and attitudes towards condoms may also be influenced by other social and cultural factors. Several studies have addressed barriers to condom use among this population; however this study aims to understand how some young people defy dominant social and cultural barriers and live protective sexual lives. In depth interviews will be used to explore their experiences and perceptions on condom use, while FGDs will be used to explore their knowledge about HIV/ AIDS and prevention methods and their reasons for condom use in sexual relationship. How different social norms influence condom use will also be explored. Findings from the study will be used in improving existing HIV/ AIDS prevention programs and in development of new and effective ones.

Review
The particpants are girls and boys in Senior High School in Ghana from the ages of 14-20. The participants will be recruited from an HIV / AIDS prevention education session through purposive sampling. Potential participants will be identified with the assistance of teachers in the school. 30 participants will be recruited. For minors, parental consent, in addition to child assent, will be sought.

Participation involves participating in in-depth interviews which will be utilised to explore experiences, perceptions and views of the participants on condom use in HIV/ AIDS prevention, as well as in focus group discussions in gender and age segregated groups, which will be used to explore the participants' general knowledge about HIV/ AIDS and prevention methods, and why young people have relationships, including sexual relationships.

Approval from the Regional Committee for Medical and Health Research Ethics is only required for projects which fall within the scope of the Norwegian Health Research Act. The Act applies to all medical and health research on human beings, human biological material or personal health data, cf. § 2. "Medical and health research" is defined as "activity conducted using scientific methods to generate new knowledge about health and disease", cf. § 4.

The Committee considers that the project under review will bring new knowledge about reasons for condom use and about knowledge and perceptions regarding condom use, but not about health and disease as such. The project thus falls outside of the scope of the Health Research Act, and approval from the Regional Committee for Medical and Health Research Ethics is not required.

The Committee's Decision
The study is exempt from review, cf. §§ 2 and 4 of The Health Research Act.

Appeals process
The decision of the Committee may be appealed to the National Committee for Research Ethics in Norway. The appeal will need to be sent to the Regional Committee for Research Ethics in Norway, South-East B. The deadline for appeals is three weeks from the date on which you receive this letter.

The Committee's decision was unanimous.

Yours sincerely,

Grete Dyb
Chairperson REc South East, Section B

Jakob Elster
Senior Advisor

CC: Management of Administration, University of Oslo

APPENDIX E - Ethical Clearance from NSD in Norway

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Heidi Kvalvaag
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

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Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr: 985 321 884

Vår dato: 27.01.2016 Vår ref: 46093 / 3 / AGL Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 11.12.2015. Meldingen gjelder prosjektet:

46093	*HIV/AIDS awareness and behavior change among young people: A qualitative study to understand the reasons for condom use in HIV/AIDS prevention among Senior High School students in Ghana*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Heidi Kvalvaag*
Student	*Kingsley Ntiamoah Arthur*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 27.06.2016, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Audun Løvlie

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Kontaktperson: Audun Løvlie tlf: 55 58 23 07

Vedlegg: Prosjektvurdering

Kopi: Kingsley Ntiamoah Arthur knarthur@yahoo.co.uk

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 46093

The purpose of the project is to explore experiences and perceptions on condom use, while FGDs will be used to explore their knowledge about HIV/AIDS and
prevention methods and their reasons for condom use.

The sample will receive written information about the project, and give their consent to participate. The letter of information and consent form are somewhat incomplete, and we ask that the following is changed/added:
- Date for project completion
- That all of the data material will be made anonymous by project completion

Please note that when children actively participate in research, participation is always voluntary, even though parents have given their consent. Children should be given information adapted to their age, and it must be made sure that they understand that their participation is voluntary and that they can withdraw at any time.

There will be registered sensitive information relating to healt conditions and sex life.

The Data Protection Official presupposes that the researcher follows routines and regulations of Universitetet i Oslo regarding data security. If personal data is to be stored on portable storage devices, this needs to be cleared with Universitetet i Oslo.

Estimated end date of the project is 27.06.2016. According to the notification form all collected data will be made anonymous by this date.
Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:
- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting digital audio and video files

APPENDIX F – Ethical Clearance from GHS – ERC in Ghana

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah. Frimpong@ghsmail.org

23rd December, 2015

Kingsley Ntiamoah Arthur
University of Oslo
Institute of Health and Society
P. O. Box 1130, Blindern
0318 - Oslo

ETHICS APPROVAL - ID NO: GHS-ERC: 06/10/15

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"HIV/AIDS Awareness and Behaviour Change among Young People: A Quanlitative Study to Understand the Reasons for Condom Use in HIV/AIDS Prevention among Odomaseman Senior High School Students in Ghana"

This approval requires that you submit yearly review of the protocol to the Committee and a final full review to the Ethics Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please note that this approval is given for a period of 12 months, beginning December 23rd, 2015 to December 22nd, 2016.

However, you are required to request for renewal of your study if it lasts for more than 12 months.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX G – Permission from GES in Ghana

GHANA EDUCATION SERVICE

Telephone: 03520-27550
Email: Sunyani.west.ges@gmail.com

Our Ref. No.GES/SWED/37/V.3/64.....
Your Ref. No.:.....

Republic of Ghana

Sunyani West District Office
Post Office Box 2142
Odomase - Sunyani, B/A.
Ghana West Africa

28th August, 2015.

THE HEADMISTRESS
ODOMASEMAN SHS
SUNYANI WEST
ODOMASE-B/A

PERMISSION TO CONDUCT RESEARCH
KINGSLEY NTIAMOAH ARTHUR

The bearer of this note (named above) is a Research Candidate at the Department of community medicine at the University of Oslo. He is researching into the topic 'HIV/AIDS awareness and behavior change among young people'.

He has been granted permission by the District Director to use your students as respondents to conduct his interview.

Kindly give him the necessary attention.

Thank you.

MARY KONAMA (MS.)
DEPUTY DIRECTOR
H. R. M. D.
For: DISTRICT DIRECTOR
SUNYANI-WEST

cc:

- Ethical Review Committee
  Research and Development
  Division
  Ghana Health Service
  P. O. Box Mb 190
  Accra
- Kingsley Ntiamoah Arthur
  Olav M TorviksVei 18
  H 0304
  Oslo – 0864
  Norway