FINAL REPORT

SITUATIONAL ANALYSIS OF ADOLESCENT GIRLS AND YOUNG WOMEN IN GHANA – Synthesizing Data to Identify and Work with the Most Vulnerable Young Women

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ACRONYMS

BECE	Basic Education Certificate Examination
DFID	Department for International Development
DOVVSU	Domestic Violence and Victims Support Unit
EMIS	Education Management Information Systems
ESP	Education Strategic Plan
ESPR	Education Sector Performance Report
FCUBE	Free Compulsory Universal Basic Education
FGM	Female Genital Mutilation
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GETFund	Ghana Education Trust Fund
GEU	Girls' Education Unit
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GMHS	Ghana Maternal Health Survey
GNAS	Ghana National Adolescent Survey
GOG	Government of Ghana
GPI	Gender Parity Index
GPRS	Ghana Poverty Reduction Strategy
GPRS	Growth and Poverty Reduction Strategy
GSFP	Ghana School Feeding Program
GSS	Ghana Statistical Service
INGOs	International Non-Governmental Organizations
JHS	Junior High School
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOE	Ministry of Education
MOESS	Ministry of Education, Science and Sports
MOH	Ministry of Health
NAR	Net Attendance Ratio
NER	Net Enrolment Rate
NGO	Non-Governmental Organization
NPC	National Population Council
NSA	National Survey of Adolescents
PHC	Population and Housing Census
SGBV	Sexual and Gender-Based Violence
SHS	Senior High School
SSSCE	Senior Secondary School Certificate Examination
TVET	Technical and Vocational Education Training

UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WASSCE	West African Secondary School Certificate Examination
WFP	World Food Programme
WHO	World Health Organization

DEFINITION OF TERMS

Adolescents: 10-19 year olds[1]

Teenagers: 13-19 year olds[2]

Young women: 20-24 year olds

Completion Rate (CR): measures the total number of students of any age in the last grade of school, minus the number of students repeating in that grade, divided by the number of children of official graduation age.

Gender Parity Index (GPI): measures the relative access of female to male education.

Literacy Rate: measures the percentage of the population aged 15 years and over who can both read and write with understanding, a short simple statement on his/her everyday life.

Net Admission Ratio (NAR1): measures new entrants in the first grade or level of education who are of the official school entrance age, expressed as a percentage of the population of the same age.

Net Attendance Ratio (NAR2): measures the percentage of the school-age population (primary, 6-11 years; secondary 12-17 years) attending school.

Net Enrolment Rate (NER): measures enrolment of the official age group for a given level of education expressed as a percentage of the corresponding population.

Retention rate (RR): measures the rate at which students persist in their educational program at an institution, expressed as a percentage.

Transition Rate (TR): measures the number of pupils (or students) admitted to the first grade of a higher level of education in a given year, expressed as a percentage of the number of pupils (or students) enrolled in the final grade of the lower level of education in the previous year.

[1] While the situational analysis aimed to focus on 10-24 year old women, nationally representative data sets such as the Demographic and Health Survey and the Multiple Indicator Cluster Survey include only women age 15-49. Hence, data is not collected on girls age 10-14. In addition, the Ghana National Survey of Adolescents reported on adolescents age 12–19, which still falls short of the interest of this situational analysis. Hence, depending on the availability of data the age range for adolescents will vary in this report.

[2] Even though teenagers include 13-19 year olds, this might vary at some point in this report because of lack of data.

EXECUTIVE SUMMARY

Background

Adolescents and young people are entitled to decent livelihoods; however, girls face disproportionate risks and distinctive consequences related to the vulnerabilities they experience. Young girls compared to their male counterparts are more likely to drop out of school, to marry at an early age, and to bear the consequences of poor sexual and reproductive health outcomes. Adolescent girls confront distinct physical and social vulnerabilities that threaten their human rights and livelihoods. The needs and opportunities for girls' and boys' diverge during early adolescence, with girls entering puberty on average two years earlier than boys. For many girls in the developing world, this marks the beginning of a protracted risk period during which they have little or no control over critical social, health, and economic outcomes. Girls are disproportionately vulnerable to violations of their human rights, inadequate reproductive health services, education and subjected to child marriage - all limiting realization of their full human potential. The recognition that adolescent girls and young women face a complex array of issues led the UNFPA Country Office (CO) to initiate an in-depth situational analysis of adolescent girls and young women in Ghana. The aim of the situational analysis was to identify and work to improve the sexual and reproductive health and rights (including gender-based violence and child marriage) vulnerabilities adolescent girls and young women face.

Objectives of the situational analysis

The objectives of this situational analysis of adolescent girls and young women in Ghana were:

1. To identify and analyze the major trends in issues that impact upon adolescent girls and young women in Ghana: teenage pregnancy, abortion, gender based violence, and education (access, retention, transition) as well as child marriage;
2. To define gaps and barriers in data for addressing issues pertaining to adolescent girls and young women in Ghana;
3. To identify the achievements of programs, policies and plans on issues of adolescent girls and young women in Ghana;
4. To identify and analyze the enabling factors that perpetuate the phenomenon of child and forced marriages in Ghana; and
5. To make recommendations on relevant program areas focused on adolescent girls and young women for consideration by UNFPA CO (especially for the child marriage initiative)

Methods

Multiple approaches (desk review, quantitative and qualitative approaches) were used to achieve the set objectives of the situational analysis. The desk review utilized nationally representative survey reports such as the GDHS (1993-2014), MICS (2006 & 2011), NSA (2004) and GMHS (2007). Reports from international and national institutions including UNICEF, Ghana Health Service (GHS) and Ministry of Education (MOE) were reviewed. Other relevant literature such

as peer reviewed journal articles was also used. Datasets including the GDHS and the Ministry of Education's EMIS were analyzed where appropriate. The quantitative data analyses were conducted using statistical techniques such as frequencies, cross tabulations and binary logistic regression models. Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted for the qualitative strand of this study. The KIIs were conducted with key stakeholders on issues surrounding adolescent girls and young women's wellbeing in the Greater Accra, Central and Northern regions. The FGDs were conducted in selected UNFPA country program support regions (Northern and Central). These are regions with high prevalence of teenage pregnancy (Central, 21.3%) and child marriage (Northern, 35.8%) (Ghana Statistical Service, Ghana Health Service, & ICF International, 2015). The FGDs were conducted in Zabzugu-Tatale (Northern region) and Assin South, Ekumfi and Agona West (Central region). The qualitative data was transcribed (verbatim) and analyzed using the thematic approach. The results were presented under main themes and sub-themes to add meaning and context to findings from the desk review and quantitative analysis where appropriate.

Key findings

Teenage pregnancy and motherhood

Data from the GDHS revealed that the trend in median age at first sexual intercourse among young women (20-24 years) increased from 16.9 years in 1993 to 18.5 years in 2008 and 18.4 years in 2014. The proportion of adolescent girls (15-19 years) who had sexual intercourse by age 15 declined from 12% in 1993 to 7% in 1998 and increased to 12% in 2014. Among young women (20-24 years), the percentage who had sexual intercourse by age 15 declined from 15% in 1993 to 7% in 2008 and increased to 10% in 2014. Additionally, the trend in the proportion of teenagers (15-19 years) who had begun child bearing (either pregnant with first child or have ever had a live birth) declined from 22% in 1993 to 13% in 2008 and increased to 14% in 2014. The proportion of teenagers who had begun child bearing was consistently higher in rural areas compared to urban areas from 1993 to 2014. Teenage motherhood was highest in Volta, followed by Central and Brong Ahafo regions in 2014.

Abortion

The 2007 GMHS report indicated that the induced abortion rate was 17 per 1,000 among adolescents (15-19 years) and 25 per 1,000 among young women (20-24 years). In general, 3% of adolescent girls (15-19 years) and 12% of young women (20-24 years) have ever had an induced abortion and 3% of adolescent girls and 6% of young women thought induced abortion was legal under certain circumstances in Ghana. Data from the GDHS showed that the percentage who ever terminated a pregnancy among women age 15-24 declined from 9% in 1998 to 7% in 2003 and 2008, and increased to 11% in 2014. Among adolescent girls (15-19 years), pregnancy termination declined from 4% in 1998 to 2% in 2008 and increased to 3% in 2014. In addition, pregnancy termination among young women (20-24 years) declined from 14% in 1998 to 12% in 2003 and increased to 14% and 19% in 2008 and 2014 respectively.

Gender-based violence

Data from the 2016 DVG survey revealed that 49% of adolescent girls and 48% of young women experienced psychological violence (domestic or non-domestic) in the last 12 months preceding the survey. In the domestic sphere, 36% of adolescent girls and 19% of young women experienced social violence. Data from the 2008 GDHS also showed that about 11% of women (15-24 years) had ever been pushed or had something thrown at them by their partners. In addition, 16% of women (15-24 years) had ever been slapped by their partners. Data on attitudes towards gender-based violence from the GDHS (2003-2014) showed that the proportion of women (15-24 years) who justified gender-based violence against women declined from 50% in 2003 to 32% in 2014. Justification of violence against women consistently declined from 51% in 2003 to 35% in 2014 among adolescent girls (15-19 years). Among young women (20-24 years), justification of gender-based violence against women declined from 48% in 2003 to 29% in 2014.

Education

Among adolescent girls (15-19 years), the proportion with no education declined from 18% in 1993 to 4% in 2014. With respect to young women (20-24 years), it declined from 26% in 1993 to 12% in 2014. The Net Attendance Ratio (NAR) for girls at secondary level of education increased from 35% in 2003 to 42% in 2008 and declined to 39% in 2014. Gender parity was achieved at the primary level of education in the 2012/13 (GPI, 0.99) and 2013/14 (GPI, 0.99) academic years. The Net Enrolment Rate (NER) at primary level for girls increased from 77% in 2010/11 academic year to 89% in the 2013/14 academic year. Retention of girls at the primary level of education decreased from 770 per 1,000 girls in 2004/05-2009/10 academic years to 576 per 1,000 girls in 2008/09-2013/14 academic years. Net JHS completion rate increased from 62% in 2009/10 academic year to 66% in 2013/14 academic year.

Child marriage

Child marriage declined from 28% in 2003 to 25% in 2008 and 21% in 2014. The prevalence of child marriage is higher in rural areas than in urban areas. Child marriage among young women who have never attended school decreased from 49% in 2003 to 46% in 2008 and 2014. Child marriage is highest in the three northern regions (Upper East, Upper West and Northern), Eastern and Brong Ahafo regions. In addition, the study identified poverty, place of residence, lack of education, pregnancy and cultural norms such as betrothal marriage and exchange of girls for marriage as the main drivers of child marriage. The consequences of child marriage include; dropping out of school, pregnancy complications, loss of autonomy and gender-based violence against girls

Key recommendations

Teenage pregnancy and motherhood

- A multi-sectoral approach is needed to curb teenage pregnancy and motherhood. Hence, the UNFPA in collaboration with the GHS, MOE, National Population Council (NPC),

local institutions, donors and development partners should embark on advocacy to raise awareness about causes and consequences of teenage pregnancy and motherhood. Specifically, these advocacy programs should be directed at rural areas, adolescents with no education and those in the Central, Volta and Brong Ahafo regions, which have high prevalence of teenage pregnancy and motherhood cases.

- Modern contraceptive use was found to be consistently low among adolescent girls. UNFPA should work with partners to implement sustainable behavior change interventions in reproductive health and family planning.

Abortion

- UNFPA should collaborate with the GHS and the various development partners including IPAS, Marie Stopes International to provide education and referrals to adolescent girls and young women to access family planning and comprehensive abortion care (CAC) services. This could be done by investing in mass media campaigns as well as increasing both the availability and access to CAC services.

Gender-based violence

- The gender focus of the UNFPA CO should work with the Ministry of Gender, Children and Social Protection and the Domestic Violence and Victims Support Unit (DOVVSU) to develop and/or strengthen programs that will sensitize and educate adolescents on the Domestic Violence Act of Ghana. In addition, the general public should be sensitized on the need to report cases of violence to the appropriate authorities.

Education

- UNFPA should contribute in assisting Ghana Education Service to strengthen the existing national comprehensive program on girls' education.

- UNFPA in collaboration with Ministry of Education, GES and other institutions, should devote major efforts to the enrolment and retention of girls at the secondary and tertiary levels of education.

Child marriage

- UNFPA CO Program should support the Ministry of Gender, Children and Social Protection and the Ministry of Education and other partners to develop tailored advocacy programs for adolescent girls with emphasis in rural areas and the three northern regions (Upper East, Upper West and Northern). This program should focus on educating communities and raising awareness on the consequences of child marriage.

- Interventions for reducing child marriage should include a component that aims at improving retention of adolescent girls in schools, since education of girls serves as a protective factor against child marriage.

- UNFPA CO support efforts should be directed towards curbing teenage pregnancy, which will lead to reducing child marriage particularly in the Central Region where teenage pregnancy was found to be a precursor to child marriage. This could be done through working with the reproductive health program partners, both local and international, to provide reproductive health services including family planning.
- To curb child marriage, out of school adolescents should be economically empowered through vocational skills building.
- Law enforcement agencies should put major focus on implementing and enforcing the existing laws governing child marriage in Ghana.

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1 INTRODUCTION

1.1 Background

A country's development is closely linked to the well-being of its adolescents and young people, because they represent the future of every society (UNESCO, 2013). The definitions of adolescents and young people are not consistent in the literature. For instance, the term "adolescent" is sometimes used synonymously with "teenager", which ranges from 13 to 19 years, however, "adolescent" has also been considered to be from 10-19 years (also see Ghana Statistical Service, 2013b; Song, Park, Paik, & Joung, 2009). The World Health Organization defines adolescents as young people between the ages of 10 and 19 years (World Health Organization, 2016). In addition, individuals, organization and countries have variously defined the term "youth" or "young people" as persons 10-24, 15-24 and 15-35 years (e.g., Blum & Nelson-Mmari, 2004; Ministry of Youth and Sports, 2010; United Nations, 2001). For the purpose of this report, the term "adolescent girls" refers to females' aged 10-19[3] and "young women" refers to females' age 20-24 (also see insert).

Definitions of Youth:

UN General Assembly (1985): Persons between 15 and 24 years.

African Youth Charter (2006): Persons between 15 and 35 years.

Ghana National Youth Policy (2010): Persons between 15 and 35 years.

Adolescence is the period between childhood and adulthood or the second decade of life (WHO, 2009). This is a critical period of development with regard to self-consciousness, gender, sexuality, exploration, risk taking and the desire for experimentation, especially with sex, drugs and alcohol (Forhan et al., 2009; WHO, 2009). During this period, adolescents seek to comprehend their new roles, their new ideas and their new self-awareness, all of which can result in feelings of anxiety and uncertainty. For most adolescents, this period of their lives can be challenging as they become aware of their sexual and reproductive rights and needs (Durham, 1999). They rely on their families, peers, schools and health service providers for information, assistance and the skills to navigate the transition into adulthood (Gagnon & Simon, 2011). This transition may expose adolescents and young people to sexually transmitted infections (STIs) including HIV, unintended pregnancies, low educational attainment due to dropping out of school and early marriages (UNESCO, 2013).

Globally, there are approximately 880 million adolescent girls and young women aged 15–24 years (UNAIDS, 2014). Despite making up 12% of the world's population, they are often left without a voice or control of their own bodies (UNAIDS, 2014). Gender-based violence, limited access to health care and education, coupled with violation of their human rights are obstacles that hinder adolescent girls and young women from being able to protect themselves against psychosocial problems that can negatively affect their development and welfare, particularly as they transition into adulthood (United Nations Children's Fund, 2009). Indeed, the sexual and reproductive health challenges as well as gender-based violence

[3] This may vary depending on the availability of data

that adolescent girls and young women face are further worsened by the phenomenon of child marriage.

In Ghana, the population growth rate of 2.4% and 2.5% for the 1984-2000 and 2000-2010 inter-censual periods respectively show that the country's population is growing rapidly. The rapid growth of Ghana's population has resulted in a youthful population, with approximately two in every five (38.3%) people in the country being less than 15 years old (Ghana Statistical Service, 2013b). The number of old adolescents (15-19 years) and young adults (20-24 years) increased from 1.1 million in 1960 to 2.3 million in 1984, 3.5 million in 2000 and 4.9 million in 2010 (Ghana Statistical Service, 2013a).

According to the 2010 Population and Housing Census, a little more than one person in four (26.5%) in Ghana was a child below the age of 10 years. Twenty-two percent (22.4%) of Ghana's population was aged 10-19 years and 9.4% of the population was aged 20-24 years. Of the total (12,633,978) female population in the 2010 Population and Housing Census, 25.4% were less than 10 years old. A little more than a fifth (21.7%) was aged 10-19 years and 9.7% were aged 20-24 years (Ghana Statistical Service, 2013b). Ghana's population is young; if appropriate measures are put in place, the country can benefit from the youth bulge.

However, the positive effect of the youth bulge on socio-economic development is not automatic. Hence, the government will have to harness the "demographic dividend" by investing in young people's education, health, and sexual and reproductive rights. The government will have to steer economic growth and job creation and improve on governance and accountability to take advantage of the youth bulge in the country (Zulu, 2014). In addition, if these young people are protected from child marriage and teenage pregnancy, provided with comprehensive abortion care and adequately educated, the country will benefit.

Addressing the issues undermining the growth and development of adolescent girls and young women especially is critical for the development of any country. For instance, delaying marriage can improve the health and wellbeing of the mother and her child (Godha, Hotchkiss, & Gage, 2013; Lloyd, 2006; Raj, Saggurti, Balaiah, & Silverman, 2009; United Nations Children's Fund, 2012). Further, early marriage exacerbates girls' risk of physical, sexual, psychological and economic abuse, teenage pregnancy, abortion, limited access to education as well as reduction of adolescent girls and young women's decision-making power (also see Clark, Bruce, & Dude, 2006; Lloyd, 2006).

1.2 Objectives

Recognizing the complex array of issues that confront adolescent girls and young women, this report presents the situation of adolescent girls and young women in Ghana with respect to sexual and reproductive health and rights. Specifically, the study sought to:

1. identify and analyze the major trends in issues that impact upon adolescent girls and young women in Ghana: teenage pregnancy, abortion, gender based violence, and education (access, retention, transition) as well as child marriage;
2. define gaps and barriers in data for addressing issues pertaining to adolescent girls

and young women in Ghana;
3. identify the achievements of programs, policies and plans on issues of adolescent girls and young women in Ghana;
4. identify and analyze the enabling factors that perpetuate the phenomenon of child and forced marriages in Ghana; and
5. make recommendations on relevant program areas focused on adolescent girls and young women for consideration by UNFPA (especially for the child marriage initiative).

1.3 Methodology

To achieve the set objectives, three approaches were utilized:

a) Desk review drawing from national and regional surveys focused on adolescent girls and young women. Where necessary, the raw data from national surveys were also analyzed.
b) Key informant interviews with selected focal persons from key sectors that work directly or indirectly with adolescent girls (health, education, gender, social welfare, police service, etc.).
c) Focus group discussions with adolescent girls affected by, or at risk of child marriage. In addition, key informant interviews with focal persons in government institutions, non-governmental institutions and in the community.

1.3.1 Quantitative procedures

The desk review involved analysis of nationally representative studies, as well as other non-nationally representative studies in Ghana. The main nationally representative studies used for this analysis were the Ghana Demographic and Health Survey (GDHS), Ghana Multiple Indicator Cluster Survey (MICS), Ghana Maternal Health Survey and the Ghana Ministry of Education's Education Management Information Systems (EMIS) data. In addition, information from other non-national surveys were also used including journal articles and policy documents. A brief description of the data sources is provided below:

Ghana Demographic and Health Survey: The GDHS is a nationally representative survey that was first conducted in 1988, and has since been conducted every five years. The 2014 GDHS is the most recent, which should have been conducted in 2013 if the five-year interval was to be followed. The GDHS data serve a number of policy and programmatic purposes. Policy makers use these surveys to guide their decisions about the allocation of limited resources, family planning and health services among others. The GDHS collects data from women age 15-49 and men 15-59 years on various topics. For the purpose of this analysis, data including socio-demographic characteristics, marriage (age at first marriage) and education (educational attainment, literacy and school attendance) were used. In addition, the GDHS contains information on sexual and reproductive health (termination of pregnancy, contraceptive use, pregnancy and motherhood) as well as gender-based violence (attitudes towards gender-based violence against women), which were also analyzed (Ghana Statistical Service, Ghana Health Service, & ICF Macro, 2009). Table 1.1 shows the sample sizes for

adolescent girls and young women in the Ghana Demographic and Health Surveys from 1993 to 2014.

Table 1. 1: Sample sizes of adolescent girls and young women in the Ghana Demographic and Health Surveys (GDHS, 1993-2014)

	Survey years				
	1993	1998	2003	2008	2014
Age					
15-19	803	910	1,148	1,025	1,625
20-24	829	900	1,012	878	1,613
Total	1,632	1,810	2,160	1,902	3,238

Multiple Indicator Cluster Survey (MICS): The Multiple Indicator Cluster Survey is a nationally representative survey, which was first conducted in Ghana in 1995 by the Ministry of Health (MoH) with technical assistance from Ghana Statistical Service (GSS). The second round of national survey was in 2006; collecting data from women and men aged 15-49 years. The survey was conducted by the Ghana Statistical Service in collaboration with the Ministry of Health, UNICEF, Ghana and Macro International (Ghana Statistical Service, 2006). The most recent national survey was conducted in 2011, collecting data from women aged 15-49 and men aged 15-59. The survey was conducted by the Ghana Statistical Service with financial and technical support from UNICEF, USAID/CDC, UNFPA, the Japanese Government, and the Ministry of Health/National Malaria Control Program. ICF/MACRO and the Navrongo Research Centre also provided technical support (Ghana Statistical Service, 2011). The Multiple Indicator Cluster Survey (MICS) aims at providing indicators to monitor progress on matters relating to women and children. For this analysis, data on the socio-demographic characteristics of women, marriage (age at first marriage) and gender-based violence (attitudes towards gender-based violence) were used. Table 1.2 shows the sample sizes for adolescent girls and young women in the MICS surveys in 2006 and 2011.

Table 1. 2: Sample sizes of adolescent girls and young women in MICS surveys (MICS, 2006 & 2011)

	Survey years	
	2006	2011
Age		
15-19	1,218	1,899
20-24	1,075	1,674
Total	2,293	3,573

National Survey of Adolescents (NSA): The National Survey of Adolescents provides data on 12–19 year-olds in Ghana, conducted between January and May 2004. The total number of adolescent girls interviewed was 2,193. The Institute of Statistical, Social and Economic Research of the University of Ghana, Legon, organized the survey in collaboration with ORC Macro, the Department of Geography and Tourism of the University of Cape Coast and the Guttmacher Institute. The NSA is a nationally representative household survey, which collects data on sexual and reproductive health of adolescents. For this analysis, information on abortion including ways to abort pregnancy was extracted from the NSA.

Ghana Maternal Health Survey (GMHS): The Ghana Maternal Health Survey is a nationally representative survey that was conducted in 2007. The Ghana Statistical Service and the Ghana Health Service jointly conducted the GMHS survey with technical assistance from Macro International. The survey collected data on maternal health in two phases. Phase I was fielded in some 240,000 households to obtain information on deaths in the households' especially female deaths. Phase II followed with a verbal autopsy on the causes of deaths for 4,203 women age 12-49 identified in Phase I. In addition, a woman's questionnaire was fielded in Phase II in a sub-sample of households that collected information from 10,370 women age 15-49 on various maternal health-related issues including pregnancies, live births, abortions and miscarriages, and utilization of health services in relation to these events. The total number of adolescent girls (15-19 years) and young women (20-24 years) interviewed were 2,064 and 1,756 respectively. The GMHS was conducted to serve as a source of baseline information for the Reducing Maternal Morbidity and Mortality (R3M) program initiated in 2006 in three regions of Ghana: Greater Accra, Ashanti, and Eastern regions. This allowed program implementers to compare the R3M regions against the other regions (Ghana Statistical Service, Ghana Health Service, & Macro International, 2009). Data on induced abortion such as age-specific abortion rate, knowledge of abortion and the legality of abortion were extracted from the GMHS for the analysis of the situation of adolescent girls and young women.

Domestic Violence in Ghana (DVG): The Domestic Violence in Ghana study was conducted to provide an in-depth understanding of the attitudes to and incidence, determinants and consequences of domestic violence in Ghana. The study was led by the Institute of Development Studies (IDS) in the United Kingdom (UK) and carried out in cooperation with the Ministry of Gender, Children and Social Protection, the Ghana Statistical Service (GSS) and researchers at the Institute of Statistical, Social and Economic Research (ISSER) in Accra. The study adopted a mixed-methods approach. This involved the collection of primary quantitative data through a representative household-level survey of 4,995 individuals, and the collection of qualitative in-depth data on key factors that may explain the incidence of domestic violence in Ghana. The main quantitative tool used in the study was a survey entitled the "Ghana Family Life and Health Survey 2015" (GFLHS 2015). The GFLHS 2015 was conducted between April and August 2015. The GFLHS 2015 included one household and one individual questionnaire. The study focused on men, women, boys and girls between the ages of 15 and 60 years. This age group extends the usual age group included in international surveys (typically 15 to 49 years), to capture the incidence of domestic violence among older women and men. The GFLHS 2015 asked detailed questions about individual experiences of any of the five broad categories of domestic violence that occurred in the 12 months prior to the survey. The total number of adolescent girls and young women interviewed was 191 and 380 respectively (Institute of Development Studies (IDS), Ghana Statistical Services (GSS), & Associates, 2016).

Population and Housing Census (PHC): The Ghana Statistical Service has conducted five post-independence national censuses. After independence in 1957, Ghana adopted the United Nations' recommendation to conduct censuses in years ending in 'zero' or close to 'zero'.

Hence, the first census conducted after independence was in 1960 and the second in 1970. However, there was no census in 1980 due to political instability in the country, breaking the decennial census taking. In 1984, a census was conducted and then in 2000. The most recent census was conducted in 2010, which put the population of Ghana at 24,658,823: adolescent girls age 15-19 = 1,298,877 and young women age 20-24 = 1,222,764 (Ghana Statistical Service, 2013a). The population and housing census collects data on various issues including socio-demographic characteristics and marriage. Information on the number or proportion of adolescents and young women in the country were drawn from the census reports.

MOE, Education Management Information Systems (EMIS): The EMIS database is managed by the Ministry of Education, Ghana, to provide adequate and reliable data and information for scientific policy formulation, planning and implementation of various programs and projects in the sector. The Ministry of Education launched the EMIS Project in January 1997 with technical support during the first and second phases from Harvard University and funds from the World Bank and the Government of Ghana. The EMIS Project was planned to build on the already existing EMIS established in 1988 in the Ministry as part of the education reforms. Currently, the Ministry receives technical support from UNESCO Institute for Statistics (UIS). The Ministry of Education conducts Annual School Censuses and collects various information from schools including retention and transition of students in schools (Ministry of Education, 2014a). In this study, basic, secondary and tertiary school statistics reports from the 2001/02 to 2013/14 academic years are considered. Reference is also made to the Ministry of Education Sector Performance Reports published in 2010, 2012 and 2013, respectively. Table 1.3 shows the total enrolment figures for males and females at various levels of education.

Table 1. 3: Numbers enrolled for the various levels of education by male and female (MOE, 2001/02-2013/14)

Academic Year	Male	Female	Total
Enrolment Totals: Primary Level			
2001/2002	1,359,150	1,227,284	2,586,434
2002/2003	1,323,518	1,201,067	2,524,585
2003/2004	1,403,913	1,282,220	2,686,133
2004/2005	1,525,548	1,403,988	2,929,536
2005/2006	1,606,178	1,516,725	3,122,903
2006/2007	1,732,162	1,633,600	3,365,762
2007/2008	1,860,289	1,755,734	3,616,023
2008/2009	1,908,232	1,802,415	3,710,647
2009/2010	1,953,359	1,855,899	3,809,258
2010/2011	2,028,893	1,933,886	3,962,779
2011/2012	2,075,010	1,987,016	4,062,026
2012/2013	2,096,218	2,009,695	4,105,913
2013/2014	2,101,731	2,015,421	4,117,152
Enrolment Totals: JSS/JHS Level			
2001/2002	468,514	397,122	865,636
2002/2003	468,934	396,299	865,233
2003/2004	498,786	420,548	919,334
2004/2005	548,156	462,090	1,010,246
2005/2006	557,261	483,741	1,041,002
2006/2007	605,086	527,232	1,132,318
2007/2008	652,146	571,864	1,224,010
2008/2009	684,113	601,164	1,285,277
2009/2010	690,664	611,276	1,301,940
2010/2011	707,847	627,553	1,335,400
2011/2012	729,034	656,333	1,385,367
2012/2013	759,884	692,701	1,452,585
2013/2014	765,191	708,730	1,473,921
Enrolment Totals: SHS Level			
2005/2006	191,025	145,150	336,175
2006/2007	232,777	181,714	414,491
2007/2008	246,646	191,125	437,771
2008/2009	272,906	217,428	490,334
2009/2010	296,954	240,378	537,332
2010/2011	397,199	330,877	728,076
2011/2012	415,123	343,345	758,468
2012/2013	455,908	386,679	842,587
2013/2014	398,481	352,225	750,706
Enrolment Totals: TVET			
2005/2006	15,766	15,700	31,466
2006/2007	37,503	31,389	68,892
2007/2008	31,477	31,477	60,898
2008/2009	39,695	34,582	74,277
2009/2010	34683	29472	64155
2010/2011	40465	31383	71848
2011/2012	50,088	29,898	79,986
2012/2013	42,179	19,317	61,496
2013/2014	29,116	11,949	41,065
Enrolment Totals: Polytechnics			
2008/2009	27,174	11,482	38,656
2009/2010	30,519	13,163	43,682
2011/2012	32,863	14,256	47,119
2012/2013	32,863	14,256	47,119
Enrolment Totals: Public Universities			
2008/2009	64,220	38,328	102,548
2009/2010	72,656	34,984	107,640
2011/2012	73,627	35,651	109,278
2012/2013	73,627	35,651	109,278

Other studies: Other studies in the country, including quantitative and qualitative were also utilized in the analysis.

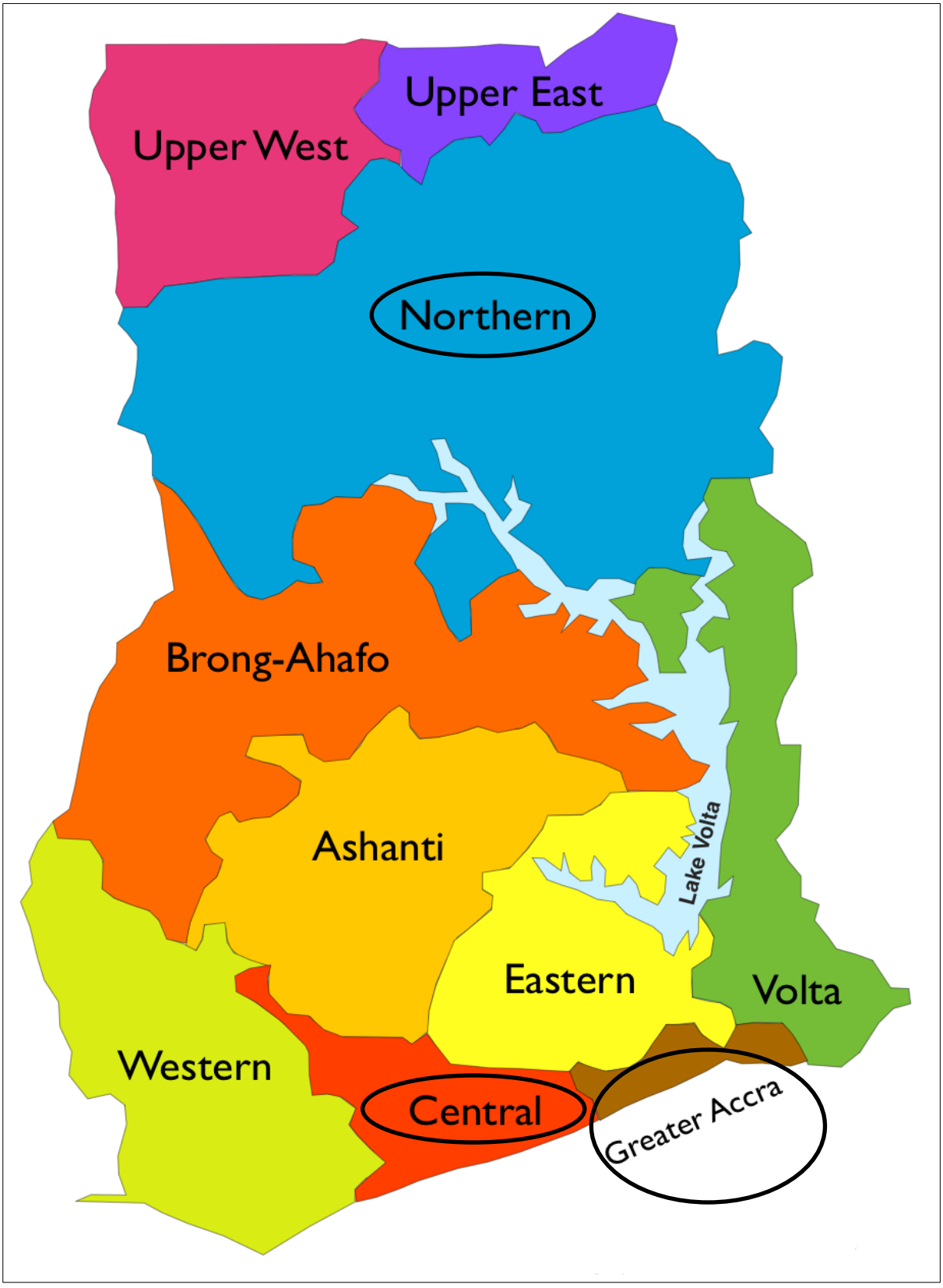
1.3.1.1 Quantitative data analysis

Where appropriate, univariate and bivariate techniques such as frequencies and cross tabulations were used to analyze the data. With respect to trends in teenage pregnancy and motherhood, abortion, gender-based violence and education, frequencies and cross tabulations were used. Regarding the analysis of child marriage, frequencies and cross tabulations were used to examine trends in child marriage. In addition, binary logistic regression was used to identify the drivers of child marriage in Ghana. The quantitative analysis was conducted using stata (version 13) statistical analysis software.

1.3.2 Qualitative procedures

Qualitative data can be used to build on statistical results by adding meaning, context and depth (Bryman, 2012; Teddlie & Tashakkori, 2009). Focus group discussions (FGDs) and Key Informant Interviews (KIIs) were conducted to engage stakeholders (adolescent girls, young women, parents, community leaders and those working directly or indirectly on issues affecting young people age 10-24) in face-to-face discussions on child marriage. The discussions involved norms and practices surrounding child marriage as well as how the phenomenon can be addressed. The KIIs and FGDs were conducted from June to August 2016.

Figure 1. 1: Map of Ghana showing the regions where the KIIs and FGDs were conducted



Source: Google images

Study sites: The focus group discussions (FGDs) targeted the northern and southern sectors of Ghana. The FGDs were conducted in selected UNFPA country program support regions

(Northern and Central). These are regions with high prevalence of teenage pregnancy (Central: 21.3%) and child marriage (Northern: 35.8%) (Ghana Statistical Service et al., 2015). The qualitative data was collected in Zabzugu-Tatale (Northern region) and Assin South, Ekumfi and Agona West (Central region). Figure 1.1 shows the two regions where the qualitative data was collected.

Interview guides were developed based on the results from the desk review and quantitative data analyses, particularly the predictors of child marriage. The interview guides were developed according to the subgroups of the target population. Semi-structured interview guides were used with questions on various issues concerning child marriage. The FGD guides covered topics such as knowledge, attitudes and practices of child marriage. In addition, questions were asked on reasons for/causes of child marriage; cultural, social and legal norms surrounding child marriage as well as suggestions on how to address the phenomenon. Questions that were not included in the guide were also asked as the interviewers probed further on things said by interviewees.

Married 12-24 year olds were asked questions specifically about their lived experiences within marriage, while unmarried 12-24 year olds were asked about their motivations to delay marriage. In addition to the topics covered in the FGD guides, the KII guide inquired on the key informant's organization, institution or group's role in addressing the phenomenon. The data collection instruments were pre-tested in similar communities (*Nima* and *Dansoman*) in the Greater Accra region. The pre-test was to assess whether the data collection instruments were understandable and elicited the required information. The feedback from research assistants and participants in the pre-test was used to appropriately modify the data collection instruments.

Recruitment and training of research assistants: Fourteen research assistants and two supervisors were recruited to conduct the focus group discussions and key informant interviews. Research assistants were recruited for training based on their proficiency in the spoken language(s) of the districts, as well as their experience in qualitative data collection. A 3-day training workshop was held at Population Council, Ghana to explain the study objectives to the research assistants. The sampling procedure, field procedures and data collection techniques (face-to-face interviewing, active listening, probing, etc.), use of the study instruments as well as ethical guidelines were also explained to the research assistants. Emphasis was on the translation of the instrument from English into the various dominant local languages. In addition, research assistants were trained on the art of data transcription. The final selection of research assistants was based on their overall performance during the training including the pre-test.

For the main fieldwork, two teams of 8 persons were formed, where one team collected data in the Central region over 7 days and the other in the Northern region over 8 days. Each research assistant was assigned at least two key informant interviews (KIIs) to conduct. However, some of the key informants were not available throughout the period of fieldwork.

Recruitment of participants: Participants for the FGDs and KIIs were recruited using purposive sampling technique, a non-probability sampling technique widely used in qualitative research to identify and select information-rich cases that are related to the phenomenon of interest (Bryman, 2012). In both Northern and Central regions, participants were identified through key contacts in various organizations, Microfin, World Education Ghana and Ghana Health Service in the Central region and NORSAAC, Ghana Health Service and ActionAid in Northern Region. The principal investigator contacted the key contacts in both organizations and discussed the purpose of the study, the target population, as well as period of the study with them. In addition, other details including mobilization of participants, logistics, transportation and community entry were also discussed with the key contacts.

Once feasibility was established, the key contacts identified community volunteers to mobilize eligible participants. The volunteers and key contacts sought audience with the traditional and local authorities approximately 10 days prior to data collection to inform them of the purpose of the study, target groups and key persons as well as seek their permission to conduct the research in their respective communities.

Focus group discussions: Each focus group had a maximum of 10 participants. Whereas female moderators and note-takers conducted female focus group discussions, male moderators and note-takers conducted male focus group discussions. All the focus group discussions were audio recorded. Focus group discussions were conducted in three communities (Asubo-Awutu, Obidan and Dosii-Central) in the Central region and in four communities (Zabzugu, Sabare, Tasundo and Kukpaligu) in the Northern Region.

The focus group discussions were conducted among the following subgroups:

1. 12-17 year-olds who are married
2. 18-24 year olds (preferably, who got married before the age of 18)
3. Unmarried 12-17 year-olds (at risk of child marriage)
4. Unmarried 18-24 year olds
5. Parents/guardian, grandparents, and other adult community members

In each region, 10 focus group discussions were conducted (in total, 20 focus group discussions). See details of the focus group discussion categories by region in Table 1.4.

Table 1. 4: Breakdown of focus group discussions conducted, by characteristics

	Age Group/Type	Married/ Unmarried	Community
Northern Region*			
FGD #			
1	12-17 Age Group	Married	Sabare
2	12-17 Age Group	Married	Zabzugu
3	12-17 Age Group	Unmarried	Sabare
4	12-17 Age Group	Unmarried	Zabzugu
5	18-24 Age Group	Married	Kukpaligu
6	18-24 Age Group	Married	Tasundo
7	18-24 Age Group	Unmarried	Tasundo
8	18-24 Age Group	Unmarried	Zabzugu
9	Male Parents	na	Kukpaligu
10	Female Parents	na	Kukpaligu
Central Region			
FGD#			
1	12-17 Age Group	Married	Obidan
2	12-17 Age Group	Married	Asubu-Agona
3	12-17 Age Group	Unmarried	Assin-Dosii
4	12-17 Age Group	Unmarried	Obidan
5	18-24 Age Group	Married	Asubo-Awutu
6	18-24 Age Group	Married	Obidan
7	18-24 Age Group	Unmarried	Dosii-Central
8	18-24 Age Group	Unmarried	Obidan
9	Parents	na	Dosii-Central
10	Parents	na	Obidan

na- not applicable

*- Parents in Kukpaligu in the Zabzugu-Tatale districts asked for separate male and female parents interviews

Key Informant Interviews (KIIs) were conducted with focal persons/key informants/key stakeholders at governmental and non-governmental institutions, as well as at the community level. A total of 30 KIIs were conducted in the Central, Northern and Greater Accra regions. KIIs were audio recorded after receiving informed consent from participants. See Table 1.5 for details of focal persons interviewed.

Table 1. 5: Details of Key Informant Interviews

No.	Organization/Institution	Town/Community	Region
1	G.E.S.	Cape Coast	Central
2	Religious leader (Christian)	Cape Coast	Central
3	Social Welfare	Cape Coast	Central
4	Community representative	Assin Dosii	Central
5	Religious leader (Muslim)	Cape Coast	Central
6	Community representative	Assin Dosii	Central
7	G.E.S.	Elmina	Central
8	Social Welfare	Elmina	Central
9	GHS directorate	Cape Coast	Central
10	DOVVSU (Ghana Police Service)	Cape Coast	Central
11	Community representative	Cape Coast	Central
12	Community leader	Agona Asubo	Central
13	Community leader	Agona Asubo	Central
14	DOVVSU	Nima	Greater Accra
15	World Vision	North-Kaneshie	Greater Accra
16	Ebenezer A.M.E. Zion School	Dansoman	Greater Accra
17	Chief of Zabzugu community	Zabzugu	Northern
18	Hope for future Generation	Dzorwulu	Greater Accra
19	G.E.S.	Zabzugu	Northern
20	Chief imam	Nima	Greater Accra
21	Opinion leader	Zabzugu	Northern
22	Zumuchi women group	Nima	Greater Accra
23	Opinion leader	Kukpaligu	Northern
24	Opinion leader	Zabzugu	Northern
25	Ghana Health Service	Zabzugu	Northern
26	Ghana Police Service	Zabzugu	Northern
27	Religious leader	Kukpaligu	Northern
28	Parliamentarian	Zabzugu	Northern
29	Compassion International	Haatso	Greater Accra
30	Opinion leader	Tema	Greater Accra

1.3.2.1 Qualitative data analysis

Research assistants transcribed (some with the help of a translator) the audio-recorded interviews and discussions verbatim into English. Codebooks modeled initially around topics of the interview guides were developed. Through the iterative process of coding and analysis, codes were added to the codebook. The transcripts were coded manually, guided by open and axial coding. To ensure inter-coder reliability, transcripts were analyzed by a team of 5 persons (research assistants and principal investigator). The initial codes generated were then grouped into preliminary categories of themes. Through reading, re-reading and constant comparison, the themes were categorized into themes and sub-themes. The results from the

qualitative component of the study were triangulated with the results of the quantitative component in section 6 and other relevant themes were presented separately.

1.3.3 Ethical considerations

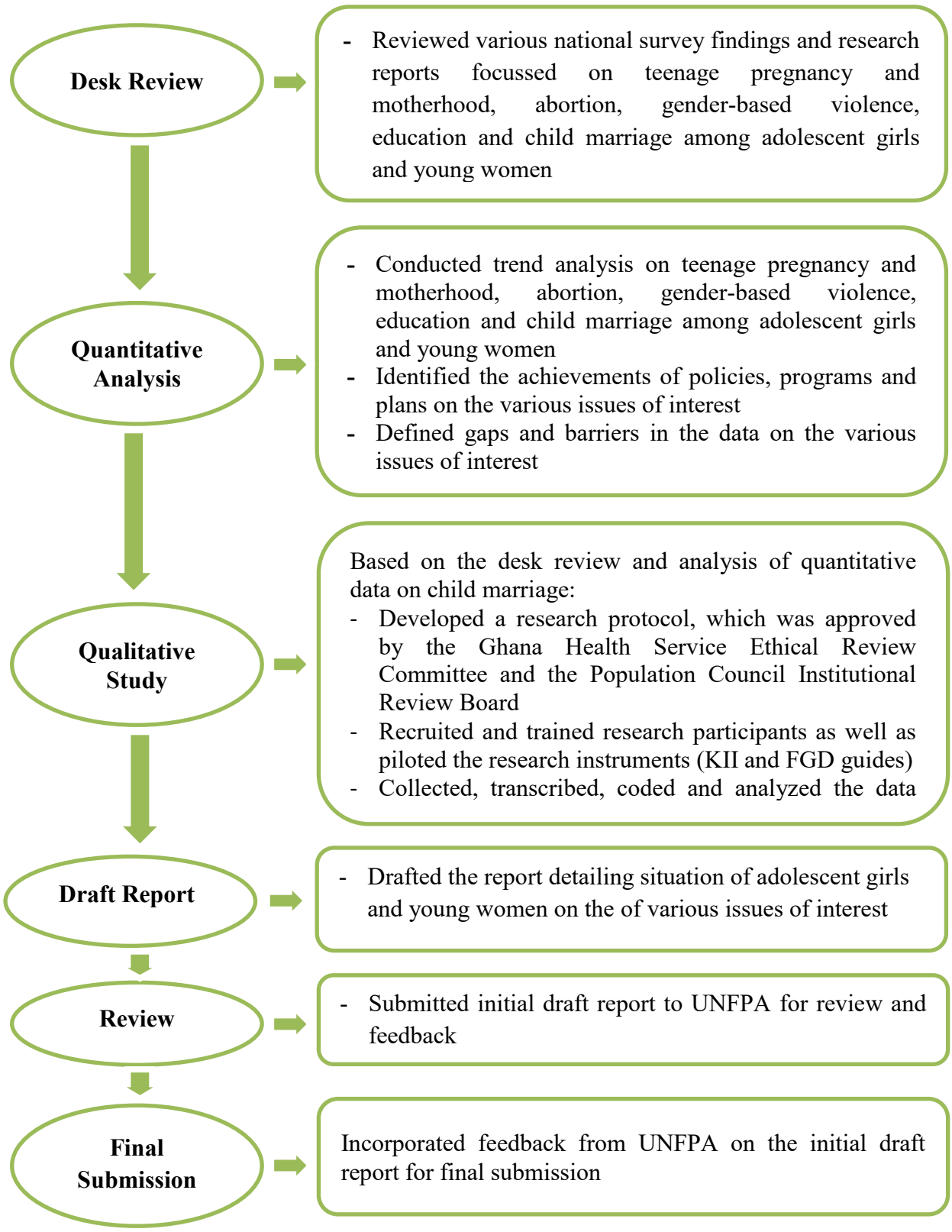
Ethical clearance was acquired from the Ghana Health Service Ethical Review Committee and the Population Council Institutional Review Boards. Permission was also sought from community leaders in the study areas. The study also sought the consent of each participant by explaining the purpose of the study, possible risks or discomfort, benefits, confidentiality, and compensation to the participants. Where necessary, moderators read and translated the informed consent form to the participants. In addition, participants were informed of the voluntary nature of the study and that they had the right to leave the study at any time during the interview.

1.3.4 Limitation

The qualitative studies were conducted in selected districts in the Northern and Central regions; hence, the results cannot be generalized for the whole country. However, these findings give some indications of and reflect the issues surrounding child marriage in these areas. These findings might not be very different from what is experienced in other parts of the country.

Figure 1.2 summarizes the methodological approach used in this project.

Figure 1.2: Framework of the situational analysis



1.4 Structure of the report

This report presents the situation of adolescent girls and young women with respect to their sexual and reproductive health and rights including teenage pregnancy and motherhood, abortion, gender-based violence, education and child marriage. The report consists of seven sections.

Section 1, the introductory section, sets the context providing background information on adolescent girls and young women. The objectives and methodologies employed to achieve the set objectives, ethical considerations and limitation of the study are also presented.

Section 2 examines teenage pregnancy and motherhood among adolescent girls (15-19 years) and young women (20-24 years) using data from the GDHS. The introduction of the section looks at age at first sexual intercourse, followed by reasons why adolescent girls and young women engage in sexual intercourse, knowledge and use of family planning, pregnancy and reasons for falling pregnant. The consequences of early pregnancy among adolescent girls are also presented. In addition, the section examines the trends in teenage pregnancies and motherhood, and explores policies, plans and programmatic approaches aimed at curbing pregnancy among adolescents. The section concludes with the identification of gaps in the data to address teenage pregnancy and motherhood in Ghana.

Section 3 looks at abortion among adolescent girls and young women. The first part of the section is the introduction, which includes abortion policy in Ghana, stigmatization and abortion, knowledge of abortion, pregnancies ending in abortion, reasons why adolescent girls and young women seek induced abortion and the legality of abortion in Ghana. Further, the section highlights trends in abortion in Ghana. The section also examines achievements in terms of policies, plans and programs related to abortion, as well as gaps and barriers in the data on abortion.

Section 4 assesses gender-based violence against adolescent girls and young women. The introduction of the chapter highlights the factors influencing gender-based violence, consequences of gender-based violence and legislations on gender-based violence. Additionally, the section looks at trends in attitudes towards gender-based violence among adolescent girls and young women. The section also examines the achievements in terms of programs, policies and plans made in relation to gender-based violence against women in Ghana. Finally, the section identifies gaps in the data on gender-based violence against adolescent girls and young women.

Section 5 examines education among adolescent girls and young women. The section begins with an introduction, which includes a summary of the educational system in Ghana, and policies and programs on education. In addition, the section presents trends on educational attainment, literacy and school attendance among adolescent girls and young women. Trends in education in relation to access, retention and transition are also assessed. The section outlines the achievement of policies and programs with respect to education. Finally, gaps and barriers identified in the data with respect to education among adolescent girls and young women are also presented.

Section 6 focuses on child marriage. First, the section presents an introduction that encompasses legal norms in relation to child marriage, enabling factors of child marriage and the effects of child marriage. The section further looks at trends in child marriage, drivers of child marriage and how the child marriage menace can be curbed. Additionally, the section looks at the achievements of policies, plans and programs on child marriage as well as the gaps and barriers in data with respect to addressing child marriage.

Section 7 presents the conclusion and recommendations for consideration by UNFPA.

2 TEENAGE PREGNANCY AND MOTHERHOOD

Highlights:

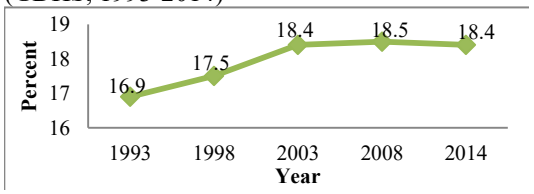
- *Proportion of adolescent girls (15-19 years) who had sexual intercourse by age 15 declined from 12% in 1993 to 7% in 1998 and increased to 12% in 2014*
- *Proportion of young women (20-24 years) who had sexual intercourse by age 15 declined from 15% in 1993 to 7% in 2008 and increased to 10% in 2014*
- *Trends in the proportion of teenagers (15-19 years) who had begun child bearing declined from 22% in 1993 to 13% in 2008 and thereafter increased to 14% in 2014*
- *Trends in the proportion of teenagers who had begun child bearing were consistently higher in rural areas compared to urban areas*

2.1 Introduction

Teenage pregnancy and motherhood are challenges facing adolescent girls and young women in the world and especially in developing countries including Ghana. It is a phenomenon that has significant ramifications at a personal level and beyond (Singh & Darroch, 2000). When adolescents and young women become pregnant and give birth, the entire future of that adolescent or young woman could be changed or altered. Adolescent and young mothers face numerous challenges that place demands not only on the young mother's stage of development, but also on their ability to adapt to the obligations of parenthood. Adolescent and young mothers are faced with a double burden; meeting the needs of their infant and seeking ways to satisfy their own needs as adolescent girls and young women (Gyesaw & Ankomah, 2013). Largely, early pregnancy can be attributed to age at first sexual intercourse and contraceptive use among adolescent girls and young women.

2.1.1 First sexual intercourse

Figure 2. 1: Trend in young women (20-24 years) median age at first sexual intercourse (GDHS, 1993-2014)



Many girls initiate sex at a young age, usually between the ages of 15 and 19 years, however, they are unprepared for the consequences of their behavior (World Health Organization, 2012). Even though Ghana's Criminal Offences Act of 1960—Act 29 (see Panel 1) indicates that a person below the age of 16 cannot consent for sexual intercourse, some girls start sexual activity early (Keller, Hilton, & Twumasi-Ankrah, 1999). The five rounds of Ghana Demographic and Health Survey data show that median age at first sexual intercourse among young women (20-24 years) consistently increased from 16.9 years in 1993 to 18.5 in 2008 and thereafter, remained roughly constant at 18.4 years in 2014 (Figure 2.1).

Panel 1: Legislation on protecting children sexual intercourse

Criminal Offences Act of 1960 (Act 29), amended by PNDCL 102 of 1985

Consent: Section 14

a) A consent is void if the person giving it is under twelve years of age, or in the case of an act involving a sexual offence, sixteen years, or is, by reason of insanity or of immaturity, or of any other permanent or temporary incapability whether from intoxication or any other cause, unable to understand the nature or consequences of the act to which he consents".

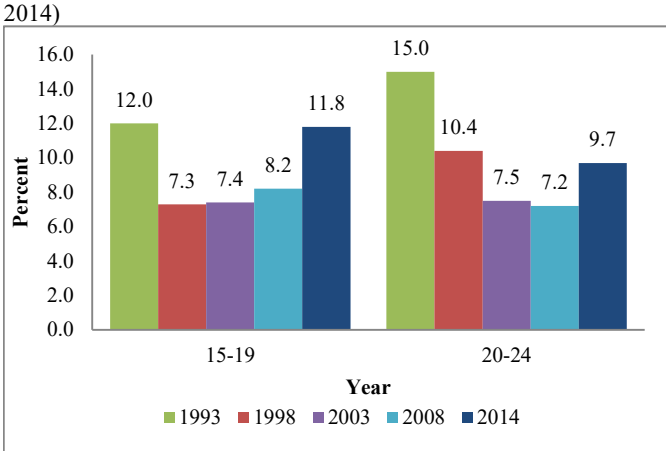
Defilement: Section 101

1) For purposes of this Act defilement is the natural or unnatural carnal knowledge of any child under sixteen years of age.

2) Whoever naturally or unnaturally carnally knows any child under sixteen years of age, whether with or without his or her consent commits an offence and shall be liable on summary conviction to imprisonment for a term of not less than seven years and not more than twenty-five years.

A study among adolescents in Dodowa, Ghana, found that 44% of adolescent females had ever had sexual intercourse (Afenyadu & Goparaju, 2003). In a nationally representative survey, the proportion of Ghanaian girls aged 15-19 years who had first sexual intercourse by exact age 15 steadily increased from 7.4% in 2003 to 8.2% in 2008 and 11.8% in 2014. Among young women (20-24 years), the proportion who had first sexual intercourse by exact age 15 declined marginally from 7.5% in 2003 to 7.2% in 2008 and thereafter, increased to 9.7% in 2014 (Figure 2.2). From 1993 to 2003, the proportion of young women compared to adolescent girls who had sexual intercourse by age 15 was higher. However, in 2008 and 2014 the reverse was observed (Figure 2.2).

Figure 2. 2: Trends in proportion of adolescent girls and young women who had sexual intercourse by exact age 15 (GDHS, 1993-2014)



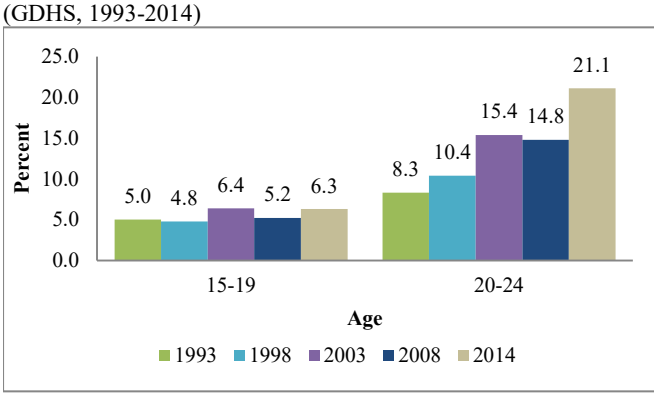
2.1.2 Reasons for engaging in sexual intercourse

Generally, various factors influence adolescent girls and young women to engage in sexual intercourse. Gyesaw & Ankomah (2013) in a study in a suburb of Accra, Ghana revealed that some teenage girls engage in sexual intercourse because of poverty and in some cases, teachers or people in authority take advantage of their role and position and coerce adolescent girls and young women to have sexual intercourse with them. Nevertheless, some adolescent girls and young women engage in sexual intercourse for pleasure with their "boy lovers" (fiancées or boyfriends), others engage in sexual activity because of peer pressure to raise their ego among their peers (Owusu & Dwomoh, 2012). However, because of lack of knowledge and use of family planning methods, these adolescent girls and young women likely fall pregnant.

2.1.3 Knowledge and use of family planning

Improved knowledge about sex and family planning will not only prevent early and unwanted pregnancies but also STIs including HIV (World Health Organization, 2012). Lack of knowledge about sex and family planning and the lack of skills to put that knowledge into practice put adolescents and young women at risk of pregnancy. Young adolescents were naive and did not know anything about the implications of sexual intercourse; they did not even know they could fall pregnant from engaging in sexual intercourse (Gyesaw & Ankomah, 2013). In a study in Ghana, of the 190 sexually active adolescent respondents, 41% did not use a condom, 34% did not use any modern contraceptive (e.g. vaginal foaming tablet, pill, condom, IUD, injectables, Norplant) and 30% did not use any family planning method at all during their last sexual encounter. Some of the adolescents indicated that if girls drink soda (Fanta) after sex, they would not get pregnant (Afenyadu & Goparaju, 2003). Data from the GDHS shows that use of any modern method of contraception is higher among young women than among adolescent girls (Figure 2.3). The trend in use of modern contraceptive method has not been consistent among the two age groups. Among adolescent girls, the proportion using any modern contraceptive method was about the same (5%) in 1993 and 1998 and increased to 6.4% in 2003. It declined to 5% in 2008 and increased in 2014 to the level observed in 2003 (6.3%). Among young women, there was a consistent increase in the use of any modern contraceptive method from 8.3% in 1993 to 15.4% in 2003. It remained about the same (14.8%) in 2008 and increased drastically to 21.1% in 2014.

Figure 2.3: Trends in proportion of adolescent girls and young women currently using any modern method of contraception (GDHS, 1993-2014)



2.1.4 Pregnancy and reasons for falling pregnant

In Ghana, adolescent girls and young women are usually not ready to become mothers. In most cases, girls fall pregnant because of a combination of social customs, parental influence, and personal financial exigencies (Keller et al., 1999). The 2004 Ghana National Survey of Adolescents reported that 12.5% of adolescent girls (15-19 years) had ever been pregnant and 9% of adolescent girls (15-19 years) had ever had a birth (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterso, 2006). A study in the Kwaebibirem district in Ghana showed that from 2003 to 2011, the Kade Government hospital in the district recorded the lowest proportion of deliveries to teenagers in 2004 (12%) and the highest in 2011 (18%) (Owusu & Dwomoh, 2012). Adolescent girls and young women who fall pregnant often report that their families are in economic difficulties. In a study in a suburb of Accra, Ghana some young mothers indicated that the sexual encounter that resulted in their pregnancy was the result of transactional sex. Some of the young mothers narrated the financial challenges they faced and how they felt they could exchange sex for material gains; indicating that many of their

parents and other relatives could not or would not provide their basic needs (Gyesaw & Ankomah, 2013).

2.1.5 Consequences of early pregnancy among adolescent girls and young women

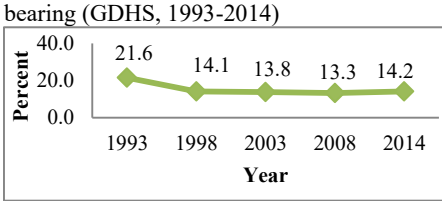
Early pregnancy and motherhood can have several negative consequences for adolescent girls and young women. Early pregnancy can foreclose an adolescent girl or young woman's ability to pursue education and job opportunities, which has implications for her position and potential contribution to society (Gyan, 2013). Adolescent girls and young mothers are more likely to experience complications during pregnancy and delivery than older mothers, which result in higher morbidity and mortality for themselves and their children (Henry & Fayorsey, 2002). Early childbearing can result in unhappiness because the birth was unplanned, parents often not happy and marital conflict may arise from marrying in order to have a child born within a socially recognized union (Gyesaw & Ankomah, 2013). Early pregnancies and marriages are also associated with elevated overall fertility rates (Raj et al., 2009; WHO, 2012).

2.2 Trends in teenage pregnancies and motherhood

2.2.1 Trend in adolescent motherhood

According to GDHS, a little more than a fifth (21.6%) of adolescent girls (15-19 years) had started child bearing[4] in 1993, but this declined drastically to 14% in 1998 and was about the same in 2003 (13.8%). In 2008, it declined to 13% and increased in 2014 (14.2%) to the level recored in 1998 (Figure 2.4).

Figure 2. 4: Trend in Proportion of adolescent girls who have begun child bearing (GDHS, 1993-2014)



The trends in proportion of adolescent girls who have begun child bearing vary by socio-demographic characteristics (Table 2.1). From 1993-2014, the highest proportion of adolescent girls aged 15 years who started child bearing was in 2003 (3.3%) and lowest in 2008. Among those aged 19 years, the proportion who started child bearing in 1993 was 45%, which declined to 32% in 1998 and 25% in 2003. However, the proportion of 19 year old adolescent girls who started child bearing increased to 29% in 2008 and further increased to 36% in 2014.

Consistently, the porportion of adolescent girls who started child bearing is higher in rural areas than in urban areas. For instance, in 2014 the proportion of adolescent girls who had started child bearing was 16.7% in rural areas and 11.5% in urban areas. In urban areas, the trend in the proportion of adolescent girls who had started child bearing declined from 1993 to 2003. However, the proportion of adolescent girls who had begun child bearing increased from 7.2% in 2003 to 11% in 2008 and increased to 12% in 2014 in urban areas. In rural areas, the proportion of adolescent girls who had begun child bearing decreased from 26% in 1993, which was the highest to 17.4% in 1998, however, it increased to 21.8% in 2003 and

[4] Begun child bearing includes adolescent girls who have either had a live birth or are pregnant with their first child.

thereafter, declined to 15.7% (the lowest in rural areas from 1993-2014) in 2008 and increased to 17% in 2014.

Table 2. 1: Trends in the proportion of adolescent girls age 15-19 who have begun child bearing by selected background characteristics (GDHS, 1993-2014)

	1993		1998		2003		2008		2014	
	%	N	%	N	%	N	%	N	%	N
Age										
15	1.5	133	1.6	215	3.3	238	0.7	213	1.9	380
16	6.7	163	5.8	182	6.4	243	4.5	187	7.0	359
17	13.0	162	13.9	153	11.8	229	11.1	205	11.0	272
18	36.6	194	21.1	202	24.5	250	21.4	239	19.7	327
19	45.0	151	31.7	158	24.8	188	28.9	181	36.1	287
Residence										
Urban	16.4	366	8.5	341	7.2	629	10.7	493	11.5	796
Rural	25.9	437	17.4	569	21.8	519	15.7	532	16.7	829
Education										
No education	33.3	144	22.1	127	26.0	141	30.9	72	23.2	69
Primary	30.2	126	23.5	169	20.8	269	25.9	222	19.0	368
Middle/JSS/JHS	18.5	437	10.8	535	10.4	588	9.5	571	14.0	906
Secondary+	6.3	96	2.9	79	3.0	150	1.3	159	6.2	282
Region										
Western	26.5	83	9.3	123	14.2	122	6.5	94	12.7	197
Central	33.3	81	18.7	112	24.1	93	23.2	101	21.3	153
Greater Accra	15.7	121	5.8	162	9.5	203	6.6	162	8.3	248
Volta	11.1	81	10.7	102	17.1	88	15.9	91	22.1	122
Eastern	22.2	108	21.2	104	13.2	108	8.0	106	16.8	151
Ashanti	22.5	120	19.6	122	10.3	255	11.0	202	11.9	307
Brong Ahafo	25.3	91	16.6	83	13.6	112	22.2	80	21.3	167
Northern	21.2	66	16.6	32	23.6	76	22.6	102	10.1	146
Upper East	17.9	28	14.0	48	12.6	62	10.6	56	9.7	89
Upper West	*	24	17.3	20	9.8	29	12.5	30	9.9	47
Wealth quintile										
Lowest	-		-		26.1	166	17.9	153	15.3	338
Second	-		-		23.0	170	21.3	200	21.3	356
Middle	-		-		20.1	221	14.2	221	15.2	316
Fourth	-		-		9.7	261	11.2	230	12.1	307
Highest	-		-		1.9	331	3.9	221	5.7	308
Total	21.6	803	14.1	910	13.8	1,148	13.3	1,025	14.2	1,625

* signifies that the figure is based on fewer than 25 cases, and has been suppressed
- not available in the report
N Total number of women age 15-19

Generally, as education increases, the proportion of adolescent girls who had started child bearing decreases. For instance, in 2014, 23.2% of adolescents with no education and 19% of those with primary education had started child bearing. Among those with Middle/JSS/JHS and secondary+ level education, 14% and 6.2% respectively had started child bearing. Worthy of note is the increase in the proportion of adolescent girls with middle/JSS/JHS and

Secondary+ who started child bearing. Child bearing increased from 9.5% in 2008 to 14% in 2014 among those with Middle/JSS/JHS level of education and from 1.3% in 2008 to 6.2% among those with secondary+ level of education.

From 1998-2014, Greater Accra consistently recorded the lowest proportions (5.8% in 1998, 9.5% in 2003, 6.6% in 2008 and 8.3% in 2014) of adolescent girls who had started child bearing. In 2003, as wealth quintile increased from the lowest to the highest, the proportion of adolescent girls who had started child bearing decreased. While the proportion of adolescent girls who started child bearing in the lowest and middle quintile appeared to be declining from 2003 to 2014, the proportion of adolescents in the middle quintle decreased from a fifth (20.1%) in 2003 to 14.2% in 2008 and thereafter, increased to 15.2% in 2014. With adolescents in the fourth and highest quintile, the proportion of them who had started child bearing consistently increased from 2003 to 2014 (Table 2.1).

2.3 Achievement of policies, plans and programs on teenage pregnancy and motherhood

The welfare of adolescents and young women has become a major focus for governments, policy makers and service providers (Awusabo-asare & Abane, 2004). This is because adolescence is a window of opportunity to safeguard the health and well-being of the next generation. The policy environment for adolescent reproductive health in Ghana is one in which stakeholders are aware of the problems, but decisive actions have not been forthcoming (Moreland & Logan, 2000). Adolescents and young people are usually subsumed within the wider population with respect to legislation and policy and receive very little attention.

Nevertheless, Ghana has made efforts to tackle teenage pregnancy through policies, legislative instruments and programs that broadly address the well-being of adolescents and young women. The Government of Ghana through the National Population Council (NPC), in response to the International Conference on Population and Development (ICPD) in 1994, Cairo, developed the Reproductive Health Service Policy and Standards in 1996. Although this policy provided a framework to address the reproductive health needs of women, it subtly ignored the unique needs of adolescents. Consequently, the Adolescent Reproductive Health Policy was developed in 2000. This policy provided broad guidelines and frameworks for policymakers and adolescent reproductive health implementers on the provision of sexual and reproductive health services to adolescents and young people in Ghana. However, there is a dearth of information about the implementation, monitoring and, most importantly, the evaluation of interventions aimed at improving the sexual and reproductive health of Ghanaian youth (Awusabo-asare & Abane, 2004).

The Adolescent Reproductive Health Policy in 2000 set a number of targets to guide adolescent reproductive health policy and program. The targets related to early pregnancy include; to motivate young people to increase the age of onset of sexual activity, which was at the time around 12 years, to over 15 years of age by 2010, and to reduce the proportion of females younger than 20 who give birth by 50% by 2010 and by 80% by 2020.

To motivate young people to increase the age of onset of sexual activity, which was at the time around 12 years, to over 15 years of age by 2010[5]

To assess this target set in the 2000 Adolescent Reproductive Health Policy, data from the 1998 GDHS is used as the base year and the 2014 GDHS as the target year. The median age at first sexual intercourse among young women aged 20-24 was 17.5 years in 1998, in 2014, it was 18.4. The policy was targeting an increase of 3 years (from 12 to 15 years) in age at first sexual activity; however, the data shows barely a year increase in median age at first sexual intercourse among young women aged 20-24 years. In addition, the proportion of adolescent girls who had sex by exact age 15 increased from 7.3% in 1998 to 11.8% in 2014 (Table 2.2). Nevertheless, the proportion of young women who had sexual intercourse by exact age 15 remained relatively the same in 1998 and 2014 (about 10%).

Table 2. 2: Selected indicators of age at first sexual intercourse (GDHS, 1998 & 2014)

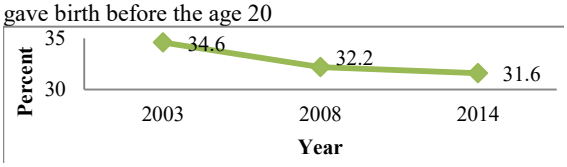
	% had sex by age 15		Median Age at first sex	
Age group	1998	2014	1998	2014
15-19	7.3	11.8	-	-
20-24	10.4	9.7	17.5	18.4

- data not available

To reduce the proportion of females younger than 20 who give birth by 50% by 2010 and by 80% by 2020

This target is assessed using data from the 2003-2014 GDHS. The data shows that the proportion of young women (20-24 years) who gave birth by age 20 decreased from 34.6% in 2003 to 32.2% in 2008 (6.9% decline) and was about the same in 2014 (31.2%). From these figures, it appears the 2010 target was far from being met and more efforts will be required if the 2020 target of 80% reduction is to be realized.

Figure 2. 5: Trend in proportion of young women who gave birth before the age 20



The Ministry of Health and the Ghana Health Service have also implemented youth-focused services within health centers. At these centers there are safe spaces called "Adolescent friendly corners" where trained health personnel provide a range of sexual and reproductive health services for young people, including information, counseling, family planning and post-abortion care. In addition, programs have been held for groups, such as street youth, religious youth and female porters among others. These programs have applied behavior change communication approaches, peer education, and livelihood and development skills to promote safer sexual and reproductive health behavior.

In its present state, the National Youth Policy (2010) provides broad and holistic policies for adolescents and their well-being. It recognizes the major challenges facing youth, such as health, teenage pregnancy, early marriage and access to education among others. The policy has the objective of promoting a healthy environment and policy framework within which young people can obtain information and services on reproductive health and exercise their

[5] Note: This target was taken directly from the 2000 Adolescent Reproductive Health Policy of Ghana; however, we were unable to verify the source of the data from the document.

reproductive rights. It also seeks to address these issues by empowering young people through collaborative efforts at developing programs tailored to meet their needs.

Furthermore, legal norms have characterized some of the feats achieved in young people's sexual and reproductive health. For example, legislative and constitutional instruments such as the 1992 Constitution of Ghana outline certain provisions that protect the well-being of adolescents (see Panel 2).

Panel 2: Constitutional provision on protecting children's health

The 1992 constitution of Ghana

- *No child shall be deprived by any other person of medical treatment, education or any other social or economic benefit by reason of religious or other belief*
- *A child shall not be subjected to torture or other cruel, inhumane or degrading treatment or punishment*
- *Every child has the right to be protected from engaging in work that constitutes a threat to his/her health, education or development*

Note: In Ghana, the Constitution defines a child as a person below the age of 18 years.

It can be inferred that these clauses exist to protect adolescents from all forms of social injustices that could mar their well-being including health and transition to adulthood. Even though these legislations do not directly deal with teenage pregnancy, they provide a broader avenue through which Government and other related agencies and institutions can work to provide specific frameworks and interventions to address teenage pregnancy and motherhood.

National Adolescent Health and Development (ADHD) Program: The Ghana Health Service with the aim of addressing the health needs of adolescents (10-19 years) and young people (20-24 years) in Ghana developed the ADHD program. As part of the ADHD program, adolescent friendly health services are being provided. These services are tailored to meet the particular needs of adolescents and young people. These services are promotive, preventive, curative and rehabilitative. Components of the ADHD program are identification and management of common health problems affecting adolescents and young adults, provision of adolescent focused services including counseling, information and education in general health including reproductive health and referrals (Ghana Health Service, 2013). In 2015, the Adolescent Health (ADH) Mobile Application was launched for education service providers on adolescent health-related issues as a complement to the information being provided by the ADHD Program (Nyavi, 2015).

2.4 Gaps and barriers in the data

In Ghana, there is a dearth of consistent nationally representative data on adolescent girls aged 10-14 years on their sexual behavior, knowledge and use of family planning and pregnancy and motherhood. Data on these indicators are very important in ensuring the country meets the reproductive health needs of adolescent girls.

3 ABORTION

Highlights:

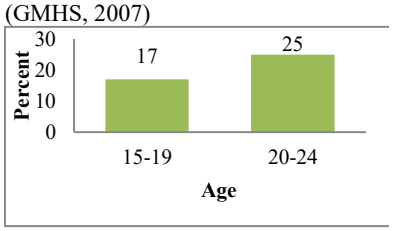
- *The induced abortion rate was 17 per 1,000 among adolescents age 15-19 years and 25 per 1,000 among young women age 20-24*
- *3% of adolescent girls age 15-19 and 12% of young women age 20-24 have ever had an induced abortion*
- *Pregnancy termination among adolescent girls age 15-19 declined from 4% in 1998 to 2% in 2008 and increased to 3% in 2014*
- *Pregnancy termination among young women age 20-24 declined from 14% in 1998 to 12% in 2003 and increased to 19% in 2014*

3.1 Introduction

Abortion is a sensitive and highly contentious topic, with religious, moral, cultural and political dimensions in many countries including Ghana. Abortion can either be safe or unsafe and because it can be unsafe, it is regarded as a public health concern (Mesce & Clifton, 2011). The complications of abortion carried out according to medical guidelines carry very low risk. However, unsafe abortions contribute substantially to maternal morbidity and deaths globally (Grimes, 2006; World Health Organization, 2011). From 2010–2014, it was estimated that 56 million induced abortions occurred each year worldwide, representing an increase from 50 million annually during 1990–1994, mainly because of population growth. In Africa, it was estimated that 8.3 million induced abortions occurred from 2010–2014 (Guttmacher Institute, 2016).

In a study among teenage mothers in a suburb of Accra, more than half of the participants mentioned that abortion was discussed when they fell pregnant. While some parents usually advice their teenagers and young women against abortion, other parents facilitate it (Afenyadu & Goparaju, 2003; Gyesaw & Ankomah, 2013). A study in Ghana also found that 19% of sexually active female adolescents indicated that they already had a child and 29% mentioned they had ever been pregnant. This suggests that some pregnancies did not progress to delivery (Afenyadu & Goparaju, 2003). The 2007 GMHS reported that the age-specific induced abortion rate was 17 per 1,000 women aged 15-19 years and 25 per 1,000 women among women aged 20-24 years (Figure 3.1).

Figure 3. 1: Age specific induced abortion rate per 1,000 women (GMHS, 2007)



3.1.1 Abortion policy in Ghana

The 1960 Criminal Code of Ghana (Act 29), amended by PNDCL 102 of 1985 permits abortion for pregnancies that result from rape, incest, or "defilement of the female idiot," where there is high risk that the child would suffer from a serious deformity, or if the pregnancy threatens the woman's physical or mental health (Panel 3). However, Ghana did

not integrate safe abortion into national reproductive health policy until 2003 (Ministry of Health, 2008).

Panel 3: Legislation on abortion in Ghana

Criminal Offences Act of 1960 (Act 29), amended by PNDCL 102 of 1985

Section 58—Abortion or Miscarriage

2) It is not an offence under subsection (1) of this section if an abortion or a miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:

a) where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;

b) where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis; or

c) where there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.

The MOH and the GHS revised the national reproductive health policy in 2003 to incorporate the provision of post abortion care and included an objective to clarify the provision of comprehensive abortion care as permitted by law (Aboagye, Gebreselassie, Asare, Mitchell, & Addy, 2007; PAC Consortium Service Delivery Task Force, 2014). To ensure the full implementation of the revised policy, the Government of Ghana in 2006 collaborated with international organizations to launch the "Reducing Maternal Mortality and Morbidity" (R3M) program to improve comprehensive abortion care services to reduce mortality and morbidity caused by unsafe abortion (Sundaram et al., 2014). Comprehensive abortion care (CAC) includes the entire package of services to provide safe abortion care and post-abortion care. The national Reproductive Health Service Policy and Standards provides various guiding principles, specific to rape and consent see Panel 4 (Ghana Health Service, 2014).

Panel 4: Some guiding principles for the implementation of CAC services

The 2014 National Reproductive Health Service Policy and Standards

b. Rape
Legal evidence of defilement, rape or incest is not required in order for the client to obtain an abortion. (A client's word is sufficient).

d. Consent
Minors
A minor is a person below the age 18 years (Reference: Children's Act of Ghana 1998, Act 560)

- *The service provider shall encourage minors to consult a parent or a trusted adult if they have not done so already, provided that doing so will not put the minor in danger of physical or emotional harm. However, abortion services shall not be denied because such minor chooses not consult them.*
- *A parent, next of kin, another adult or trained service provider acting in loco parentis (in place of the parent) shall give consent on behalf of the minor.*
- *The confidentiality of the minor should be respected, subject to the usual exceptions that apply to patient-provider confidentiality.*
- *Providers should recognize that, in cases where pregnancy occurs in a minor under 16 years of age and is a result of defilement (statutory rape), such patients are entitled to abortion services.*

In 2006, Ghana Health Service – in collaboration with Ipas Ghana, WHO and other stakeholders – released safe abortion standards and protocols. These guidelines, adopted in 2006, outlined the components of Comprehensive Abortion Care, including counseling and the provision of contraceptives, defined mental health conditions that could qualify a patient for an abortion; and called for expanding the base of abortion providers by authorizing midwives and nurses to perform first-trimester procedures (Ipas, 2008; Ministry of Health, 2008). However, in many cases, the law still tends to be interpreted as prohibiting abortion, and availability of abortion is still limited in the public health sector.

A survey of health care facilities in 10 districts of Ghana found that about half (47.8%) of health workers were uncertain of the circumstances under which Ghana's law permits abortion. With respect to knowledge of certain legal indications for abortion, approximately one in five (20.6%) health workers and management correctly identified all seven legal indications for abortion in Ghana. In addition, the study found that less than one in seven (13.3%) public health facilities reported offering legal abortion services and only 21% of providers knew all the legal indications for abortion. The study also asked questions on knowledge of Ghana Health Service policy regarding legal termination of pregnancy. While over one-quarter of management staff (25.8%) and a little more than a fifth of providers (21.6%) perceived that the law requires written parental consent for adolescents, nearly one-half of management staff (47%) and one-quarter of the providers (23.2%) incorrectly reported

that the law requires husband's or boyfriend's written consent[6]. Additionally, about half (50.2%) of providers reported having concerns about providing abortion services because of their religious beliefs (Aboagye et al., 2007; also see Aniteye & Mayhew, 2013).

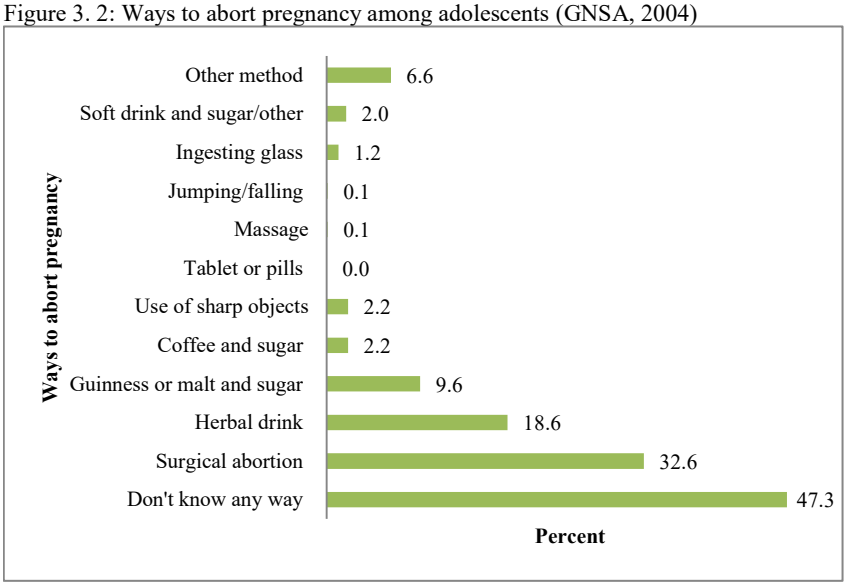
3.1.2 Stigmatization and abortion

Even when safe abortion options are available, the stigma associated with abortion is so powerful that it often forces women especially adolescent girls and young women to seek an unsafe, clandestine abortion because they want to avoid being seen or identified in a health facility (Adanu, Ntumy, & Tweneboah, 2005; Awusabo-Asare et al., 2006). Traditional and cultural values, social perceptions, religious teachings and criminalization of abortion have contributed to stigmatization of abortion in Ghana (Lithur, 2004). Research shows that abortion is stigmatized because it is perceived to violate the ideals of womanhood and it is viewed as dirty or unhealthy (Norris et al., 2011). Despite the fact that abortion is stigmatized, abortion still accounts for a substantial proportion of pregnancy outcomes.

3.1.3 Knowledge of abortion

The 2004 Ghana National Survey of Adolescents (GNSA) showed that about half (47.3%) of adolescents aged 12-19 years did not know any way to abort a pregnancy and about a third (32.6%) knew of surgical abortion. Worryingly, a fifth (18.6%) of the adolescents indicated that herbal drink could be used to abort a pregnancy, one in ten (9.6%) indicated that Guinness or Malta and sugar could be used to abort a pregnancy. Others also mentioned Coffee and Sugar, use of sharp objects, jumping and falling, ingesting glass and soft drink and sugar/other among others (Figure 3.2).

Figure 3. 2: Ways to abort pregnancy among adolescents (GNSA, 2004)

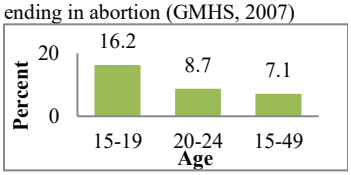


Note: Totals exceed 100 because multiple responses were possible

[6] The law does not require parental consent. However, the 2006 GHS Comprehensive Abortion Care Standards and Guidelines include provisions for a parent's consent or consent of an adult acting in loco parentis in nonemergency circumstances.

3.1.4 Pregnancies ending in abortion

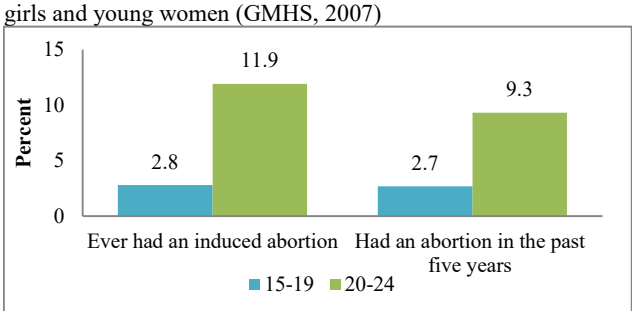
Figure 3. 3: Proportion of pregnancies ending in abortion (GMHS, 2007)



The 2007 Ghana Maternal Health Survey reported that 16.2% of pregnancies among adolescent girls age 15-19 years end in abortion. This was higher than the 8.7% observed among young women aged 20-24 years[7] (Figure 3.3), both of which were higher than the 7.1% of pregnancies ending in abortion among women 15-49 years (Ghana Statistical Service, Ghana Health Service, & Macro International, 2009).

The 2004 Ghana National Survey of Adolescents reported that 0.3% of younger adolescent girls (12-14 years) and 1.1% of older adolescent girls (15-19 years) had ever tried to end a pregnancy or been involved in ending a pregnancy. However, 11.5% of younger adolescent girls and 28.8% of older adolescent girls reported that they had close friends who have ever tried to end a pregnancy (Awusabo-Asare et al., 2006). In 2007, 2.8% of adolescent girls aged 15-19 years had ever had an induced abortion. Of the adolescents who have ever had an induced abortion, 89.3% had undergone induced abortion once and 10.7% had undergone induced abortion 2 to 3 times (Figure 3.4). Among young women (20-24 years), 11.9% of them had ever had an induced abortion, of which 76.2% were once and 23.5% were 2 to 3 times. In the last five years preceding the 2007 GMHS, 2.7% of adolescents (15-19 years) and 9.3% of young women aged 20-24 years had an induced abortion (Ghana Statistical Service, Ghana Health Service, & Macro International, 2009).

Figure 3. 4: Percent distribution of abortion among adolescent girls and young women (GMHS, 2007)



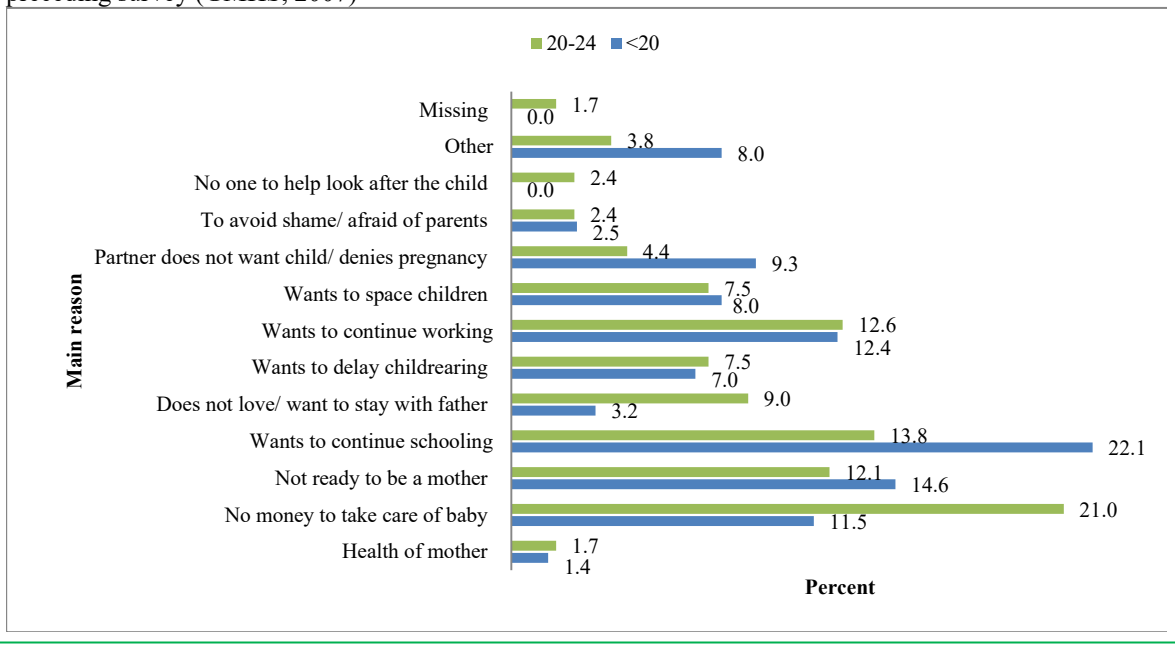
Other studies in Ghana have reported different levels of abortion in various parts of the country. A fertility survey of unmarried adolescents and young adults in Greater Accra and Eastern regions of Ghana showed that 46.5% of young women aged 15-24 years who had ever been pregnant reported that they had had an abortion. Among adolescent girls (15-19 years) and young women (20-24 years), 40.5% and 50.0% of those who had ever been pregnant reported that they had had an abortion (Agyei, Biritwum, Ashitey, & Hill, 2000). Another study to monitor pregnant women's health and pregnancy outcomes, including self-induced abortion was conducted in four (Central, Eastern, Volta and Greater Accra) of the 10 regions in Ghana between January and March 1997 and followed up from March 1997 to March 1998. The study found that 4.5% of adolescent girls (15-19 years) and 25.5% of young women (20-24 years) had an abortion (Ahiadeke, 2001). Additionally, a study on sexual health issues conducted among never-married youth aged 12-24 in three Ghanaian towns (Takoradi, Sunyani and Tamale) found that one-third of sexually experienced females reported having ever been pregnant; of those, 70% reported having had or having attempted to have an abortion (Glover et al., 2003).

[7] Pregnancies ending in abortion in the five years preceding the 2007 GMHS

3.1.5 Reason for induced abortion

Adolescent girls and young women seek induced abortion for various reasons. From the 2007 GMHS, the most important reason why adolescent girls (less than 20 years) sought induced abortion services was that they wanted to continue their education (22.1%), followed by the fact that they were not ready to become mothers (14.6%), wanted to continue working (12.4%) and had no money to take care of a baby (11.5%). Among young women (20-24 years), the most important reason was no money to take care of a baby (21.0%), followed by wanting to continue schooling (13.8%), wanting to continue working (12.6%) and not being ready to become a mother (12.1%) (Figure 3.5).

Figure 3. 5: Percent distribution of the main reason for the most recent induced abortion in the last five years preceding survey (GMHS, 2007)



3.1.6 Status of abortion

As indicated earlier, abortion services are legal under certain circumstances in Ghana. Only 3.3% and 5.6% of adolescent girls and young women respectively thought abortion was legal in Ghana (Figure 3.6). Among adolescent girls and young women who thought abortion was legal in Ghana, 41.9% and 45.4% respectively indicated that abortion was legal if the pregnancy was as a result of rape, 37.6% and 34.4% of adolescent girls and young women respectively thought abortion was legal if the life of the mother was in danger. In addition, 26.4% and 22.3% of adolescents and young women respectively indicated that abortion was legal if it was a risk to the physical health of the mother and 22.7% and 15.4% of adolescents and young women respectively indicated that they did not know the circumstances under which abortion was legal (Figure 3.7).

Figure 3. 6: Percent of adolescent girls and young women who think abortion is legal (GMHS, 2007)

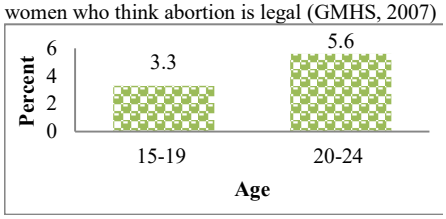
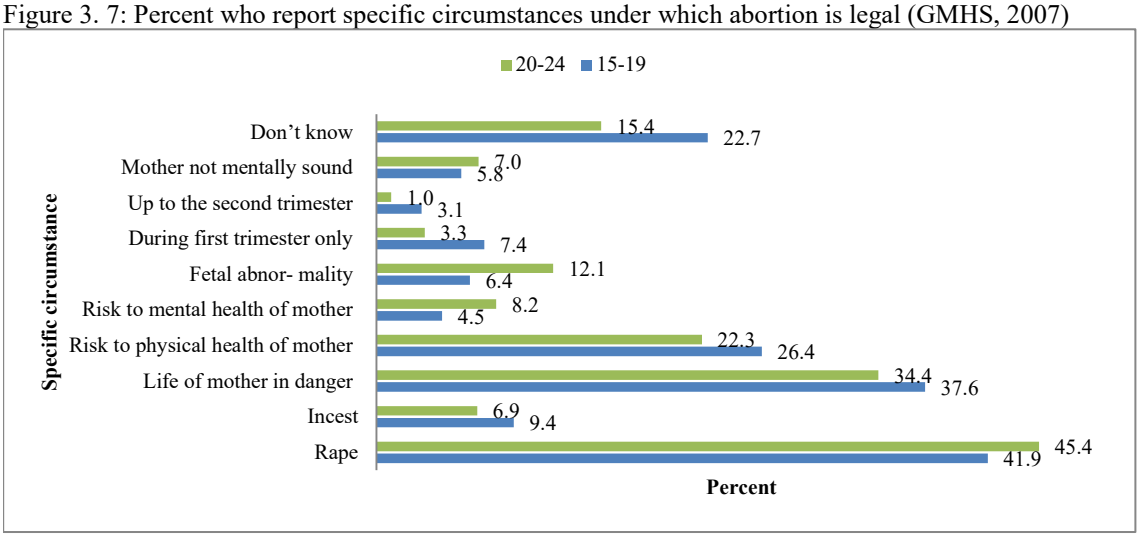


Figure 3. 7: Percent who report specific circumstances under which abortion is legal (GMHS, 2007)



3.2 Trends in termination of pregnancy

A thorough search in the literature showed that the GDHS is the only nationally representative survey that has collected multiple rounds of data on termination of pregnancy. The GDHS asks female respondents aged 15-49 whether they have ever terminated a pregnancy, where termination of pregnancy encompassed miscarriage, abortion or stillbirth. However, the question does not allow for the disaggregation of pregnancy into spontaneous and induced abortion, hence, this section looks at the trends in the proportions adolescent girls (15-19 years) and young women (20-24 years) who have ever terminated a pregnancy.

Data from the GDHS shows that the trend in termination of pregnancy among young women (20-24 years) declined from 13.8% in 1998 to 12.3% in 2003. However, it increased to 13.5% in 2008 and drastically increased to 19% in 2014. Among adolescents (15-19 years), termination of pregnancy decreased from 3.6% in 1998 to 3.1% in 2003 and further declined to 2.3% in 2008 but increased to 3.3% in 2014 (Figure 3.8).

Figure 3. 8: Trends in termination of pregnancy among adolescent girls and young women (GDHS, 1998-2014)

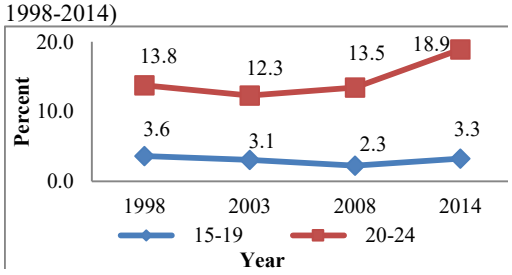


Table 3.1 shows the trends in termination of pregnancy by selected background characteristics. Generally, 2014 recorded the highest proportion (11.1%) of terminated pregnancies between 1998 and 2014, followed by 1998 and the least was recorded in both 2003 (7.4%) and 2008 (7.4%). It is only in 2003 (7.7% in urban areas versus 7.0% in rural areas) and 2014 (12.6% in urban areas versus 9.5%) that the proportion of young women (15-24 years) that reported termination of pregnancies was higher in urban areas compared to rural areas. The trend in termination of pregnancies in urban areas declined from 8.2% in 1998 to 7.4% in 2008, however, it increased substantially to 12.6% in 2014. In rural areas, the

trend in termination of pregnancies among young women (15-24 years) declined from 9% in 1998 to 7% in 2003 and was about the same in 2008 but increased to 10% in 2014.

Table 3. 1: Trends in termination of pregnancy among adolescent girls and young women by selected background characteristics (GDHS, 1998-2014)

	1998		2003		2008		2014	
	%	*N*	*%*	*N*	*%*	*N*	*%*	*N*
Residence								
Urban	8.2	677	7.7	1,160	7.4	953	12.6	1,655
Rural	8.9	1,133	7.0	1,000	7.4	949	9.5	1,583
Education						*		
No education	9.7	342	7.2	339	4.4	202	13.9	262
Primary	11.7	321	6.6	473	7.2	380	12.2	595
Middle/JSS/JHS	7.9	931	8.5	1,013	8.6	899	10.3	1,461
Secondary+	5.6	215	5.0	335	6.7	420	10.7	921
Region								
Western	12.1	246	8.0	215	6.5	160	14.4	386
Central	7.8	205	6.6	177	4.3	173	8.5	304
Greater Accra	4.2	306	6.6	382	11.3	335	12.8	582
Volta	4.8	203	3.3	180	1.9	161	10.3	239
Eastern	15.1	218	6.2	218	6.0	188	11.8	316
Ashanti	10.3	283	9.0	455	10.9	403	13.0	600
Brong Ahafo	10.8	139	15.1	225	7.0	162	12.1	298
Northern	5.4	75	2.8	150	6.6	176	5.1	283
Upper East	4.9	96	4.0	108	3.6	93	2.9	145
Upper West	6.1	39	4.4	51	2.1	50	8.0	85
Wealth quintile								
Lowest	-	-	2.9	303	5.3	263	7.1	567
Second	-	-	7.9	330	6.3	353	10.3	616
Middle	-	-	10.1	409	8.2	397	13.2	703
Fourth	-	-	8.7	516	9.0	461	14.4	720
Highest	-	-	6.4	603	7.2	427	9.2	633
Total	8.7	1,810	7.4	2,160	7.4	1,902	11.1	3,238

- Not analyzed
* 2 missing cases in education, 2008
N Total number of women age 15-24

Across all levels of education, the highest proportion of termination of pregnancy was recorded in 2014 and young women (15-24 years) with no education recorded the highest proportion of termination of pregnancy followed by those with primary education in 2014 (no education: 13.9%, primary: 12.2%, middle/JSS/JHS: 10.3%, secondary+: 10.7%).

Pregnancy termination among young women (15-24 years) with no education and primary level education declined from 1998 to 2008 and increased in 2014. However, pregnancy termination among young women (15-24 years) with middle/JSS/JHS and secondary+ level of education consistently increased from 2003 to 2014. With the exception of Eastern, Northern and Upper East regions, termination of pregnancy was highest among young

women (15-24 years) in 2014. While termination of pregnancy has consistently increased from 4.2% in 1998 to 12.8% in the Greater Accra region, it has consistently declined from 4.9% in 1998 to 2.9% in 2014 in the Upper East region (Table 3.1).

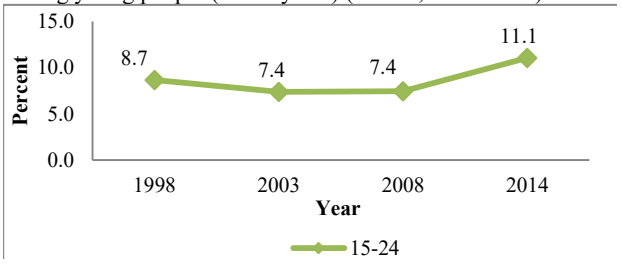
3.3 Achievements of policies, plans and programs on abortion

The Adolescent Reproductive Health Policy and the National Adolescent Health and Development Program have helped to move forward the national agenda to address issues surrounding abortion in Ghana.

Adolescent Reproductive Health Policy: The Adolescent Reproductive Health Policy was drafted in 2000 by the National Population Council to provide broad guidelines for policy makers, implementers of programs, and the public on reproductive health among adolescents and young people. One of the objectives of the policy is to support the implementation of programs that will help to either reduce or eliminate unintended pregnancies, reproductive tract infections (including HIV/AIDS), unsafe abortions, female genital mutilation/cutting, early marriage and malnutrition among adolescents (National Population Council, 2000).

Targets of the Adolescent Reproductive Health Policy include reducing the incidence of abortion among young people by 50 per cent by the year 2010. Since there has not been a consistent nationally representative survey that collects data on abortion (induced abortion), termination of pregnancy is used to assess this target in the Adolescent Reproductive Health Policy. From Figure 3.9, using 2003 as the base year and 2014 as the target year, termination of pregnancy among young people (15-24 years) has increased from 7.4% in 2003 and 2008 to 11.1% 2014, indicating that the target of reducing the incidence of abortion among young people by 50 per cent by the year 2010 was far from being achieved.

Figure 3. 9: Trend in proportion of termination of pregnancy among young people (15-24 years) (GDHS, 1998-2014)



The revision of the Adolescent Reproductive Health Policy is currently ongoing. The meeting to set the targets was held in Kumasi, Ghana from 22nd - 24th February 2016. At the meeting, the agreed targets for abortion were the following: By 2034, reduce total induced abortion rate among females aged 15-19 years from 17% in 2007 to 5% and among those aged 20-24 years from 25% to 5%. By 2034, reduce the incidence of unsafe abortion practices among young people by 80% (National Population Council, 2016).

3.4.1 Gaps and barriers in the data

There is a lack of nationally representative data that track the trend of induced abortion among adolescent girls (10-19 years) and young women (20-24 years). There is also a lack of recent nationally representative data on reasons for seeking abortion of pregnancies (either safe abortion or unsafe abortion) and attitudes of service providers towards adolescents and young women who seek abortion services. In addition, there is a lack of nationally

representative data on the role partners, parents and peers play in the decision of adolescents and young women to seek abortion services.

4 GENDER-BASED VIOLENCE

Highlights:

- *The proportion of women age 15-24 who justify gender-based violence against women has declined from 50% in 2003 to 32% in 2014*
- *Justification of gender-based violence was relatively higher in rural areas than in urban areas among women age 15-24 years*
- *49.3% of adolescent girls and 47.9% of young women experienced psychological violence (domestic or non-domestic) in the last 12 months preceding the survey*
- *In the domestic sphere, 35.7% of adolescent girls and 19.3% of young women experienced social violence in the last 12 months preceding the survey*

4.1 Introduction

Gender-based violence affects both men and women; in recent years however, it has received a lot of attention because there has been increasing concerns about violence against women in general and domestic violence in particular, in both developed and developing countries. Gender-based violence against women, which is the focus of this section is any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (United Nations, 1993). Violence against women, in its various forms, is endemic in communities and countries around the world, cutting across class, race, age, religious and national boundaries, with implications for women's health and intergenerational effects (Heise, Raikes, Watts, & Zwi, 1994; Issahaku, 2015; World Health Organization, 2001).

The World Health Organization notes that adolescents and young adults are the primary victims of violence in every region of the world. Rape and domestic violence account for 5% to 16% of healthy years of life lost by women of reproductive age and depending on the studies, from 10% to 50% of women experience physical violence at the hands of an intimate partner during their lifetime (World Health Organization, 2001).

In Ghana, gender-based violence is still a problem, especially in homes, which manifests in emotional, psychological and economic terms as well as through certain cultural practices such as forced marriage and enforced stay in abusive relationships (Amoakohene, 2004; Asiedu, 2014).

Data from the 2008 GDHS showed that ever-married adolescent girls and young women (15-24) experience various forms of gender-based violence from their partners. With respect to physical violence, about one in ten (10.5%) ever married women aged 15-24 had ever been

pushed or had something thrown at her. In the last 12 months preceding the survey in 2008, 9% of them still experienced this form of violence. About 16% of ever-married women (15-24 years) had ever been slapped by their partners and in the last 12 months preceding the survey, about 15% of them had been slapped by their partners. Slapping appeared to be the most common form of physical violence, it also had the highest proportion of occurring often (1.6%) and sometimes (13.0%). There are instances where the partners of women (15-24 years) threatened them with weapons such as knives and guns. Women age 15-24 also go through various forms of sexual violence from their partners such as being physically forced to have sexual intercourse or perform sexual acts she did not want to. Of the three indicators of emotional violence considered, insulting or making women feel bad about themselves was the most common. More than a quarter (27.6%) of women age 15-24 had ever experienced this form of violence. In the last 12 months preceding the survey, about the same proportion (26.4%) of women age 15-24 had experience of being insulted or made to feel bad about themselves.

Table 4. 1: Percent of ever-married women age 15-24 who have experienced various forms of violence committed by their husband/partner, ever and in the 12 months preceding the survey (GDHS, 2008)

		In the past 12 months		
	Ever	Often	Sometimes	Any
Physical violence				
Pushed her, shook her, or threw something at her	10.5	1.5	7.6	9.1
Slapped her	16.1	1.6	13.0	14.6
Twisted her arm or pulled her hair	4.6	0.7	3.5	4.2
Punched her with his fist or with something that could hurt her	4.3	0.9	2.7	3.5
Kicked her, dragged her, or beat her up	8.7	1.3	6.0	7.4
Tried to choke her or burn her on purpose	0.6	0.1	0.0	0.1
Threatened her or attacked her with a knife, gun, or any other weapon	1.3	0.0	0.9	0.9
Sexual violence				
Physically forced her to have sexual intercourse with him even when she did not want to	4.9	0.4	3.3	3.7
Forced her to perform any sexual acts she did not want to	3.1	0.0	2.6	2.6
Emotional violence				
Said or did something to humiliate her in front of others	17.8	4.3	12.7	17.1
Threatened to hurt or harm her or someone close to her	10.1	3.4	5.7	9.1
Insulted her or made her feel bad about herself	27.6	7.4	19.0	26.4

N = 314

More recently (2016), the domestic violence in Ghana (DVG) report revealed that 71.5% of women reported having experienced at least one form of violence (domestic or non-domestic) over their lifetime and 42.9% of women experienced at least one form of violence in the 12 months prior to the survey. With respect to the incidence of domestic violence in the last 12

months preceding the survey, 27.7% of the women experienced at least one form of violence (Institute of Development Studies (IDS) et al., 2016).

The DVG report defined the following forms of violence considered in the study as follows: *social violence,* acts of controlling behavior, such as preventing someone from seeing friends or family; stopping someone from leaving the house; requiring to know where someone is at all times; stalking; spreading false information, videos or photos without permission; or forcing women to have an abortion. *Physical violence,* slapping, pushing, shoving, hitting, kicking, dragging or throwing objects at someone; choking, strangling or burning someone; using a weapon, hazardous chemicals or substances against someone; or kicking or pulling someone's external genitalia (for male respondents only). *Sexual violence*, acts of unwanted sexual comments or physical contact; rape by physical force, or otherwise forced sex (for instance, by blackmail or threats); denial of using protection during sex; a sexual partner hiding their HIV status; sexual acts and intercourse that were performed on the basis of feeling there was no option; or penetration with an object against someone's will. *Psychological violence*, the use of insults, belittling or humiliation in private or in front of others; threats of abandonment; being ignored or treated indifferently; intimidations and acts aimed at scaring someone; threats of using weapons against someone; or threats of hurting someone or someone one cares about. *Economic violence*, the denial of household money for expenses (chop money) even if enough financial means are available; unsolicited taking of money; control of belongings and spending decisions; damage to or destruction of someone's property; denial of the right to work; forcing someone to work against their will; or denial of food and other basic needs.

Psychological violence was the most common form of violence (domestic or non-domestic) that adolescent girls (49.3%) and young women (47.9%) experienced in the last 12 months preceding the survey (Table 4.2). In the domestic sphere, social violence was the most common form of violence that adolescent girls (35.7%) and young women (19.3%) faced. On the contrary, sexual violence was the least common form of domestic violence adolescent girls (4.3%) and young women (4.9%) experienced.

Table 4. 2: Percent of women who experienced violence in the 12 months prior to the survey (DVG, 2016)

	Domestic or non-domestic	
	15-19 years	**20-24 years**
	(N = 191)	*(N = 380)*
Social violence	44.2	31.5
Physical violence	28.0	14.1
Sexual violence	38.2	40.4
Psychological violence	49.3	47.9
Economic violence	30.4	31.7
	Domestic	
Social violence	35.7	19.3
Physical violence	15.2	9.4
Sexual violence	4.3	4.9
Psychological violence	15.2	9.4
Economic violence	17.2	15.9

Another study in northern Ghana also found that 7 out of 10 women had experienced gender-based violence within the past 12 months, of which 62% had experienced psychological violence, 29% had experienced physical violence, and 34% had experienced sexual violence (Issahaku, 2015). Additionally, a study in Ghana on defilement using data from the Domestic Violence and Victims Support Unit of the Ghana Police Service in Ejisu-Juabeng revealed that 9 defilement cases were recorded in 2007, 32 cases in 2008 and 2009 respectively, 28 cases for 2010 and 23 for 2011. Of the 117 cases analyzed, 96 (82.1%) involved victims less than 16 years of age. The study found that only one case of sodomy involved a boy victim, all other victims were females. The mean age of victims was 13.1 years. The youngest victim was 1 year of age and the oldest was 17 years (Morhe & Morhe, 2013).

4.1.1 Factors influencing gender-based violence

Gender-based violence can be attributed to lack of education, poverty, lack of employment, husbands with higher levels of control and women who witnessed family violence in their lives (Tenkorang, Owusu, Yeboah, & Bannerman, 2013). In addition, egalitarian decision-making and equal household contributions have been reported to be associated with a reduced acceptance of abusive actions toward women (Mann & Takyi, 2009).

4.1.2 Consequences of gender-based violence

The consequences of gender-based violence are enormous. Throughout the world, millions of deaths and physical injuries are recorded each year because of gender-based violence. Violence has health and psychological implications for victims, perpetrators of violence, as well as witnesses to violence. The WHO reported that some of the health effects of gender-based violence include mental illness, behavioral disorders and reproductive and sexual health problems (World Health Organization, 2001).

Studies in Ghana shows that abused women usually suffer from various health issues, including injury, thoughts of suicide, sleep disruption, and fear of partner (Issahaku, 2015). In addition, women are psychologically and emotionally hurt when partners insult or scream at them especially in front of their children (Amoakohene, 2004). In other cases, pregnant women are physically abused, which is related to perinatal mortality and neonatal mortality (Pool, Otupiri, Owusu-Dabo, de Jonge, & Agyemang, 2014).

4.1.3 Legislations on gender-based violence

In Ghana, the government and civil society have initiated interventions to fight against gender-based violence against women. Over the years, these interventions have been in the form of legislation, education, awareness creation, counseling, investigation and prosecution of offenders (Amoakohene, 2004).

1992 Constitution of Ghana

> ***The 1992 Constitution of Ghana- Chapter 5***
>
> *(2) Every person in Ghana, whatever his race, place of origin, political opinion, colour, religion, creed or gender shall be entitled to the fundamental human rights and freedoms of the individual contained in this Chapter but subject to respect for the rights and freedoms*

The 1992 Constitution of Ghana outlines the fundamental human rights and freedoms for all citizens (see insert). In addition to the constitutional provision protecting women against discrimination, the constitution also provides provisions to protect women during and after childbirth as well as at work (Panel 5) (Republic of Ghana, 1992).

Panel 5: Constitutional provision protecting women

> ***The 1992 Constitution of the Republic of Ghana***
>
> ***Chapter Five***
>
> *(1) Special care shall be accorded to mothers during a reasonable period before and after childbirth; and during those periods, working mothers shall be accorded paid leave.*
>
> *(2) Facilities shall be provided for the care of children below school-going age to enable women, who have the traditional care for children, realise their full potential.*
>
> *(3) Women shall be guaranteed equal rights to training and promotion without any impediments from any person.*

National Gender Policy

The 2015 National Gender Policy was enacted "to mainstream gender equality and women's empowerment concerns into the national development process in order to improve the social, legal, civic, political, economic and cultural conditions of the people of Ghana; particularly women and men, boys and girls in an appreciable manner and as required by National and International Frameworks" (Republic of Ghana, 2015, p. 20). Specifically, the policy seeks to address some of the following; women's empowerment, women's right and access to justice, leadership and accountable governance for women, and gender roles and relations (see Panel 6).

Panel 6: Legislation on gender mainstreaming

The 2015 National Gender Policy

Broad policy objectives

1) *To accelerate efforts and commitments of government in empowering women (especially women with disability) to have safe and secure livelihood, access to economic opportunities, decent work to improve earnings while addressing disparities in education, socio-economic and cultural issues, health and agriculture, trade and related matters. The core issue here is about 'Women's Empowerment'*
2) *To speed up enforcement and domestication of ratified International Treaties, policies and strategies adopted by the Government to tackle violence, discrimination and promote gender equality and women's empowerment nationwide. In pursuance of this objective the rights based approaches will be emphasised. This objective addresses what the Policy classifies as 'Women's Right and Access to Justice'*
3) *To support the passage and implementation of an Affirmative Action Law, and put in place transformative measures (including leadership development) that will enable women and men participate equally in achieving at least the 40% women representation in politics, on Boards and at all levels of decision making. In pursuance of this objective, a well-developed institutional capacity and a healthy political environment based on rule of law, government effectiveness, control of corruption, regulatory quality, will be promoted as necessary conditions for women's interest and rights. This objective area refers to 'Leadership and Accountable Governance for Women'*
4) *To improve women's economic opportunities including engendering macro-economic and trade policies so that the basic and strategic needs of both men and women are addressed. In pursuance of this objective, Gender Responsive Budgeting, trade, tax literacy, access to credit and encouragement of a savings-culture among women will be enforced*
5) *To transform inequitable gender relations in order to improve women's status relative to that of men. In pursuance of this objective, state policies in all areas will be identified and monitored with a GE and WE lens to ensure equity compliance. The objective is about promoting Gender Roles and Relations.*

The Domestic Violence Act of Ghana (Act 732)

Specific to domestic violence, the government of Ghana enacted into law the Domestic Violence Bill on May 3, 2007. The DV Act (732) defines what constitutes domestic violence (Panel 7) and adds that use of violence in the domestic setting is not justified on the basis of consent (Republic of Ghana, 2007).

Panel 7: Legislation on domestic violence

Domestic Violence Act, 2007 (Act, 732)

1. Domestic violence means engaging in the following within the context of a previous or existing domestic relationship:

(a) an act under the Criminal Code 1960 (Act 29) which constitutes a threat or harm to a person under that Act;

(b) specific acts, threats to commit, or acts likely to result in

(i) physical abuse, namely physical assault or use of physical force against another person including the forcible confinement or detention of another person and the deprivation of another person of access to adequate food, water, clothing, shelter, rest, or subjecting another person to torture or other cruel, inhuman or degrading treatment or punishment;

(ii) sexual abuse, namely the forceful engagement of another person in a sexual contact which includes sexual conduct that abuses, humiliates or degrades the other person or otherwise violates another person's sexual integrity or a sexual contact by a person aware of being infected with human immunodeficiency virus (HIV) or any other sexually transmitted disease with another person without that other person being given prior information of the infection;

(iii) economic abuse, namely the deprivation or threatened deprivation of economic or financial resources which a person is entitled to by law, the disposition or threatened disposition of moveable or immovable property in which another person has a material interest and hiding or hindering the use of property or damaging or destroying property in which another person has a material interest; and

(iv) emotional, verbal or psychological abuse namely any conduct that makes another person feel constantly unhappy, miserable, humiliated, ridiculed, afraid, jittery or depressed or to feel inadequate or worthless

The Domestic Violence Act specifies various punishments for perpetrators of any act of domestic violence from summary conviction to a fine of not more than five hundred penalty units or to a term of imprisonment of not more than two years or to both. The Domestic Violence Act further stipulates that, in addition to imposing a fine or a prison term, the offender can be ordered in a case of domestic violence to pay compensation to the victim as the Court may determine (Republic of Ghana, 2007).

The Domestic Violence Act has been undermined by the fact that people are not well educated about it. A study at the Domestic Violence and Victim Support Unit (DOVVSU) in Accra, Ghana revealed that victims of abuse and the public are not well educated on the Domestic Violence Act, which negatively affects reporting of issues of domestic violence (Agbitor, 2012).

The Domestic Violence and Victims Support Unit (DOVVSU)

The creation of the Domestic Violence and Victims Support Unit of the Police Service (DOVVSU) in October 1998, formerly known as the Women and Juvenile Unit (WAJU) of the Ghana Police Service was in response to violence against women and children in the country. The name of the unit was changed to DOVVSU in 2005 for easy awareness creation under the Ghana Domestic Violence Act and to ensure that all vulnerable persons are catered

for regardless of gender (Benson, 2011; Morhe & Morhe, 2013; Republic of Ghana, 2007). The establishment of the unit in 1998 was backed with the Convention on the Elimination of Discrimination Against Women (CEDAW), Convention On The Rights Of The Child (CRC), The Beijing platform of action, and the Millennium Development Goals among others (Benson, 2011).

The Domestic Violence and Victim Support Unit (DOVVSU) was established as a specialized unit to be equipped with the requisite skills to address issues of domestic violence in its varied forms. The unit was established because of the perceived inability of the police to properly handle complaints from people against their own family members and friends, particularly complaints related to sexual abuse. DOVVSU consists of police prosecutors and investigators, social workers, clinical psychologists and counsellors, to create an environment that provides timely and equitable response to victims of abuse. DOVVSU has been mandated to prevent, protect, apprehend and prosecute perpetrators of domestic violence and child abuse in Ghana (Benson, 2011; Morhe & Morhe, 2013).

DOVVSU has been facing some challenges to address the issues surrounding domestic violence. For example, a study showed that people were aware of institutions or organizations such as CHRAJ, FIDA and WAJU, and for some respondents, organizations like the Ark Foundation and the Gender Centre, which deal with issues of gender-based violence. When respondents were asked how often they reported any cases of domestic violence, none of the respondents who had suffered abuse reported it, not even to other family members despite the fact they believed violence against women was increasingly assuming wider social dimensions (Amoakohene, 2004). In addition, a study in Ejisu-Juaben Municipality noted that many victims of gender-based violence did not report the offence until they became sick or were pregnant (Morhe & Morhe, 2013). Largely, women face obstacles to reporting violence, which usually comes from cultural beliefs that domestic violence is a private, family matter that should be addressed outside of the criminal justice system (Cantalupo, Martin, Pak, & Shin, 2006). Aside the issue of victims not reporting cases, the study found that the Domestic Violence and Victim Support Unit did not have the requisite resources to facilitate its work, for example, the unit lacked computers to ensure a good database of cases of domestic and sexual violence (Morhe & Morhe, 2013). With respect to data collection, which has also been a challenge for the Unit, the United Nations Population Fund (UNFPA) provided support to DOVVSU to improve data collection and documentation of cases (Abbey, 2016).

The Ministry of Gender, Children and Social Protection (MoGCSP)

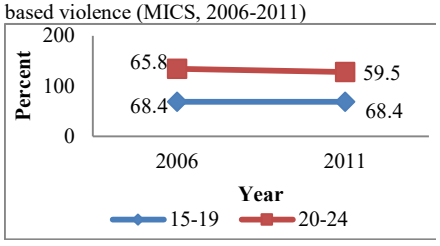
The creation of the Ministry of Women and Children Affairs, which later became the Ministry of Gender, Children and Social Protection in January 2013 appeared to be government's response to bring the abuse of vulnerable people including women and children under control and to project the Ghanaian woman as an integral part of society. The primary objective for its establishment was to have a Ministry responsible for policy formulation, coordination and monitoring and evaluation of gender, children and social protection issues within the context of the national development agenda. This is expected to lead to the achievement of gender equality, equity, the empowerment of women and girls, promoting the

survival and development of children, hence ensuring their rights. It is also to ensure harmonization of social protection interventions to better target the vulnerable, excluded and persons with disability and integrate fulfilment of their rights, empowerment and full participation into national development (Ministry of Gender Children and Social Protection, 2016).

4.2 Trends in attitudes towards gender-based violence against women

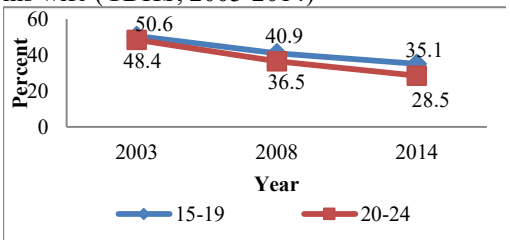
The Multiple Indicator Cluster Survey (MICS)[8] and the Demographic and Health Survey (DHS)[9] have collected information on attitudes towards gender-based violence in Ghana. Data from MICS show that justification of gender-based violence among young women (20-24 years) compared to adolescent girls (15-19 years) in 2006 and 2011 was higher. Among adolescent girls, the proportion who justified gender-based violence against women was the same (68.4%) in both 2006 and 2011. The proportion who justified gender-based violence against women among young women declined from about two-thirds (65.8%) in 2006 to 59.5% in 2011 (Figure 4.1).

Figure 4. 1: Trends in attitudes towards gender-based violence (MICS, 2006-2011)



Data from the Ghana Demographic and Health Survey also shows that the trend in the proportions of adolescent girls and young women justifying wife beating has been decreasing from 2003 to 2014. However, the proportion of adolescent girls justifying gender-based violence against women has consistently been higher. For instance, 35% of adolescent girls indicated that gender-based violence against women was justified under the measures considered compared to 28.5% of young women (Figure 4.2). From Figure 4.2, the proportion of adolescent girls (15-19 years) who justified gender-based violence decreased from about half (50.6%) in 2003 to about two-fifths (40.9%) in 2008 and further decreased to about a third (35.1%) of adolescent girls in 2014. Among young women (20-24 years), the proportion of them who justified wife beating decreased from 48.4% in 2003 to a little more than a third (36.5%) in 2008 and further decreased to 28.5% in 2014.

Figure 4. 2: Trends in percentage of women who agree that a husband is justified in beating his wife (GDHS, 2003-2014)



[8] Attitude towards gender-based violence in the MICS is based on a woman agreeing with at least one statement on wife beating. These statements including: Husband is justified in hitting or beating his wife if she - goes out without telling him, neglects the children, argues with him, refuses sex with him, burns the food, insults him, refuses to give him food, has another partner, steals, gossips. Also note that the reasons were not the same in 2006 and 2011.

[9] Attitude towards gender-based violence in the GDHS is based on a woman agreeing with at least one of the following statements: Husband is justified in hitting or beating his wife if she - burns the food, argues with him, goes out without telling him, neglects the children and refuse to have sexual intercourse with him.

Table 4.3 show trends in attitudes towards gender-based violence against women by selected background characteristics.

Generally, justification of gender-based violence among women (15-24 years) declined from about half (49.6%) in 2003 to about two-fifths (38.9%) in 2008 and less than a third (31.8%) in 2014. Justification of gender-based violence has consistently been higher in rural areas than in urban areas. In 2003 for example, the proportion of women (15-24 years) in urban areas who justified gender-based violence against women was a little more than two-fifth (44.5%) and more than half (55.3%) among their rural counterparts. The trend in justification of gender-based violence against women has been declining in both rural and urban areas from 2003 to 2014.

Table 4. 3: Trends in percentage of women age 15-24 who agree that a husband is justified in beating his wife by selected demographic characteristics (GDHS, 2003-2014)

	2003		2008		2014	
	%	*N*	*%*	*N*	*%*	*N*
Age						
15-19	50.6	1,148	40.9	1,025	35.1	1,625
20-24	48.4	1,012	36.5	878	28.5	1,613
Residence						
Urban	44.6	1,160	31.9	953	26.1	1,655
Rural	55.3	1,000	45.9	949	37.9	1,583
Education				*		
No education	66.1	339	50.6	202	57.7	262
Primary	57.6	473	47.9	380	43.7	595
Middle/JSS/JHS	46.5	1,013	40.9	899	31.9	1,461
Secondary+	31.0	335	21.0	420	16.7	921
Region						
Western	55.7	215	34.8	160	31.2	386
Central	58.4	177	47.1	173	22.5	304
Greater Accra	38.9	382	18.6	335	20.8	582
Volta	39.2	180	26.3	161	33.0	239
Eastern	48.3	218	38.0	188	27.9	316
Ashanti	47.5	455	48.5	403	28.2	600
Brong Ahafo	36.0	225	34.7	162	46.4	298
Northern	71.8	150	60.2	176	59.4	283
Upper East	74.6	108	36.2	93	34.8	145
Upper West	76.8	51	69.2	50	33.6	85
Wealth quintile						
Lowest	65.8	303	49.0	263	49.3	567
Second	58.4	330	46.1	353	40.2	616
Middle	48.7	409	39.5	397	29.8	703
Fourth	48.3	516	36.0	461	24.6	720
Highest	38.3	603	29.2	427	18.5	633
Total	49.6	2,160	38.9	1,902	31.8	3,238

* 2 missing cases in education, 2008

N Total number of women age 15-24

In all the survey years under consideration, as level of education increases, the proportion of women (15-24 years) who justify gender-based violence decreased. For instance, in 2014, 57.7% of those who had no education justified gender-based violence, 43.7% of those with primary education, 31.9% of those who had middle/JSS/JHS and 16.7% of those who had secondary+ education. In addition, while the proportion of women (15-24 years) who justified gender-based violence against increased from about half (50.6%) in 2008 to 57.7% in 2014 among those with no education, the proportion of women (15-24 years) in all other levels of education consistently declined from 2003 to 2014.

Whereas the proportion of women (15-24 years) who justify gender-based violence has consistently declined from 2003 to 2014 in the Western, Central, Eastern, Northern, Upper East and Upper West regions, it has been erratic in the Greater Accra, Volta, Ashanti and Brong Ahafo regions. In addition, Greater Accra region consistently has the lowest proportion justifying gender-based violence against women from 2003 to 2014.

As wealth quintile increases, the proportion of women (15-24 years) who justify gender-based violence decreased. With the exception of women (15-24 years) in the lowest wealth quintile, where the proportion of women (15-24 years) decreased from 65.8% in 2003 to 49% in both 2008 and 2014, the proportion of women (15-24 years) in the other wealth quintile categories consistently declined from 2003 to 2014. For instance, the proportion of those in the highest wealth quintile who justified gender-based violence against women decreased from 38.3% in 2003 to 29.2% in 2008 and further declined to 18.5% in 2014.

4.3 Achievements of policies, plans and programs on gender-based violence

Since 2009, government agencies with mandates to prevent all forms of violence against women have made significant efforts in embarking on various advocacy and awareness creation initiatives to communicate and mobilize community members to address violence against children. The Departments of Social Development, Gender and Children of the MoGCSP alone have interacted with over 250,000 people in about 250 communities across the entire country on violence against women and children (between 2009 and 2014).

Other government agencies such as the Commission for Human Rights and Administrative Justice (CHRAJ), Domestic Violence and Victim Support and Anti-Human Trafficking Units of the Ghana Police Service, Ghana Education Service (GES) and the Ghana Health Service have also engaged with various communities on violence against women. The essence of these programs is to increase publicity and awareness on violence against women and its effects. In addition, the 16 days of activism against gender-based violence has been consistently observed (Ministry of Gender Children and Social Protection, 2014).

4.4 Gaps and barriers in the data

There is lack of data to monitor the various forms of gender-based violence among adolescent girls (10-19 years) and young women (20-24 years) over time.

5 EDUCATION

Highlights:

- *The percentage of adolescent girls with no education declined from 18% in 1993 to 4% in 2014. Among young women, it declined from 26% in 1993 to 12% in 2014.*
- *The Net Attendance Ratio for girls at secondary level of education increased from 35% in 2003 to 42% in 2008 and declined to 39% in 2014.*
- *Gender parity was achieved at the primary level of education in the 2012/13 (GPI, 0.99) and 2013/14 (GPI, 0.99) academic years.*
- *The Net Enrolment Rate at primary level for girls increased from 77% in 2010/11 to 89% in the 2013/14 academic years*
- *Retention of girls at the primary level of education decreased from 770 in 2004/05-2009/10 to 576 per 1000 girls in 2008/09-2013/14 academic years*
- *Net JHS completion rate increased from 62% in 2009/10 to 66% in 2013/14*

5.1 Introduction

The Government of Ghana (GoG) has over the years shown its commitment towards achieving universal primary education by ensuring that all children of primary school-age enroll, stay in school and complete this level. This commitment has been in the form of policy directives and interventions such as the Free Compulsory Universal Basic Education Program (FCUBE), the Ghana Poverty Reduction Strategy (GPRS I), the National Early Childhood Development (ECD) policy, the Education Strategy Plan (ESP) for 2003-2015, the School Feeding Program, the Capitation Grant and distribution of exercise books and school uniforms. These measures are expected to lead to improvements in key educational indicators such as increased rates in enrolment, admission, retention, completion and gender parity.

5.1.1 The education system in Ghana

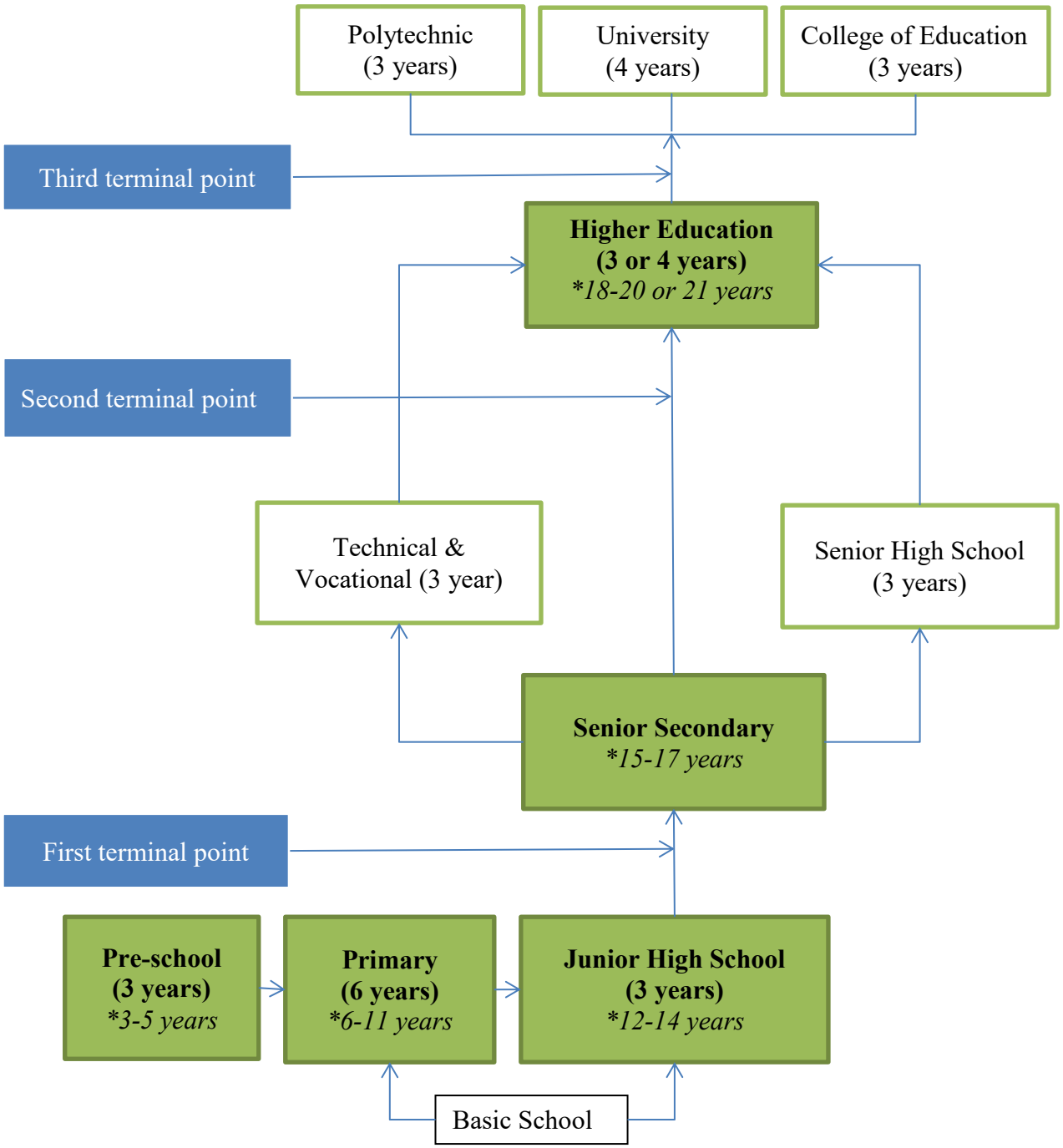
Ghana boasts of some 12,000 primary schools, 6,000 junior secondary schools, 700 senior high schools, 18 technical institutions, 21 nursing training colleges, 3 theological colleges, 20 university colleges, 6 tutorial colleges, 10 polytechnics, 9 public universities and 3 chartered private universities (NUFFIC, 2015). In 1996, the Free Compulsory Universal Basic Education (FCUBE) program was implemented for all children between the ages of 6 and 15 years, covering 9 years of basic education. Pre-school education in Ghana is not compulsory and usually caters for children within the age group 3-5 years. Primary education consists of a 3-year lower primary phase (class 1-3) and a 3-year upper primary phase (class 4-6). The primary school education curriculum places emphasis on reading and writing, arithmetic and development of problem-solving abilities. Pupils are usually expected to be 12 years old on

completion of primary education; however not all pupils do so due to repetition (NUFFIC, 2015).

The Junior High School [formerly referred to as Junior Secondary School (JSS)] phase concludes the compulsory school-age years. At the end of the junior high school period, pupils sit the Basic Education Certificate Examinations (BECE) and successful candidates proceed to the next level of education. Students have the option of getting into technical/vocational training institutions or senior high schools. Students who proceed into the Technical and Vocational Training Institutions usually spend 3 years in school and sit an examination that leads to the award of diplomas or certificates in their chosen technical or vocational field.

Students then enroll into the senior high schools, which span 3 years, during which time they are taught Mathematics, English, Social Studies and Integrated Science. In addition to these four core subjects, students choose from a number of electives that fall within the domains of Business, Agriculture, Technology and General Education in the area of Arts and the Sciences. Senior high school education ends with students writing the West African Senior Secondary School Certificate Exams (WASSSCE), which has since 2007 replaced the Senior Secondary School Certificate Exams (SSSCE). Students are usually 18 years old upon completing senior high school education. Tertiary education in Ghana consists of four years of university education, or three to four years of training at polytechnics, teacher-training colleges or other training institutions (e.g. nursing training colleges). Figure 5.1 shows the education structure of Ghana. For the purpose of this analysis, primary, secondary and tertiary levels of education are considered.

Figure 5.1: Education structure of Ghana



Source: Constructed based on information from UNESCO World data on education (UNESCO, 2006)
* Ideal age groups for the various levels of education

5.1.2 Policies and programs on education

Since 1951 and most especially after political independence in 1957, Ghana has made significant progress in the quest to ensure that school-going boys and girls are able to complete a full course of basic education (United Nations Children's Fund, 2007). The education system in its present state is the result of major policy initiatives adopted by

present and past governments. Some of the laws, policy documents and reports that have generally helped in meeting the educational needs of the Ghanaian populace include:

a) Article 38 of the 1992 Constitution of Ghana
b) Education for All (EFA, UNESCO, Dakar 2000) – International paper
c) Ghana Poverty Reduction Strategy, (GPRS I) (implemented between 2003 and 2005)
d) Growth and Poverty Reduction Strategy, (GPRS II) (implemented between 2006 and 2009)
e) Education Sector Policy Review Report (ESPRR), August 2002
f) Meeting the Challenges of Education in the 21st Century (The report of the President's Commission on Review of Education Reforms in Ghana, ERRC, October 2002).
g) The Education Strategic Plan (ESP), spanning 2003-2015
h) Education Sector Review (ESR, October 2002) and the Government's White Paper on the Report (2004)

Additionally, three major policy documents have addressed girls' education by outlining what is to be done to address the MDGs (now SGDs) for achieving universal basic education and gender parity. They are also aimed at promoting equitable access to education; improving the quality of education and ensuring effective education management in the areas of science, technology and TVET (IBIS, UNICEF, SNV, & WFP, 2009). These three policy documents are described briefly below:

Policies on girl-child education

The Growth & Poverty Reduction Strategy (GPRS II, 2003-2009): In 2006, Ghana started the implementation of its second Growth and Poverty Reduction Strategy (GPRS II). The GPRS II focused much on ensuring that Ghana developed into a middle-income country by the year 2015. Developing its human resources was one of the three main thematic areas of the GPRS II, emphasizing the creation of a competent work force for development of the country with education playing an important role. The GPRS II not only aimed to meet the MDG goal 2 but also to strengthen the quality of basic education, improve quality and efficiency in the delivery of education services and bridge the gender gap in access to education (United Nations Children's Fund, 2007).

The Government of Ghana's Education White Paper: The Government of Ghana in 2004 came out with a White Paper on Education Reform. The White Paper outlined a portfolio of reforms and objectives spanning the entire education sector, which were to be implemented from 2007 and had major targets identified for 2015 and 2020. The key objectives of the White Paper on Education Reform were two-fold. The first was to build on the Education Sector Plan commitments and ensure that all children were provided with the foundation of a high quality free basic education. The second was to ensure that second cycle education was more inclusive and appropriate to the needs of young people and the demands of the Ghanaian economy (United Nations Children's Fund, 2007). With the reform, basic education was to be expanded to include 2 years of kindergarten as well as the existing 6 years of primary and 3 years of Junior High School (JHS). The entire basic cycle was to be free and compulsory making the education sector the highest priority of all sub-sectors.

Overall funding for this sector was to be supported in full by government. The overarching target was 100% completion rates for male and female students at all basic levels by 2015.

The Education Sector Plan (ESP) targeted for 2003-2015: The Education Strategic Plan (ESP), which came into effect in 2003 and was expected to end in 2015 was developed based on the Poverty Reduction Strategy. The ESP was also designed to operate within the framework of a sector wide approach (SWAP) for education, which in Ghana is partly situated within the Multi-Donor Budget Support (MDBS) framework. The ESP provides the framework and roadmap for achieving the education related MDGs. The strategic framework of the Education Strategic Plan 2003-2015 is based around four focus areas: Equitable Access to Education, Quality of Education, Educational Management and Science, Technology and Technical and Vocational education (TVET). The ESP has ten policy goals, some of which include increasing access to and participation in education and training, improving the quality of teaching and learning for enhanced pupil/student achievement, promoting good health and environmental sanitation in schools.

Programs on girl-education

Programs and Initiatives towards improving Girls Education: To get more children in school, the Government of Ghana and the Ministry of Education, Science and Sports (MOESS) have pursued several programs to promote girls' education in order to meet its broad policy targets outlined in the ESP. These programs are carried out by the Government or in collaboration with development partners and Non-Governmental Organizations (NGOs). The programs can be categorized into two: generic and specific. The generic programs are geared towards increasing enrolment, retention, and improving quality of education in deprived areas. These programs do not specifically target girls. The specific programs on the other hand have been carried out over the years through collaborative efforts of the Girls Education Unit (GEU), UNICEF, World Food Program (WFP), World Vision, Plan International, among others. The specific programs, which are evaluated in this section, are the Capitation Grant and the Ghana School Feeding Program.

Capitation Grant (School Fee Abolition): Determined to increase enrolment of school-going age children in schools, the Government of Ghana, in the Free Compulsory Universal Basic Education (FCUBE) program in 1996, included a cost sharing scheme to cover non-tuition fees, under which parents were expected to bear limited expenses. More importantly, no child was to be turned away for non-payment of fees (United Nations Children's Fund, 2007).

To meet the MDG goals for education and national targets established in the 2003-2015 Education Strategic Plan, the Government abolished all fees charged by schools and provided schools with some grant for each pupil enrolled. The program was first piloted (with World Bank support) in Ghana's 40 most deprived districts in 2004. Under this system, every public kindergarten, primary school and junior secondary school receives a grant equivalent to $3.30 per pupil per year. With its inception, schools were no longer permitted to charge fees to parents (United Nations Children's Fund, 2007). However, the GES noted that the government would provide free tuition, textbooks, teaching and learning materials, and subsidize the cost of exercise books, as well as the Basic Education Certificate Examination

(BECE) fees for both public and private candidates. Nevertheless, parents were expected to pay other fees (Parents Teachers Association (PTA) levy) for school development activities, on condition that schools sought clearance from either the School Management Committee (SMC), District Education Oversight Committee (DEOC) or District Assemblies to avoid excessive charges being imposed. However, this opened a backdoor for schools to introduce ancillary fees and in some cases, head teachers came under intense pressure to collect levies with the consequence that children were sent home when their parents failed to pay imposed levies (Akyeampong, 2011).

Ghana School Feeding Program: Getting children in school is an important step, but keeping them in school and making sure they learn is more challenging. In 2005, the Government of Ghana initiated the Ghana School Feeding Program (GSFP). The pilot phase of the GSFP was launched in the same year under NEPAD "Home Grown" SFP concept, which aimed to contribute not only to the improvement of education service delivery but also to agricultural development and the reduction of malnutrition among school aged children. As part of the program, locally produced food were to be cultivated to feed school children, school gardens were to be established, agriculture and nutrition information and education were to be incorporated in the school curricula. Other measures, such as deworming (which impacts on the health status of children), were also part of the school feeding program (IBIS et al., 2009).

***Establishment of the Girls Education Unit (GEU)*:** In 1997, a Girls' Education Unit was established as part of the Basic Education Division of the Ghana Education Service to co-ordinate the implementation of activities related to girls' education. As part of the decentralization of the education service delivery in each of the ten administrative regions and all the then existing districts, Regional and District Girls' Education Officers were appointed to coordinate activities and improve access for girls to the education system (United Nations Children's Fund, 2007). The aim of the GEU was to specifically address the gender disparities in education by designing and implementing programs geared towards attracting and retaining girls in schools. The work of the Girls Education Officers was mainly sensitization and advocacy on the importance of education for girls where it was most needed. Since its inception, the GEU has worked to create scholarships for promising female students, revised textbooks to be more gender-sensitive, trained women on income-generating activities, created a Girls Education Week, put on Empowerment Camps and focused on partnerships with the private sector to meet the needs of female students (Lambert, Perrino, & Barreras, 2012).

Development Partners and International NGOs Interventions

The multilateral and bilateral agencies working to improve girls' education in Ghana include organizations such as UNICEF, WFP, DFID, USAID, and International Non-Governmental Organizations (INGOs) such as PLAN International, Action Aid International, OXFAM and the Foundation for African Women Educationalists (FAWE). The role of these development partners and INGOs is to promote a wide range of interventions and program to support girls across targeted districts where great disparities exist between girls and boys in education and

entrenched socio-cultural practices militate against the education of girls. These international agencies mostly work through local partners (government and local NGOs), communities and key stakeholders to ensure program goals and targets are achieved. The development partners work towards the removal of levies and other financial and non-financial barriers educational access at the national level. Some efforts at this stage are material support such as UNICEF's provision of bicycles; School Feeding and Take Home rations and supply of school equipment (IBIS et al., 2009). Most of the bilateral support from organizations is in the form of funding, technical support, logistic and capacity building (for example, making schools more child-friendly, capacity-building of women at grassroots level, School Health Education, Supporting education staff through data collection and supervision of projects). The International NGOs and their partners on the other hand provide support in the form of research, advocacy and community sensitization, sponsorships, formation of girls' clubs, provision of school infrastructure, micro credit schemes for parents and community mobilization using Participatory Learning Approach (PLA) (IBIS et al., 2009).

5.2 Trends in educational attainment

Data interpretation issues: The trends in access, retention and transition are based on data from the Ministry of Education's Annual School Census conducted between the 2001/2002 and 2013/2014 academic years. The Ministry of Education (MOE) conducts an annual school census, however not all schools, especially, private schools respond and return the requested information (Sutherland-Addy, 2002). Hence, the data might present some challenges. For instance, what may appear to be changes in enrolment could be a result of better records and more reliable information from one year to the other, rather than substantial changes in enrolment levels. This potential artifact of data has been taken into consideration in the interpretation of the data. In addition, it would have been ideal to analyze access, retention and transition by age of adolescent girls (15-19 years) and young women (20-24 years) as defined in this study. However, the MOE Annual School Census is based on the structure of the education system of Ghana: primary school (6-11 years), junior secondary (12-14 years), senior secondary (15-18 years) and Tertiary (19-24 years).

Educational attainment of adolescent girls and young women

Education provides people with knowledge and skills that can lead to better employment opportunities and quality of life. Educational level is also associated with the health of women and children as well as reproductive health behaviors (Ghana Statistical Service et al., 2015). Reaching adolescence represents a critical window during which interventions or program efforts can be directed at this age group to protect them from negative outcomes, which have implications for development.

Figure 5.2 shows the trend in adolescent girls' educational attainment from 1993-2014. With respect to the proportion of adolescent girls who attained middle/JSS/JHS education, there was an increase from 54.4% in 1993 to 58.8% in 1998, decreased slightly to 51.2% in 2003 and thereafter, increased to 55.7% in 2008 and 2014 respectively. Primary educational attainment increased from 15.7% in 1993 to 23.4%% in 2003, decreased slightly to 21.7% in 2008 and at about 23% in 2014. Adolescent girls with no educational attainment have seen somewhat of a consistent decline from 18% in 1993 to 4% in 2014. The proportion of adolescents who attained secondary education level has been increasing from 8.6% in 1998 to 17.3% in 2014.

Figure 5. 2: Trends in adolescent girls' educational attainment (GDHS, 1993-2014)

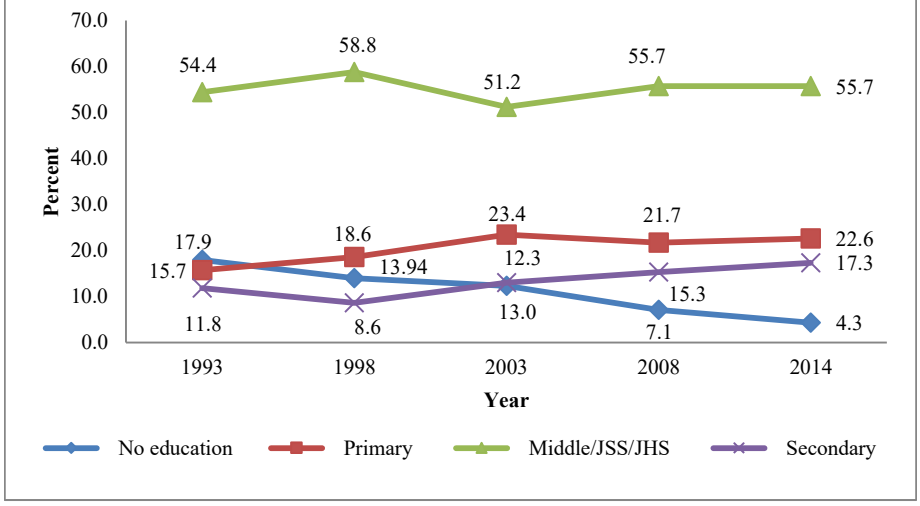
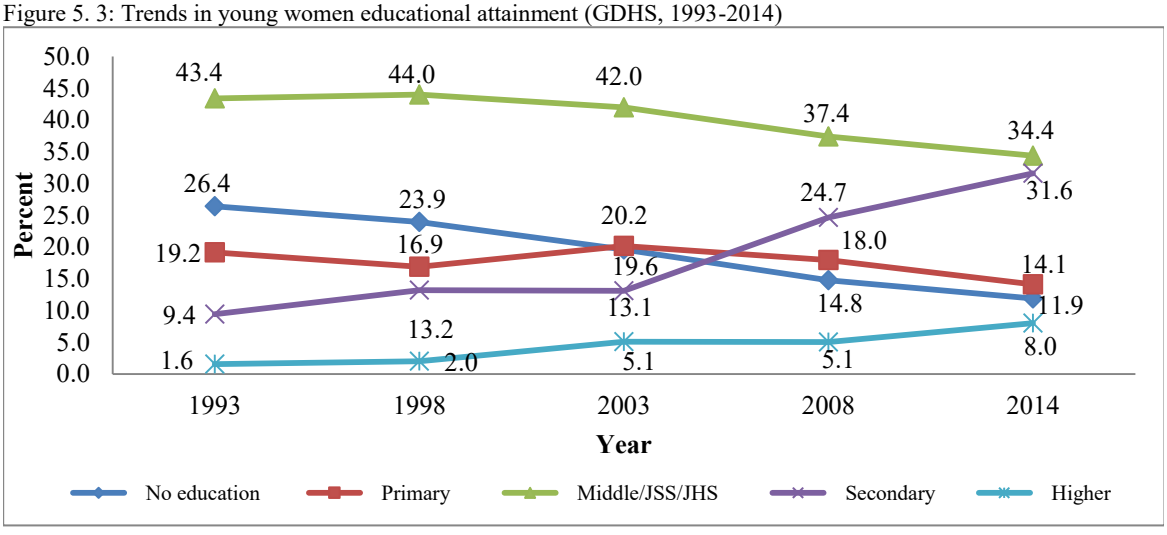


Figure 5.3 shows young women's educational attainment between 1993 and 2014. The proportion of young women who attained higher level of education has increased from 2% in 1993 and 1998 to 5% in 2003 and 2008 and increased to 8% in 2014. Both Figures 5.2 and 5.3 show an improvement in educational attainment of adolescent girls and young women. Worth noting is the higher proportions of young women (26.4% in 1993, 23.9% in 1998, 20.2% in 2003, 18.0% in 2008 and 11.9% in 2014) with no education compared to adolescent girls (17.9% in 1993, 13.9% in 1998, 12.3% in 2003, 7.1% in 2008 and 4.3% in 2014).

Figure 5. 3: Trends in young women educational attainment (GDHS, 1993-2014)



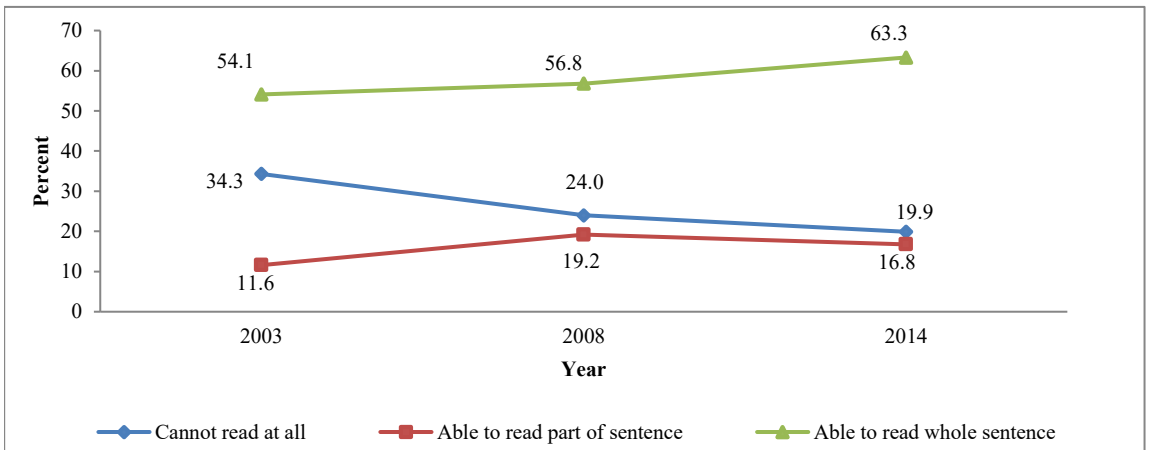
5.3 Trends in Literacy

The ability to read and write is widely acknowledged as an important asset benefitting both the individual and society. For women, literacy is associated with a number of positive outcomes, such as intergenerational health and nutritional benefits (Ghana Statistical Service et al., 2015). The 2003, 2008 and 2014 GDHS assessed respondents' ability to read among women who had never attended school and those who had primary or middle/JSS/JHS education to read. This was done by asking them to read a simple sentence in a local language (or in English). Respondents with secondary or higher education were assumed to be literate. Persons who were blind or visually impaired were excluded.

5.3.1 Trends in literacy of adolescent girls

Figure 5.4 shows that the proportion of adolescent girls who were able to read a whole sentence has consistently increased from 54.1% in 2003 to 56.8% in 2008 and 63.3% in 2014. The percent of adolescent girls who were able to read part of sentences increased from 12% in 2003 to 19% in 2008 and declined to 17% in 2014. The proportion of adolescent girls who cannot read at all consistently declined from 34% in 2003 to 20% in 2014.

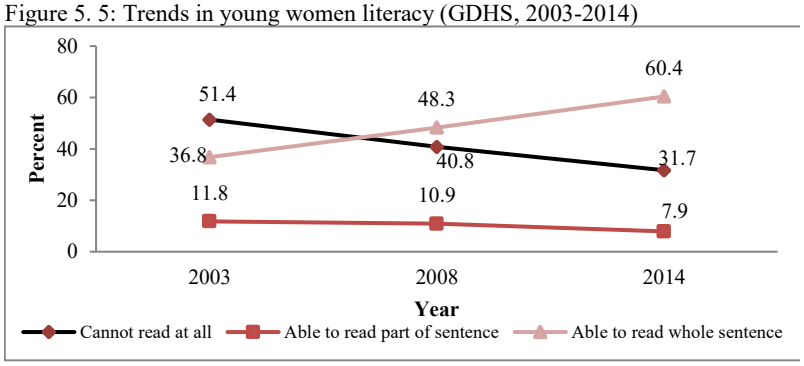
Figure 5. 4: Trends in adolescent girls' literacy (GDHS, 2003-2014)



5.3.2 Trends in literacy of young women

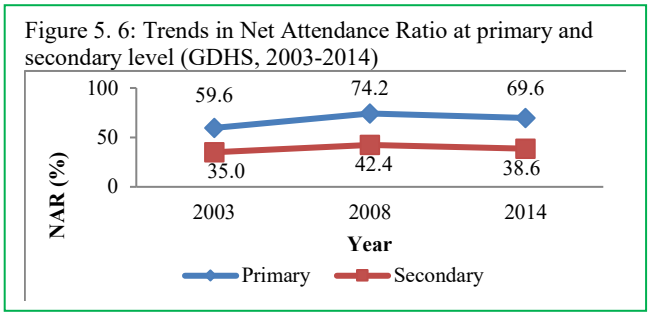
The proportion of young women who could read whole sentences increased from 37% in 2003 to 48% in 2008 and then to 60% in 2014 (Figure 5.5). On the contrary, the proportion of young women who were able to read part of sentences and those who could not read

Figure 5. 5: Trends in young women literacy (GDHS, 2003-2014)



at all consistently declined. Generally, both Figures 5.4 and 5.5 show improvement in literacy among adolescent girls and young women over the years. By 2014, about 2 out of 3 adolescent girls and young women were able to read a whole sentence correctly.

5.4 School attendance ratio



The GDHS collected information on school attendance among survey respondents in the 2003, 2008 and 2014 survey years. Specifically in 2003, the GDHS collected information on school attendance between the ages of 6 and 24 years, allowing for the computation of Net Attendance Ratios. In the 2008 and 2014 survey years, information was collected on school attendance between the ages of 3 and 24 years, covering pre-school years. Similar trends are observed in the Net Attendance Ratios for both primary (ideally 6-11 year olds) and secondary (ideally 12-14 year olds) levels, where Net Attendance Ratio increased between 2003 and 2008 and then declined in 2014. Indeed, the Net Attendance Ratios for girls in primary and secondary levels of education were at their highest in 2008, but both declined from 74% to 70% and 42% to 39%, respectively, in 2014 (Figure 5.6). Figure 5.6 also shows that over the years, attendance at the primary level has consistently been higher than at the secondary level.

5.5 Access to education

Indicators that measure coverage, and by extension, access to basic, secondary and tertiary levels of education are presented in this section. The indicators of access examined include admission, enrolment and gender parity. In addition, sex disaggregated results on admissions and enrolment from the primary to tertiary levels of education at the national level are examined from the 2001 to 2014 academic years (when data is available for the entire period).

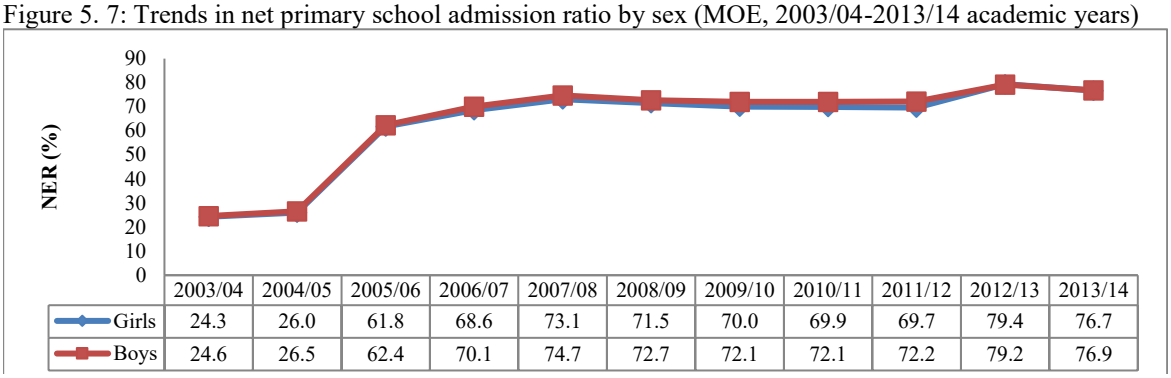
5.5.1 Trends in admission rates by sex (2003/04 – 2013/14 academic years)

Figure 5.7 shows the trends in net admission ratio for adolescent girls and boys aged 6 to 11 years who attended primary school within the 11 years' period. Primary school admission of girls improved steadily from 24% in the 2003/04 academic year to 73% in the 2007/08 academic year. While there is lack of empirical evidence to determine the factors leading to this increase, a significant factor that could account for this sharp rise was the nationwide adoption of the 'Capitation Grant' system in early 2005. The Capitation Grant allowed every public kindergarten, primary school and junior secondary school to receive a grant of the equivalent of $3.30 per pupil.

The net primary school admission rates after the 2007/08 academic year started to decline until the 2012/13 academic, 79.4% for girls and 79.2% for boys. Net primary school admission rates for girls in recent years have almost equaled that of boys (20012/13, 2013/14) though over most of the academic years, more boys were admitted in primary school than

girls. The convergence of net primary school admission ratios by sex at the national level in 2008 and 2014 are very encouraging (Figure 5.7), even though admission rates at this level only tell of the ratio of boys and girls who are in school but not those who are not in school.

Figure 5. 7: Trends in net primary school admission ratio by sex (MOE, 2003/04-2013/14 academic years)

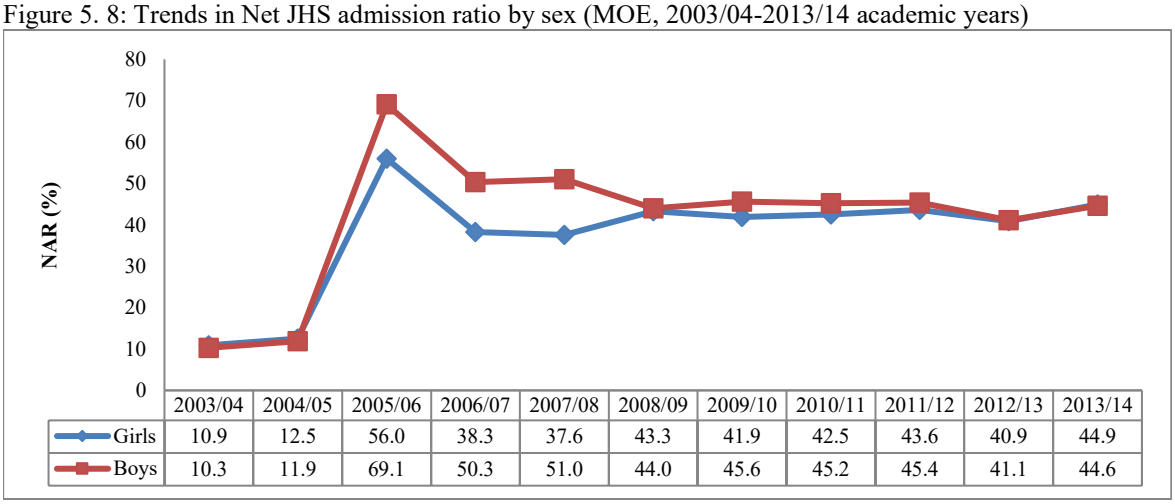


	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	24.3	26.0	61.8	68.6	73.1	71.5	70.0	69.9	69.7	79.4	76.7
Boys	24.6	26.5	62.4	70.1	74.7	72.7	72.1	72.1	72.2	79.2	76.9

Junior High School (JHS) admission ratio by sex

Trends in Net Admission Ratio for girls and boys at the Junior High School level for the 2003/04 to 2013/14 academic years show that the Net Admission Ratio for girls increased steadily from 10.9% in the 2003/04 academic year to its peak of 56% in the 2005/06 academic year (Figure 5.8). However, there was a decline after the 2005/06 academic year, with the rate reaching a low of 38% in the 2007/08 academic year for girls and 41% in the 2012/13 academic year for boys (Figure 5.8). In the 2008/09 academic year, the Net Admission Ratio for JHS was the same for both boys and girls. This was also the case in the 2012/13 and 2013/14 academic years.

Figure 5. 8: Trends in Net JHS admission ratio by sex (MOE, 2003/04-2013/14 academic years)



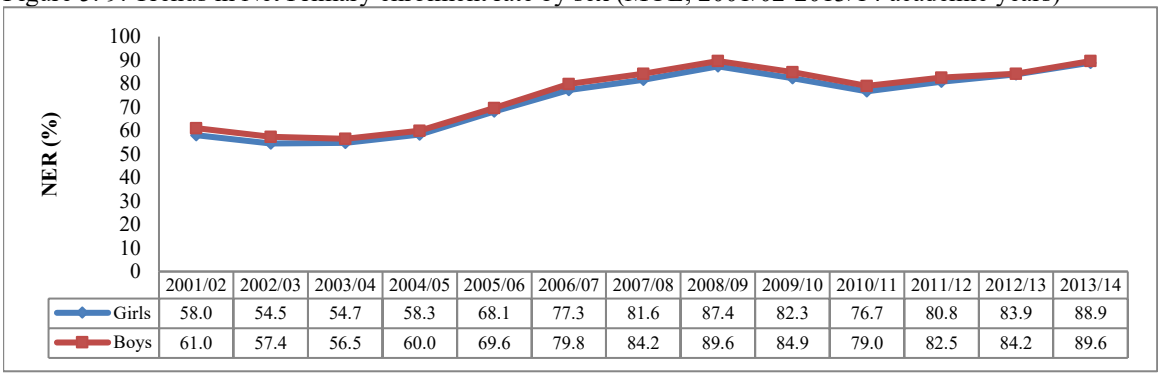
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	10.9	12.5	56.0	38.3	37.6	43.3	41.9	42.5	43.6	40.9	44.9
Boys	10.3	11.9	69.1	50.3	51.0	44.0	45.6	45.2	45.4	41.1	44.6

5.5.2 Enrolment by sex at primary (2001/02 to 2013/14 academic years)

Although trends in Net Enrolment Rate (NER) at the primary level have fluctuated over the course of two decades, rates for both girls and boys have remained almost identical for the 2001/02-2013/03 academic years (Figure 5.9). Nevertheless, the net enrolment rate for boys compared to girls from the 2001/02 academic year to the 2011/12 academic year was higher.

However, in the 2012/13 and 2013/14 academic years, the NER rates were the same for girls and boys.

Figure 5. 9: Trends in Net Primary enrolment rate by sex (MOE, 2001/02-2013/14 academic years)

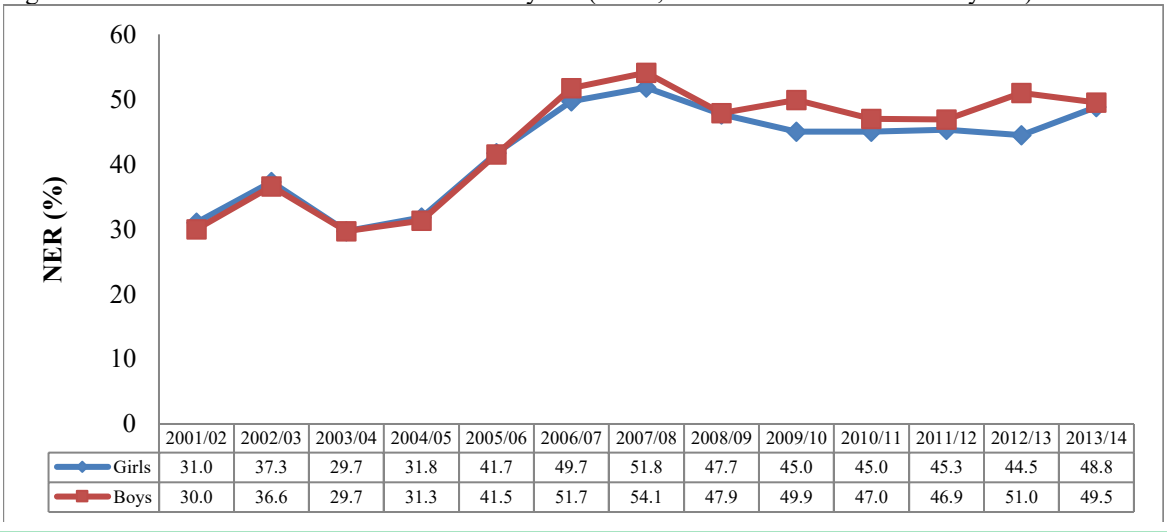


	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	58.0	54.5	54.7	58.3	68.1	77.3	81.6	87.4	82.3	76.7	80.8	83.9	88.9
Boys	61.0	57.4	56.5	60.0	69.6	79.8	84.2	89.6	84.9	79.0	82.5	84.2	89.6

Enrolment by sex at JHS levels (2001/02 to 2013/14 academic years)

From the 2001/02 to 2005/06 academic years, the NER at the JHS levels fluctuated from approximately 30% to 41.5% respectively. During this period the rates for girls and boys were equal (Figure 5.10). From 2006/07 to 2012/13, girls lagged behind boys in terms of enrolment at the JHS level, but reached parity again in 2013/14. Similar to the admission rates, the nationwide adoption of the Capitation Grant system in the 2005/06 academic year could have accounted for the improvement in enrolment between 2005/06 to 2008/09 academic years.

Figure 5. 10: Trends in Net JHS enrolment rate by sex (MOE, 2001/02-2013/14 academic years)

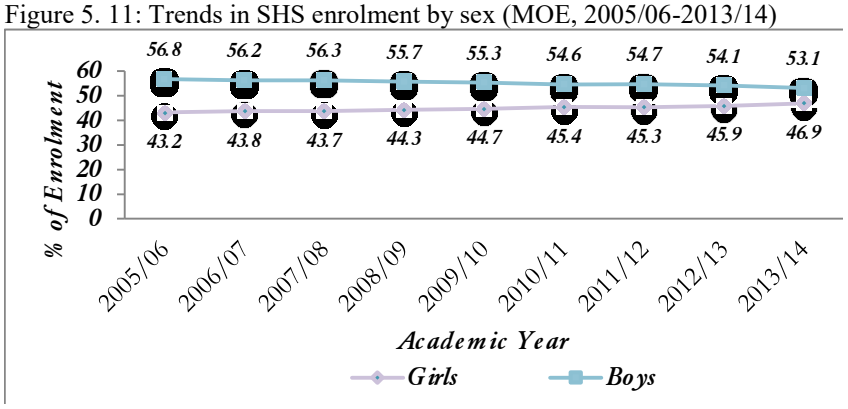


	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	31.0	37.3	29.7	31.8	41.7	49.7	51.8	47.7	45.0	45.0	45.3	44.5	48.8
Boys	30.0	36.6	29.7	31.3	41.5	51.7	54.1	47.9	49.9	47.0	46.9	51.0	49.5

Secondary school enrolment rate by sex (2005/06 – 2013/14 academic years)

Figure 5.11 shows the trends in Senior High School (formerly Senior Secondary School) enrolment over a nine-year period for girls and boys. While enrolment of boys has been higher than that of girls, the SHS enrolment gap is narrowing with time, with girls at 43% and boys at 57% in the 2005/06 academic year and girls at 47% compared to 53% for boys in 2013/14.

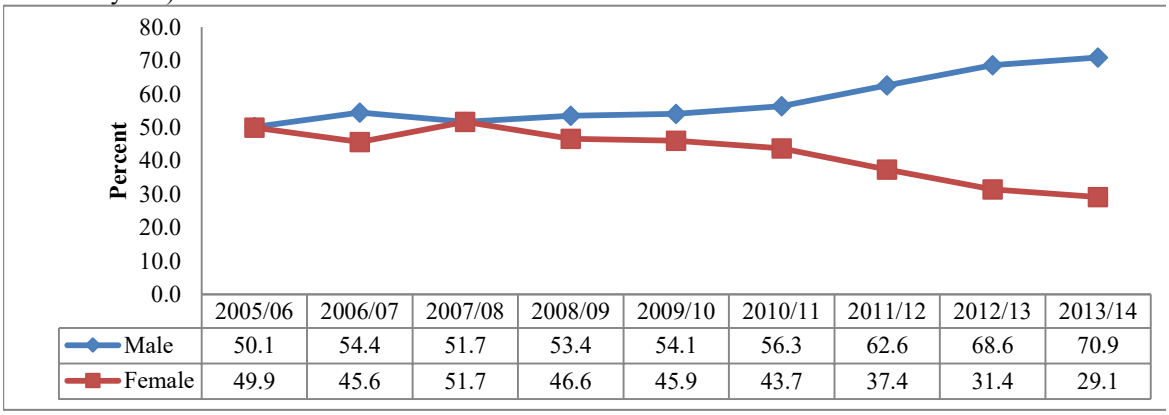
Figure 5. 11: Trends in SHS enrolment by sex (MOE, 2005/06-2013/14)



Technical and Vocational Institutes Enrolment

Enrolment in Technical and Vocational Institutes (TVIs) over the years has been inconsistent. Starting at about 50% for both males and females in the 2005/06 academic year, enrolment for females in Technical and Vocational Education Training (TVET) declined to 45.6% in the 2006/07 academic year, increased to 51.7 in 2007/08 academic years and thereafter, steadily decreased to 29.1% in the 2013/14 academic year. However, the enrolment of males in Technical and Vocational Institutions increased from 50.1% in 2005/06 academic years to 54.4% in 2006/07 academic year, decreased to 51.7% in the 2007/08 academic year and consistently increased to 70.9% in 2013/14 academic year (Figure 5.12).

Figure 5. 12: Trends in Technical and Vocational Institutions enrolment by sex (MOE, 2001/02-2013/14 academic years)



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Male	50.1	54.4	51.7	53.4	54.1	56.3	62.6	68.6	70.9
Female	49.9	45.6	51.7	46.6	45.9	43.7	37.4	31.4	29.1

Tertiary Level Enrolment

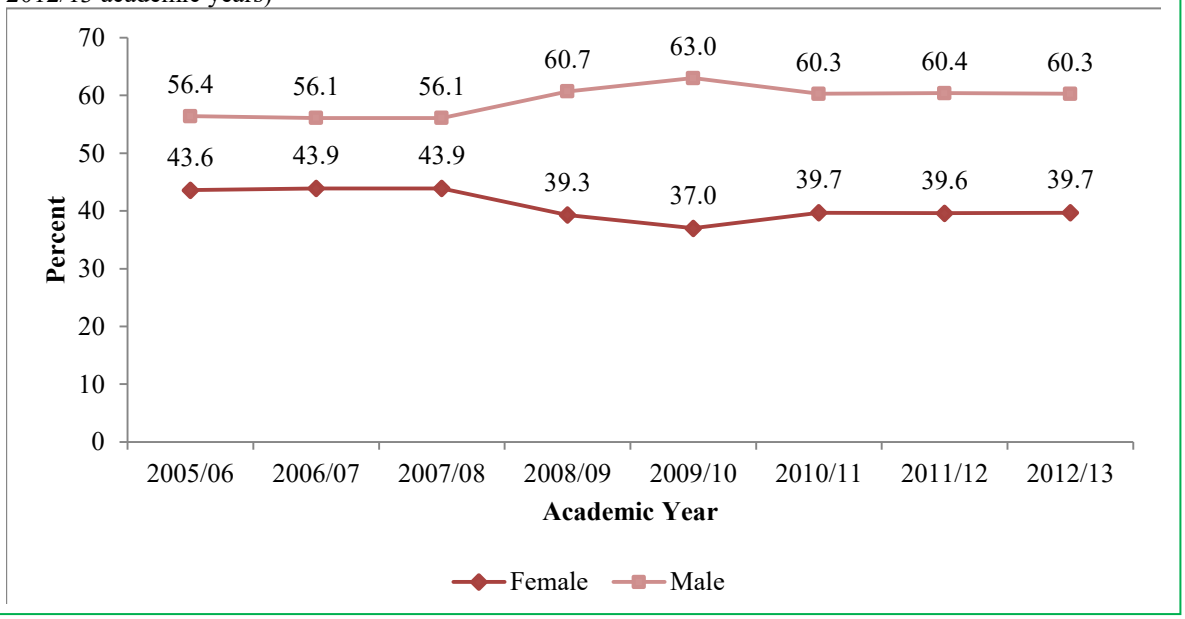
The commencement of the Education Reform Program of 1987 led to the categorization of all post senior secondary level institutions as tertiary. Thus, Training Colleges, Polytechnics and Universities are all considered as tertiary institutions. Available data on overall enrolment in these institutions are analyzed below to examine whether policies on retention implemented over the last two decades at the basic and secondary levels are yielding results at the upper

echelons of the educational ladder and also to examine the gender difference in enrolment over the years.

Enrolment in Teacher Training Colleges

There are currently 41 Colleges of Education in Ghana (Ministry of Education, 2013). Out of this number, seven are female-only institutions, one is male-only and the remaining are mixed-gender institutions. Figure 5.13, shows that the proportion of females enrolled in TTCs are lower than the proportion of males from the 2005/06 to the 2012/13 academic years.

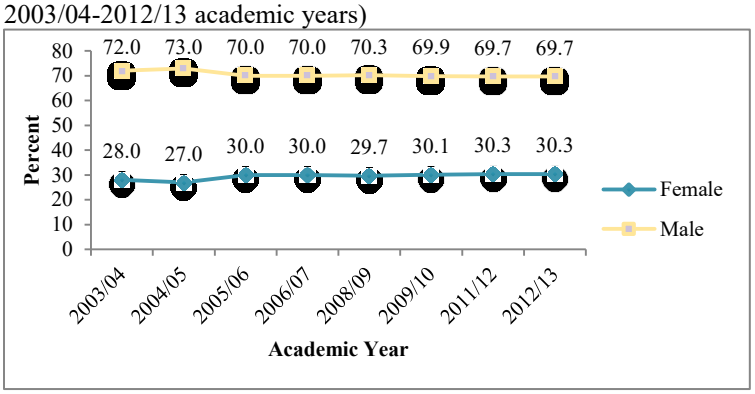
Figure 5. 13: Trends in proportion of enrolment in Teacher Training Colleges by sex (MOE, 2005/06-2012/13 academic years)



Enrolment in Polytechnics

Offering courses such as engineering, accounting secretarial studies, and management and marketing, polytechnics provide an avenue for individuals who have completed Senior High School to further their education through technical or professional education. These courses usually last between three to four academic years. Figure 5.14 shows the distribution of enrolment for both full and part-time students in eight academic years. For females, enrolment into polytechnics between 2003/04 (28%) and 2004/05 (27%) academic years did not really reduce significantly, however, it increased to 30% from 2005/06 to 2012/13 academic years. The enrolment of males compared to females has been relatively higher in all academic years.

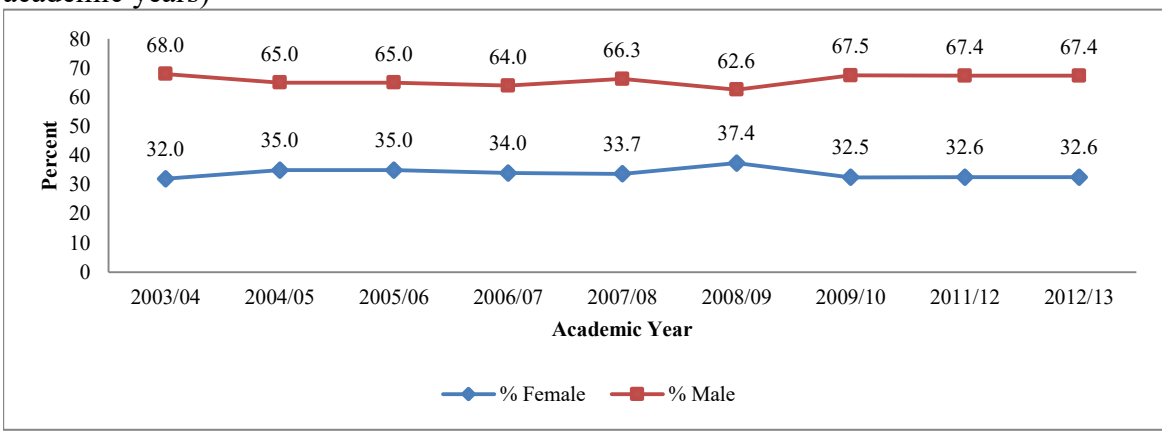
Figure 5. 14: Trends in Polytechnic enrolment in by sex (MOE, 2003/04-2012/13 academic years)



Enrolment in Universities

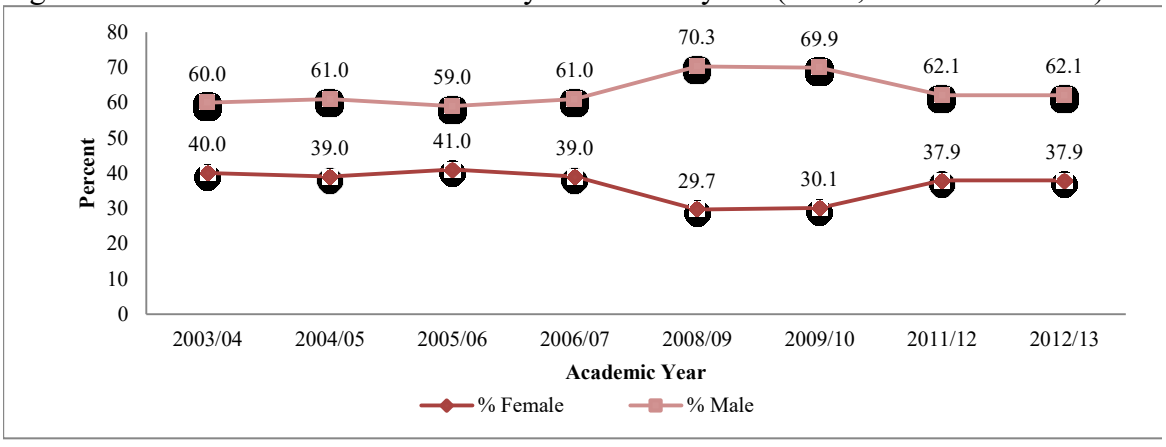
Generally, the enrolment of females compared to males into public universities has been lower from the 2003/04 academic year to the 2012/13 academic year. The difference in enrolment between males and females in public universities does not appear to be getting better across the years. In the 2003/04 academic year, 68% of male and 32% of females were enrolled into public universities. In the 2012/13 academic year, 67% of males and 33% of females were enrolled into public universities (Figure 5.15).

Figure 5. 15: Trends in Public University enrolment by sex (MOE, 2003/04-2012/13 academic years)



In the private universities, more males were enrolled than females. Worthy of note is the enrolment rate between the 2006/07 academic year and the 2011/13 academic year for both females and males. The enrollment of females declined from 39% in 2006/07 to 30% in 2008/09 and 2009/10 and then increased to 38% in the 2011/12 academic years and remained the same in the 2012/13 academic year. However, the enrollment of males was the opposite increasing from 61% in 2006/07 to 70% in 2008/09 and 2009/10 academic years and thereafter, declined to 62% and remained the same in the 2012/13 academic year (Figure 5.16).

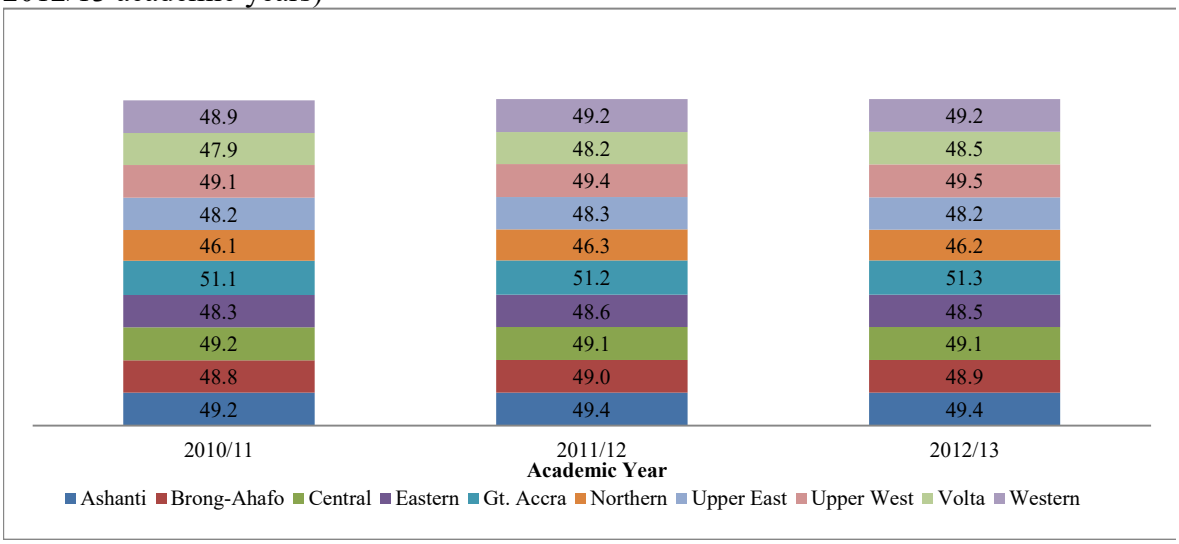
Figure 5. 16: Trends in Private University enrolment by sex (MOE, 2003/04-2012/13)



Proportion of females in Primary, JHS and SHS level by region (2010/11-2012/13 academic years)

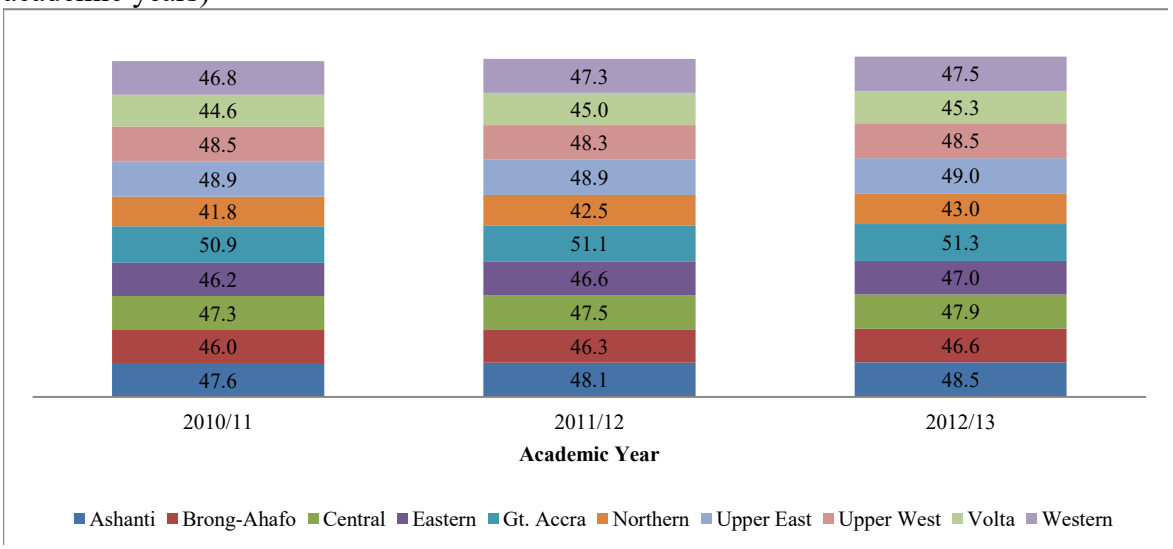
Figure 5.17 shows the trends in the proportion of girls in primary school by region. The three Northern regions and Volta region showed the least enrolment rates at all these levels. At the SHS level, the Brong Ahafo Region also recorded low female enrolment rates. The Greater Accra region recorded the highest rates at the primary and JHS levels. It is also worth noting that in all the regions and at all levels, the enrolment rates of girls has been increasing. In 2010/2011, the proportion of girls at the primary level ranged from 46.1% in the Northern region to 51.1% in the Greater Accra region, in the 2012/13 academic year the range was between 46.2% and 51.3% in the same regions.

Figure 5. 17: Trends in the proportion of girls in primary school by region (MOE, 2010/11-2012/13 academic years)



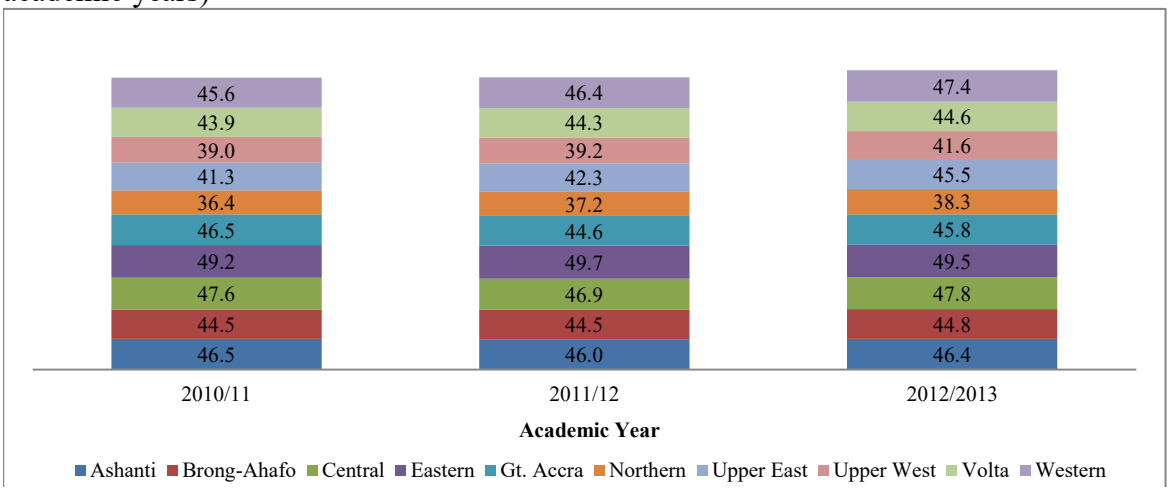
At the JHS level, the proportion of girls ranged from 41.8% to 50.9% in the 2010/11 academic year to 43.0% to 51.3% in the 2012/13 academic year as seen in Figure 5.18.

Figure 5. 18: Trends in proportion of girls in JHS by region (MOE, 2010/11-2012/13 academic years)



Compared to the Primary and JHS levels, the proportion of girls enrolled at the SHS level across the 10 regions in the past three years has been low (Figure 5.19). Girls' enrolment ranged between 36.4% and 49.2% in the 2010/11 academic year. The range however improved slightly in the 2012/13 academic year (between 38.3% and 49.5%). Contrary to the Primary and JHS level where the Greater Accra Region recorded highest proportion of enrolment, the proportion of girls at the SHS level was consistently highest in the Eastern Region over the three-year period.

Figure 5. 19: Trends in proportion of girls in SHS by region (MOE, 2010/11-2012/13 academic years)

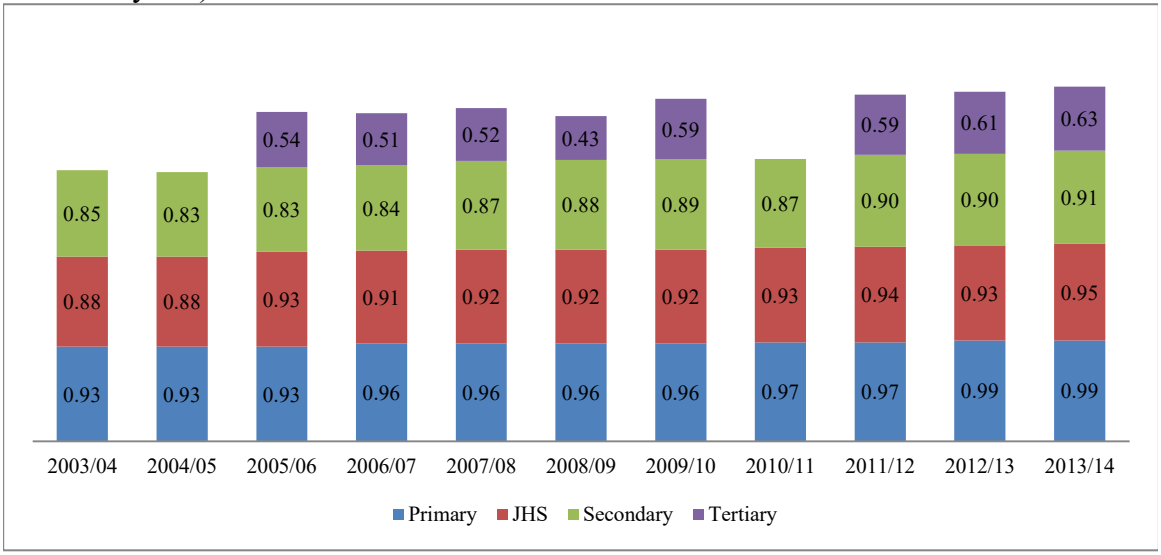


Gender parity

The GPI at the primary and JHS level (Ministry of Education, 2010, 2015) as at the 2013/14 academic year was at 0.99 and 0.95 respectively which indicates an almost equal parity reached at the primary school level while a difference still exists at the JHS level. A GPI of 0.91 at the secondary level (Ministry of Education, 2015) is very encouraging and gives an indication that should the trend continue to see an increase as it has been over the years parity

could also be reached at the secondary level. The gap between females and males education at the tertiary level (Ministry of Education, 2015) is still wide though it keeps closing over the years.

Figure 5. 20: Trends in GPI at all levels of education in Ghana (MOE, 2003/04-2012/13 academic years)



Note: Data on tertiary education GPI not available for 2003/04, 2004/05 and 2010/11

5.6 Retention

5.6.1 Primary school retention by sex

Table 5.1 shows the retention rates from primary 1 (P. 1) to primary 6 (P. 6) for seven cohorts of pupils who started school between the 2002/03 and 2008/09 academic years. In all comparisons, the retention rate from P. 1 to P. 6 was higher among females than males. Perhaps this could be explained by the emphasis on girl-child education in the country over the years. Retention rate from P. 1 to P. 6 for girls ranged from a high of 770 out of every 1000 in the 2004/05-2009/10 academic years to a low of 576 out of every 1000 in the 2008/09-2013/14 academic years for girls. Among boys, the highest rate of retention from P. 1 to P. 6 was recorded in 2005/06-2010/11 academic years (681 per 1000) and the lowest recorded in the 2008/09-2013/14 academic years was 515 per 1000. Nevertheless, the retention rate for girls has been declining since the 2004/05-2009/10 academic years to the 2008/09-2013/14 academic years. With boys, it has been declining from 2005/06-2010/11 academic years to the 2008/09-2013/14 academic years.

Table 5. 1: Retention of seven cohorts who started P. 1 and got to P. 6 (MOE, 2002/03 – 2013/14, academic years)

Academic Year	P. 1 Enrolment		Retention P. 6	
	Girls	Boys	Girls	Boys
2002/03 – 2007/08	1000	1000	723	634
2003/04 – 2008/09	1000	1000	747	655
2004/05 – 2009/10	1000	1000	770	669
2005/06 – 2010/11	1000	1000	769	681
2006/07 – 2011/12	1000	1000	700	620
2007/08 – 2012/13	1000	1000	632	563
2008/09 – 2013/14	1000	1000	576	515

5.6.2 Retention at JHS level by sex

Retention from ten cohorts of students from JHS 1 to JHS 3 from the 2002/03–2013/14 academic years show that contrary to what was observed in retention rate in primary school, retention rate from JHS 1 to JHS 3 is higher among boys compared to girls in all comparisons. Retention of girls, highest (910 per 1000) in the 2004/05 – 2006/07 academic years, has seen a steady decline to 758 per 1000 in the 2011/12-2013/14 academic years (Table 5.2). These numbers signify relatively higher attrition for girls than boys.

Table 5. 2: Retention of ten cohorts who started JHS 1 and got to JHS 3 (MOE, 2002/03 – 2013/14 academic years)

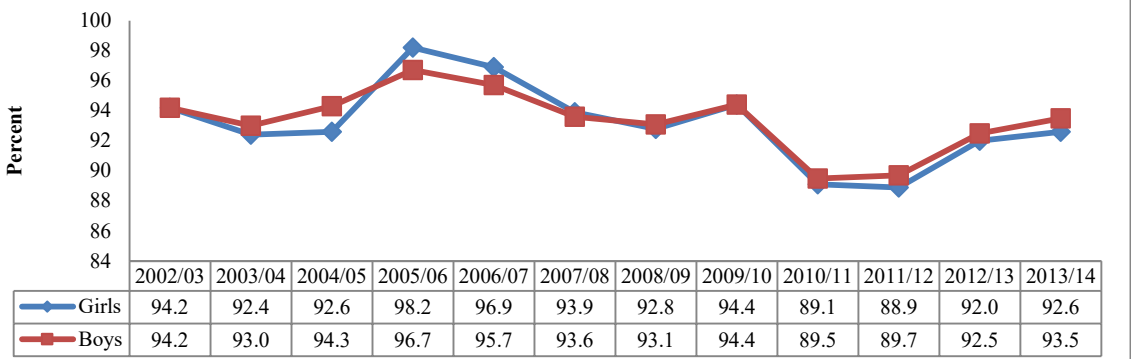
Academic Year	JSS 1 Enrolment		Retention at JSS 3	
	Girls	Boys	Girls	Boys
2002/03 – 2004/05	1000	1000	866	867
2003/04 – 2005/06	1000	1000	843	856
2004/05 – 2006/07	1000	1000	910	931
2005/06 – 2007/08	1000	1000	814	841
2006/07 – 2008/09	1000	1000	831	857
2007/08 – 2009/10	1000	1000	822	848
2008/09 – 2010/11	1000	1000	812	838
2009/10 – 2011/12	1000	1000	777	803
2010/11 – 2012/13	1000	1000	765	791
2011/12 – 2013/14	1000	1000	758	785

5.7 Transition

5.7.1 Transition from Primary 6 to JHS 1

Figure 5.21 shows the transition rates of pupils from Primary 6 (P. 6) to JHS 1 for 12 academic years (2002/03-2013), by sex. The trend in transition from P. 6 to JHS 1 has been wavering over the years. While the transition rates were higher among girls than boys between the 2005/06 and 2007/08 academic years, the rates remained at par for both girls and boys between the 2007/08 and 2010/11 academic years, after which the rates for girls have been slightly, but consistently lower.

Figure 5. 21: Trends in transition of pupils from P. 6 to JHS 1 by sex (MOE, 2002/03-2013/14 academic years)

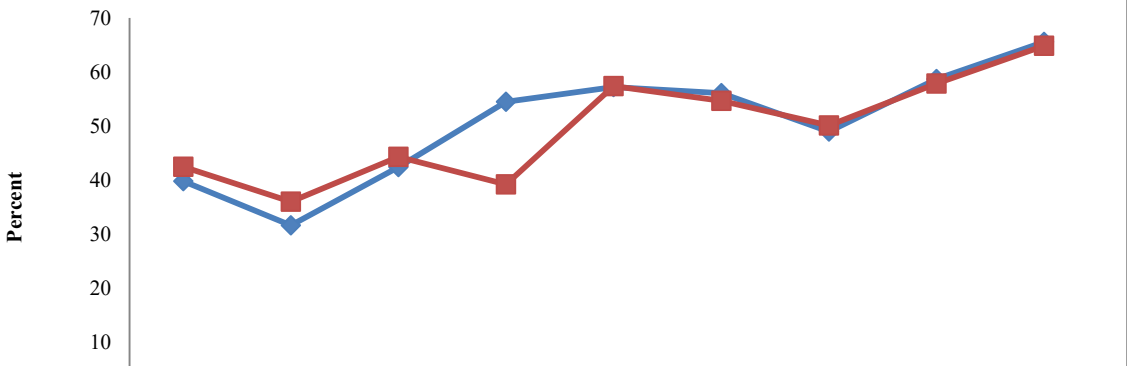


	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	94.2	92.4	92.6	98.2	96.9	93.9	92.8	94.4	89.1	88.9	92.0	92.6
Boys	94.2	93.0	94.3	96.7	95.7	93.6	93.1	94.4	89.5	89.7	92.5	93.5

5.7.2 Transition from JHS 3 to SHS 1

From 2005/06 to 2007/08 academic years, transition rates from JHS 3 to SHS 1 for girls and boys followed similar trends, although slightly lower among girls. The 2008/09 academic year experienced a drastic change in pattern, where transition rates among girls surged from 42% in the previous academic year to 54%. On the other hand, the rate for boys decreased from 44% in 2007/08 to 39% in the 2008/09 academic year. Both rates converged in 2009/10 and remained at par until the 2013/14 academic year (Figure 5.18). The steady increase in transition rate of girls from 2006/07 to 2009/10 academic year is likely to be the result of effective implementation of measures and programmatic interventions by the Government of Ghana to improve girl-child education (Figure 5.22).

Figure 5. 22: Trends in transition of JHS 3 Pupils to SHS 1 (MOE, 2005/06-2013/14 academic years)

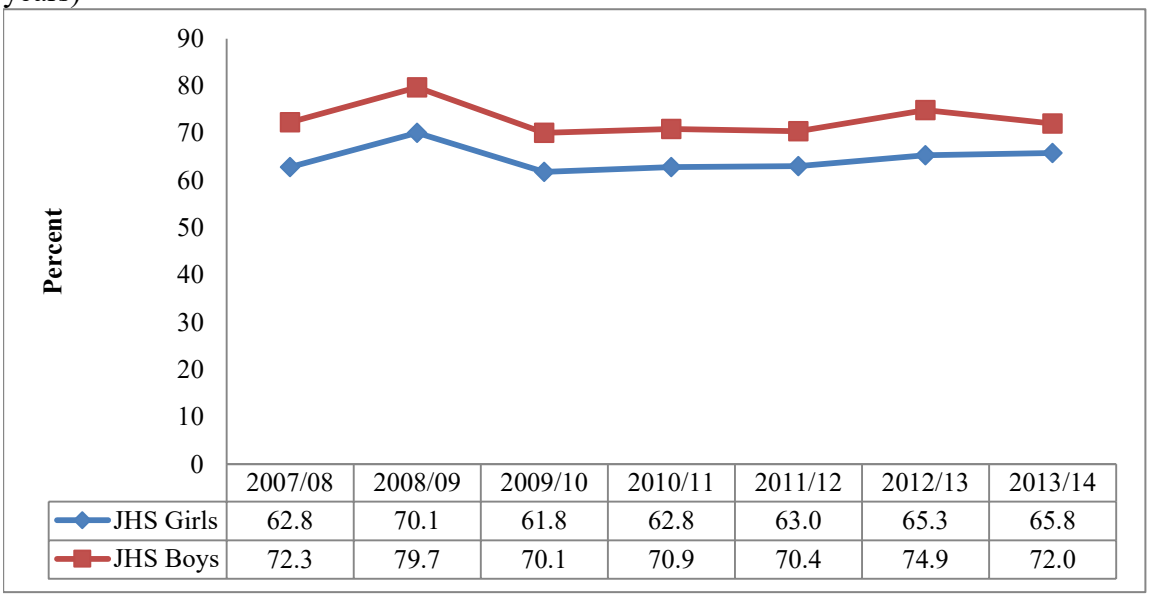


	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Girls	39.8	31.6	42.4	54.5	57.2	56.1	49.0	58.7	65.6
Boys	42.5	36.0	44.3	39.2	57.4	54.7	50.1	57.9	64.9

5.7.3 Completion Rates for JHS (2007/08 – 2013/14)

Regarding trends in completion rates for girls and boys at the junior high school level over the seven-year period (2007/08 to 2013/14 academic years), boys consistently had a higher completion rate than girls (Figure 5.23).

Figure 5. 23: Trends in Net JHS completion by sex (MOE, 2007/08-2013/14 academic years)



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
JHS Girls	62.8	70.1	61.8	62.8	63.0	65.3	65.8
JHS Boys	72.3	79.7	70.1	70.9	70.4	74.9	72.0

The trend in access, retention and transition as presented show that there has been improvement in admission and enrolments of girls and young women at the four levels of education assessed in Ghana.

5.8 The achievements of policies, plans and programs on girl-child education

The Government of Ghana has made considerable progress towards improving access, retention and transition in education, especially in basic education (six years of primary and three years of JHS). Several initiatives have helped to drive this expansion. These include the introduction of a Capitation Grant for all basic schools, school meals program, construction of additional schools, free school uniforms for the poor pupils, the take home rations program to encourage girl's education in the three Northern regions and subsidies and grants to students enrolled in tertiary education.

The Government of Ghana's Education White Paper

The overarching target of the government's White Paper on Education Reform in 2004 was 100% completion rates for male and female students at all basic levels by 2015. Available data show that in 2014, the primary completion rate was 99% for boys and 95.9% for girls. That of the JHS was 72% for boys and 65.8% for girls, which shows that the target of 100% completion rate is yet to be achieved (Ministry of Education, 2014b).

Capitation Grant (School Fee Abolition)

The Government of Ghana's Free Compulsory Universal Basic Education (FCUBE) program in 1996 mandated that no child be turned away from school for non-payment of fees. However, the initiative did not yield the expected results as about 40% of children who were supposed to be enrolled at the primary school level (6-11 years) remained out of school as of 2003. Prominent among the reasons why these children did not attend school was that their parents could not afford to pay the levies charged by the schools (United Nations Children's

Fund, 2007). In spite of the policy of free tuition in basic schools, levies were still charged as a means of raising funds, for activities such as making repairs, and for participation in cultural and sporting activities. This had the effect of deterring many families, particularly the poorest, from sending their children, especially girls, to school (United Nations Children's Fund, 2007).

The steps the government took in the 2003-2015 Education Strategic Plan to abolish all fees charged by schools and also provided schools with small grants for each pupil enrolled. The program, first piloted (with World Bank support) in Ghana's 40 most deprived districts in 2004 resulted in an overall increase in enrolment by 14.5%, with the enrolment for pre-school particularly being significant (over 36%). This success led to the nationwide adoption of what is known as the 'Capitation Grant' system in early 2005 (United Nations Children's Fund, 2007).

Replacing school fees with the Capitation Grant had a positive impact on many enrolment-related figures during the 2005/06 school year especially in net admission and enrolment rates at the basic levels of education. For example, primary school net admission ratio increased by almost 36% for both girls and boys between the 2004/05 and 2005/06 academic years. The primary school net admission ratio further increased to 79% for both boys and girls, reaching an all-time high in 2012/13 but decreased to 76.9% in the 2013/14 academic year. Between 2004/05 and 2005/06 academic years, net admission ratio at the JHS level increased from 13% to 56% for girls and from 12% to 69% for boys but declined to 45% for girls and 45% for boy in 2013/14. In addition, primary school net enrolment increased from 58% for girls and 60% for boys in 2004/05 academic year to 89% for girls and 90% for boys in 2013/2014 academic year.

Ghana School Feeding Program

The Government's School Feeding Program initiative in 2005, which aimed to reduce malnutrition among school-aged children, together with the Capitation Grant contributed to the improvement in enrolment rates and retention of pupils at the basic level. By removing the barrier of school fees, accessibility for children from poorer backgrounds increased and the provision of a daily meal has served as a further incentive for pupils to attend school regularly (Anecdotal evidence).

Establishment of the Girls Education Unit (GEU)

The Girls' Education Unit established in 1997 with the aim of addressing the gender disparities in education has designed and implemented programs geared towards attracting and retaining girls in schools through sensitization and advocacy on the importance of education for girls (United Nations Children's Fund, 2007). Most likely, these activities have contributed to the improvement in the Gender Parity Index (GPI) for primary, JHS and SHS levels. The GPI at the primary and JHS levels as at the 2013/14 academic year was 0.99 and 0.95 respectively, which indicates an almost equal parity at both levels. A GPI of 0.91 at the secondary level is also very encouraging and gives an indication that should this trend continue, parity could also be reached at the secondary level.

Development Partners and International NGOs Interventions

The multilateral and bilateral agencies such as UNICEF, WFP, DFID, and USAID have all played a crucial role in education in Ghana. In a study to assess the impact and effectiveness of development partners and INGOs in promoting girls' education, it was found that advocacy and sensitization of communities by NGOs was one of the strongest areas of activity. A well-sensitized community and signs of government commitment the study noted, create the ideal environment for interventions promoting girls' education. Teachers and chiefs were among the focus for creating support at community level for efforts at increasing enrolment in rural districts. Further, scholarship schemes aided decisions to enter into formal education, with girl clubs and other female centered programs transforming pupils into being more confident and studious. These gains notwithstanding, the study further noted that indicators measured by these agencies, especially the INGOs needed to be streamlined and made uniform to assist in assessment (Sutherland-Addy, 2002).

5.9 Gaps and Barriers in the Data in education

Key data and information gaps regarding issues pertaining to education of adolescent girls and young women identified include limited information on out-of-school children, what measures are being put in place to get them back to school and ensure they stay in school. There is no information on explanation of the drop in NER in Primary and Junior High school between 2009 and 2011. In addition, there should be empirical evidence (quantitative and qualitative) to identify the reasons for low enrolment of females in TVET, Polytechnics and Colleges of Education.

6 CHILD MARRIAGE

Highlights:

- *Child marriage declined from 28% in 2003 to 25% in 2008 and 21% in 2014*
- *In rural areas, child marriage decreased from 39% in 2003 to 27% in 2014. In urban areas, it declined from 18% in 2003 to 16% in 2014*
- *Child marriage among young women who have never attended school decreased from 49% in 2003 to 46% in 2008 and 2014*
- *The drivers of child marriage include poverty, lack of education, residence, pregnancy and cultural practices such as exchange of girls for marriage*
- *The consequences of child marriage include; dropping out of school, pregnancy complications, loss of autonomy, gender-based violence against girls*

6.1 Introduction

Child marriage (also known as early marriage) is defined as "both formal marriages and informal unions in which a girl lives with a partner as if married before the age of 18" (United Nations Children's Fund, 2005, p. 4). The definition of a child in the Ghanaian context conforms with the definition of child marriage by UNICEF (Republic of Ghana, 1998). Despite recent declines, child marriage is a practice that has persisted through generations in many parts of the developing world (Singh & Samara, 1996; United Nations Children's Fund, 2014). In developing countries, every third young woman excluding China continues to marry as a child, before age 18 (Santhya, 2011). While age at first marriage is generally increasing around the world, in many parts of South Asia and sub-Saharan Africa, a significant proportion of girls still marry before their 18th birthday (Lloyd, 2006).

It has been estimated that 720 million women alive today married or entered into union before their 18th birthday (United Nations Children's Fund, 2014). Should the current trend continue, developing countries will witness an increase in the number of child marriages: 142 million child marriages in 2011-2020 and 151 million in the subsequent decade (United Nations Population Fund, 2012). In developing countries, it is estimated that one in seven girls marry before age 15 and that 38% marry before age 18 (UNFPA & UNICEF, 2011). In Ghana, 4.4% and 5.8% of women age 15-49 married by exact age 15 in 2006 and 2011 respectively. In addition, among women age 20-24, the proportion who married before exact age 18 was 22% in 2006and 21% in 2011 (Ghana Statistical Service, 2006, 2011).

Child marriage is sometimes perceived to be a protective mechanism against premarital sexual activity, unintended pregnancies, and sexually transmitted diseases (STDs) (Nour, 2006). However, it undermines the fundamental human rights of children. Further, child marriage undermines some of the Sustainable Development Goals (1-*no poverty*, 2-*zero*

hunger, 3-*good health and well-being*, 4-*quality education* and 5-*gender equality*) as it denies girls and young women access to education, good health and freedom (UNDP, n.d.).

6.1.1 Legal norms in relation to child marriage

Child marriage violates Article 16(2) of the Universal Declaration of Human Rights, which states that "Marriage shall be entered into only with the free and full consent of the intending spouses". It also violates Article 16 of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) that women should have the same right as men to "freely choose a spouse and to enter into marriage only with their free and full consent".

The 1998 Children's Act of Ghana and the 1992 Constitution of Ghana defines a child as a person below the age of 18. By age 18, young persons are expected to have developed sufficient intellectual, emotional and physical skills, and resources to fend for themselves as well as to successfully transition into adulthood. Until then they require care from adults, support, guidance and protection (Republic of Ghana, 1998). The 1998 Children's Act of Ghana also indicates that children should not be forced into marriage and that the minimum age at marriage shall be 18 years (Panel 8).

Panel 8: Legislation on protecting children from early marriage

The 1998 Children's Act of Ghana (Act 560)

Right to refuse betrothal and marriage

14. (1) No person shall force a child –

(a) to be betrothed;

(b) to be the subject of a dowry transaction; or

(c) to be married

(2) The minimum age of marriage of whatever kind shall be eighteen years.

Even though Ghana is among the signatories to several International Conventions such as the UN Convention on the Rights of the Child and Convention on Eliminating Discrimination against Women, many girls' marriage rights are being violated with the persistence of child marriage.

There is commitment towards curbing child marriage in Ghana. The country recently launched a campaign in February 2016 to end the practice of child marriage. The First Lady of Ghana during the launch said that ending child marriage on the continent is critical to the realization of the Sustainable Development Goals (SDGs) on gender equality and poverty. She urged all African heads of state to enforce the legislation passed on the marriageable age for girls at 18 in their respective countries. She made mention of the negative consequences of the practice which were drawing girls or young women backward, depriving them of their health, education and right to a fulfilling life. It also holds back their families, communities and the country as a whole. She added that anytime a child is married, it shows our failure as an international community to care a little more.

The Ministry of Gender, Children and Social Protection established an Ending Child Marriage Unit in 2014. The Unit has since led efforts to promote and coordinate national

initiatives aimed at ending child marriage in Ghana. In addition, the ministry, in partnership with the United Nations Children's Fund (UNICEF) and key stakeholders, has identified as one of its key priorities, the development of a National Strategic Framework on Ending Child Marriage in Ghana. The strategic framework is expected to build common understanding and lead existing and future efforts across various sectors in a consistent, coordinated and more sustainable fashion (Graphic Online, 2016).

Despite international resolutions, national laws, and efforts by various national and international organizations, child marriage remains a phenomenon of concern in many countries, including Ghana, which deprives–if not violate–many young girls and women of their fundamental human rights (Jensen & Thornton, 2003). Child marriage effectively brings a girl's childhood and adolescence to a premature end. Child marriage imposes adult roles and responsibilities on young girls before they are physically, psychologically and emotionally prepared to handle them (United Nations Population Fund, 2012).

6.1.2 Enabling factors of child marriage

In traditional Ghanaian societies, marriage and fertility are very important for women and women's status. Historically, early marriage shortly after puberty rites was common in order to protect chastity and ensure fertility. Betrothal was early, sometimes before birth, often to a maternal uncle's son (Bulley, 1984). There was often a high cultural expectation for early marriage or childbirth once puberty is reached and initiation rites are performed (Fobih, 1987). In addition, traditional African religion encourages early marriage because premarital sex was, and often still is, strongly prohibited and in some cases punished. Hence, to prevent premarital sex and pregnancy out of marriage, early marriage was the norm (Addai, 2000).

To some extent, Christianity and Islam appear to support child marriage in Ghana. For instance, some girls belonging to some Christian faiths present themselves as "holy" compared to liberal Christians. Such Churches tend to openly preach against immorality and always portray themselves as the righteous few. Thus, to reduce the risk of immoral behavior among the young adults, early marriage tends to be encouraged, mostly indirectly. These groups, particularly the Pentecostal churches help young adults to marry as soon as possible by assisting them financially and materially in the organization of wedding ceremonies (Addai, 2000). Muslim groups also try to ensure that most births occur within marriage by compressing the gap between age at menarche and marriage, hence the early age at marriage is encouraged to some extent (Kirk, 1967). In Ghana, although the cultural and religious traditions that encourage early marriage have waned—indeed, couples are now legally required to be at least 18 years old to get married—early marriage persists (Hessburg et al., 2007).

6.1.3 Effects of child marriage

Child marriage affects both boys and girls, however, the implications of child marriage on girls are much higher (United Nations Children's Fund, 2005). Child marriage is associated with negative health and social consequences for girls, children/family as well as their communities. In developing countries, it has been shown that child marriage is associated with unintended pregnancy, pregnancy-related complications, preterm delivery, delivery of

low birth weight babies, fetal mortality and violence within marriage (Santhya, 2011). Female adolescents who marry at an early age face reproductive health challenges. Early sexual debut, which goes along with child marriage can further increase a young woman's health risks, because an adolescent's vaginal mucosa are not yet fully mature, which exposes young female adolescents to HIV infection (Hessburg et al., 2007). Child marriage can increase girls' risk for cervical cancer, death during childbirth, and obstetric fistulas. These girls' offspring are at high risk for premature birth and death as neonates, infants, or children (Nour, 2006). Further, child marriage is related to high fertility, a repeat childbirth in less than 24 months, multiple unwanted pregnancies, pregnancy termination, and female sterilization (Raj et al., 2009).

In sub-Saharan Africa including Ghana, each additional year of early marriage reduces the probability of literacy among women who married early by 5.7 percentage points, the probability of having at least some secondary schooling by 5.6 points, and the probability of secondary school completion by 3.5 points (Nguyen & Wodon, 2014). Evidence also suggests that child marriage often ends a girl's opportunity to continue her education and results in persistent poverty among girls (Karei & Erulkar, 2010; Nour, 2006). In Ghana, early child marriage among girls is one of the important challenges facing effective enrolment and attendance of school, which leads to school dropout (Ampiah & Adu-Yeboah, 2009).

In 29 countries including Ghana, it was found that female adolescents were more vulnerable to HIV infection. The study indicated that women who marry young tend to have much older husbands and, in polygamous societies, are frequently junior wives. These factors increase young girls' probability of HIV infection. In addition, these factors undermine young girls' bargaining power within the marriage (Clark et al., 2006). Further, early pregnancy loss among girls age 15-19 was found to be twice as high as that of other age groups in Ghana (Henry & Fayorsey, 2002). Child marriage will most likely result in early child bearing, which has implications. For instance, the 2014 GDHS reported that neonatal (42 deaths per 1,000 live births), infant (62 deaths per 1,000 live births), and under-5 mortality (84 per 1,000 live births) were highest among children born to mothers less than 20 years compared to those aged 20-29, 30-39 and 40-49 (Ghana Statistical Service et al., 2015).

Child marriage is a form of violence against adolescent girls and young women because it increases their vulnerability to sexual, physical and psychological violence throughout their lives (Erulkar, 2013). Gender-based violence in child marriages is more prevalent due to the unequal and unbalanced power dynamics. Child brides are more likely to be timid, financially and economically dependent, less educated and less autonomous, all of which can affect their ability to make certain decisions, such as having control over their own body. Child marriage also commonly imposes social isolation on girls resulting from separation from friends and family (Karei & Erulkar, 2010).

Further, in the focus group discussions of the present situational analysis, adolescent girls and young women revealed various forms of gender-based violence such as emotional and psychological violence they have been going through because of marriage, cohabitation or childbirth:

> "Some of us were staunch Christians before giving birth, but after giving birth for the men, the men say we shouldn't attend Church anymore, we are not even allowed to go visit our parents or any other person but be with them only, not even to talk to any other man but just do as he says." – FGD 12-17 Unmarried, Sabare

> "Previously when I had not taken a boyfriend <<living together as if married>> I was fine and could eat what I wanted to eat but now that I have gone in for a boyfriend, I experience all kinds of maltreatment including the hurtful words he says to me, my life has now changed. So sometimes I think about it and ask myself whether it was good for me to go in for a boyfriend or if I had not taken one life would have been better." – FGD 12-17 Married, Obidan

Others also indicated that they go through sexual and physical violence in the hands of their partners. Even though young girls indicated that these forms of gender-based violence were unacceptable, they usually do not have enough protection as people (such as the elderly in society) they expect to protect them rather justify the violent offences against them as one of the participants in the FGDs indicated:

> "Some of the men, if they want to have sexual intercourse with you and you refuse, they will beat you mercilessly and instead of an elder to advise the man on this, he will rather be supporting the man that what he is doing is right. But madam, this is not right."– FGD 12-17 Married, Awutu Asubo

Gender-based violence has made some adolescent girls regret their decision of going into marriage early blaming it on the fact that they did not know that was going to be the case:

> "Madam some of the men are not patient, any little thing they get angered and want to beat you. When I think of the past, if I had known I would not have entered into this problem <<marriage>>." – FGD 12-17 Married, Awutu Asubo

However, some adolescent girls thought that because they were already married to these abusive men, they had to manage and stay in the abusive relationship:

> "From the beginning, when I gave birth, my man sometimes insults and beat me up, so I came back to my parents crying. If I had known it will be this bitter, I will not have attempted it. But now that it had happened, I leave all to God to open a door for me." – FGD 12-17 Unmarried, Sabare

However, some adolescent girls reported cases of gender-based violence to the law enforcement agencies and actually took the initiative to end the abusive relationship by informing family they were no longer interested in the marriage:

> "Yes please. He beats me. He beat me one time and I reported him to the police and he was arrested. I want to end this marriage. I have informed my brothers to come and separate us so I can free myself but they have still not come."– FGD 12-17 Married, Awutu Asubo

In the focus group discussions, female parents were aware of young girls' vulnerability to gender-based violence (sexual, physical etc.) in marriage. Some even indicated that family members of the men are usually accomplices in the violence against these girls:

> "And when the child gets into marriage she will always have problems with the husband and the husband will be holding stick following her every day and beating her."– FGD Female Parents, Kukpaligu

> "There is no decision making with the husbands even if he wants to sleep with you and you insist you do not want to, he will not ask to know why but what he will only do is to catch you or beat you." – FGD Female Parents, Kukpaligu

> "Sending a girl under age to a marriage, the girl may not be willing to allow the man to sleep with her but the parents of the husband will sometimes come and catch the girl for the husband to sleep with her." – FGD Female Parents, Kukpaligu

6.2 Trends in child marriage

6.2.1 Child marriage indicator:

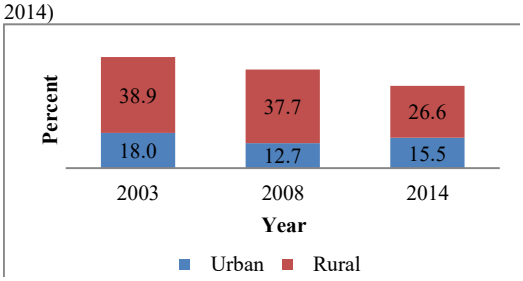
The child marriage indicator is defined as:

$$\frac{\textit{Number of women aged 20 to 24 who indicated that they were married or in union before the age of 18}}{\textit{Total number of women aged 20 to 24}}$$

The reason for restricting the analyses of child marriage to women 20 to 24 years old who first married or entered into union before age 18 was to ensure that no respondent was still at risk for marriage during adolescence (Erulkar, 2013). In other words, the percentage of girls aged 15-19 who are married or in union at any given time includes girls who are aged 18 and 19 and no longer children, according to the internationally accepted definition. Additionally, the indicator includes girls aged 15, 16 and 17 who are classified as single, but who could eventually marry or enter into a union before the age of 18. By taking a retrospective view, the indicator covering women aged 20 to 24 is not affected by these limitations and so more accurately approximates the real extent of child marriage (United Nations Population Fund, 2012).

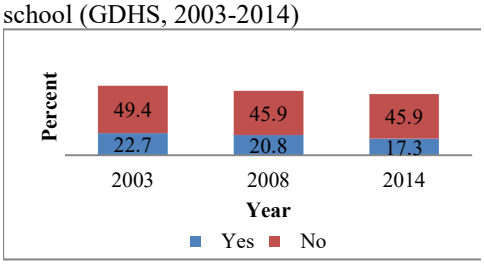
6.2.2 Trends in child marriage among young women

Figure 6. 1: Child marriage by residence (GDHS, 2003-2014)



In general, child marriage declined from 27.9% in 2003 to 24.6% in 2008 and 20.7% in 2014. With respect to residence, child marriage has been declining in both rural and urban areas. However, child marriage has been consistently higher in rural areas compared to urban areas from 2003 to 2014. In rural areas, child marriage decreased from 39% in 2003 to 27% in 2014. In urban areas, it declined from 18% in 2003 to 16% in 2014 (Figure 6.1).

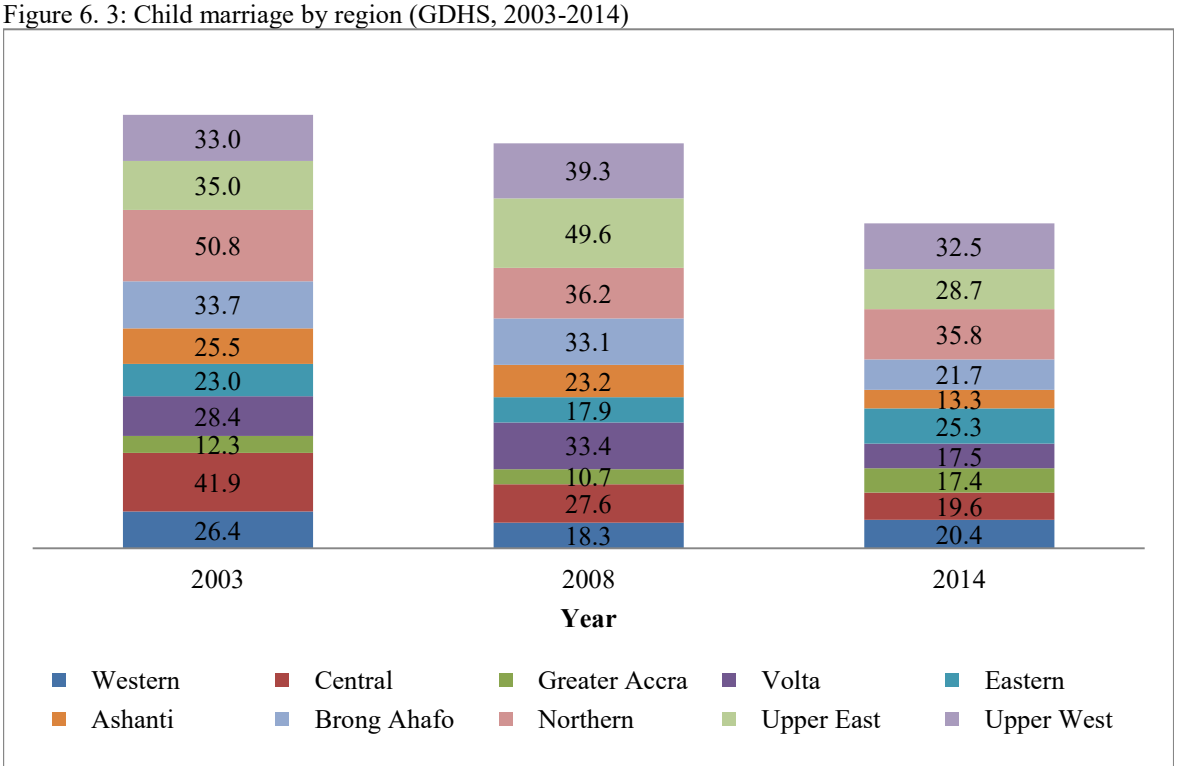
Figure 6. 2: Child marriage by ever attended school (GDHS, 2003-2014)



A higher proportion of young women who have never attended school marry as children compared to women who have ever attended school across all years in comparison. Among young women who have never attended school the proportion married as children decreased from 49% in 2003 to 46% in 2008 and 2014. Among young women who have ever attended school the proportion married as children decreased from 23% in 2003 to 21% in 2008 and further declined to 17% in 2014 (Figure 6.2).

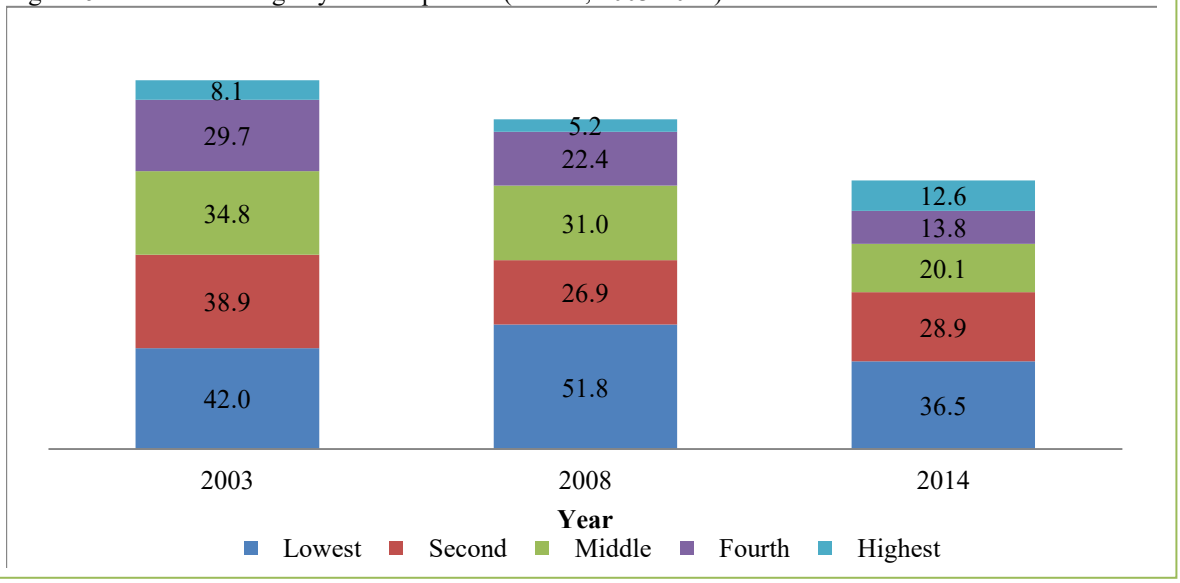
Figure 6.3 shows the trends in the prevalence of child marriage by region of residence. In general, it is in four regions (Central, Ashanti, Brong Ahafo and Northern regions) that the prevalence of child marriage has been declining from 2003 to 2014. For instance, in the Central region child marriage decreased from 41.9% in 2003 to 27.6% in 2008 and further declined to 19.6% in 2014. In the Northern region, child marriage declined from 51% in 2003 to 36% in 2008 and was about the same (35.8%) in 2014. In 2003, the prevalence of child marriage was highest in the Northern Region (50.8%) and lowest in the Greater Accra Region (12.3%). In 2014, the prevalence of child marriage was still highest in the Northern Region (35.8%), followed by Upper West (32.5%) and Upper East (28.7%) regions.

Figure 6. 3: Child marriage by region (GDHS, 2003-2014)



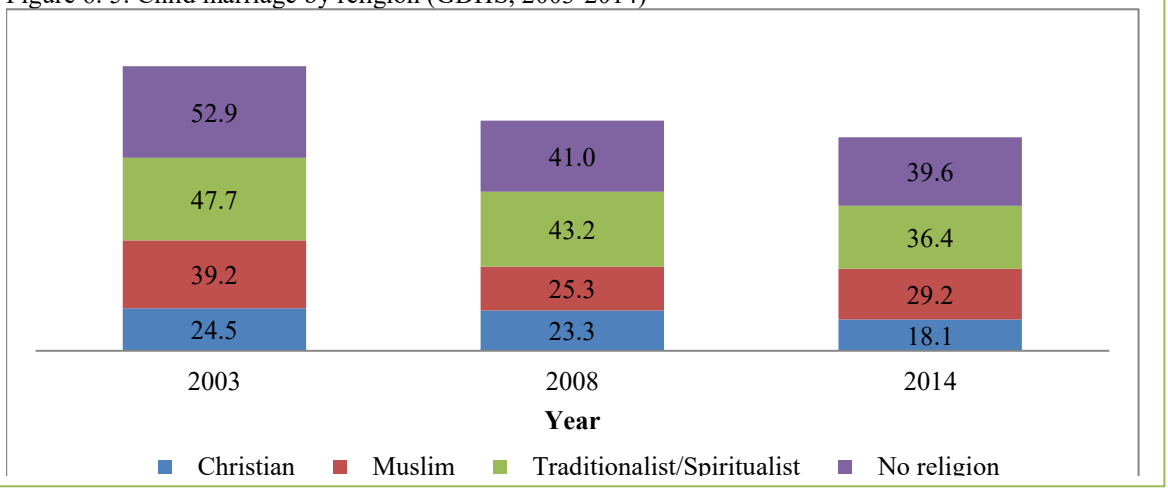
As wealth quintile increase from the lowest to the highest, the prevalence of child marriage decreases. In 2014 for example, the prevalence of child marriage decreased from 36.5% among young women in the lowest wealth quintile to 28.9% among those in second wealth quintile. It further declined to 20.1% among those in the middle, 13.8% among those in the fourth and 12.6% among those in the highest wealth quintile. Across all categories, it was only among those in the middle and fourth wealth quintile that the prevalence of child marriage consistently declined from 2003 to 2014 (Figure 6.4).

Figure 6. 4: Child marriage by wealth quintile (GDHS, 2003-2014)



With the exception of Muslims, the prevalence of child marriage consistently declined from 2003 to 2014 (Figure 6.5). The prevalence of child marriage is consistently lower among Christians decreasing from 24.5% in 2003 to 23.3% in 2008 and further declined to 18.1% in 2014. Except in 2008 where the prevalence of child marriage was highest among Traditionalist/Spiritualist, in 2003 (52.9%) and 2014 (39.6%), the prevalence of child marriage was highest among young women with no religion.

Figure 6. 5: Child marriage by religion (GDHS, 2003-2014)



6.3 Drivers of child marriage in Ghana

Based on the factors identified in the extant literature and available data in the 2003, 2008 and 2014 GDHS, a binary logistic regression model was estimated to identify the drivers of child marriage. The dependent variable is dichotomous, where 1 indicates the respondent first married/cohabited before age 18 and 0 otherwise. The variables included in the model were residence, education, region, wealth quintile and religious affiliation.

Residence: from Table 6.1, when other variables are controlled, residence was significantly related to child marriage in 2003 (OR = 1.65) and 2008 (OR = 2.63). The results show that young women in rural areas were more likely to marry as children compared to their urban counterparts. In 2014, rural women were more likely to be married as children compared to urban women; however, it was not significant.

Education: whether or not a young woman had ever attended school is consistently significantly related to child marriage from 2003 to 2014, when other variables are accounted for. The results show that young women who had never attended school were more likely to marry as children compared to their counterparts who had ever attended school in 2003 (OR= 2.09), 2008 (OR= 2.16) and 2014 (OR=3.03) (Table 6.1).

In the qualitative component of this situational analysis, it was also found that education was identified as a factor in delaying age at first marriage. Across the two study areas, when adolescent girls and young women were asked about their plans and reasons for delaying marriage, they more often than not mentioned their educational goals as the bases for delaying marriage. Adolescent girls and young women indicated that education was the

foundation of their life aspirations, recognizing that early marriage truncates educational achievements:

> "I am a student and I want to attend school to become somebody tomorrow; so I want to go to school to acquire my properties too before I marry." – FGD 18-24 Unmarried, Zabzugu

> "Yes I planned for that. When you get married before 18 years you can't further your education again." – FGD 18-24 Unmarried, Zabzugu

> "My family influenced my delay in marriage because I was always advised to further my education and be a better person before getting married." – FGD 12-17 Unmarried, Sabare

Parents also acknowledged how early marriage could derail educational achievements. Parents actually advise adolescent girls and young women to get educated first before marriage:

> "If she wants to further her education she will say she will not marry. Unless she finishes her school before she will marry." – FGD Male Parents, Kukpaligu

Region: region of residence was significantly related to child marriage in 2003 and 2014. In 2003, the results showed that only young women in Central Region were more likely (OR=2.39) to marry as children compared to those in Greater Accra Region. In 2014, it was only young women in Northern Region who were marginally less likely (OR=0.54) to marry as children compared to those in Greater Accra Region.

Wealth quintile: wealth quintile is consistently related to child marriage from 2003 to 2014. The results showed that young women in the highest wealth quintile are consistently less likely to marry as children compared to those in the lowest wealth quintile. The odds of young women in the highest wealth quintile compared to those in lowest wealth quintile marrying as children was 71% lower in 2003, 80% lower in 2008 and 63% lower in 2014 (Table 6.1).

Similar to the finding in the quantitative analysis, where especially women in the highest wealth quintile were less likely to marry as children compared to those in the lowest wealth quintile; it also came out in the qualitative interviews that poverty was a driver of child marriage. Adolescent girls and young women indicated that poverty was one of the main drivers of child marriage and this was common in both the north and in the south of Ghana:

> "When I ask my father for money, he says he doesn't have, so that is why I got married early." – FGD 12-17 Married, Sabare

> "Sometimes, because of poverty some people give their children out. Your father may be in need and may ask for help from a rich man. After the man renders help to your father, your father will say let me pay this person back for the good hospitality he has shown me by giving you in marriage to that man." – FGD 18-24 Married, Kukpaligu

> "The reason why our females marry early is because some of our parents do not have, so if the man will be able to cater for you then it means that you have to understand him. If my mother doesn't have and I have somebody who can cater for me, I will understand him, for the pressure on my mother to be relieved. So that is why we marry so early" – FGD 18-24 Married, Obidan

> "When I was in school my teacher will tell us to bring something to school and when I come home to tell my mother she complains she doesn't have money. If I ask my brother, he says the same thing. If I tell my dad, he says he does not have. As it continues that way and you meet a man who tells you that you are very beautiful, you will be thinking in your mind that even when the teacher asked you for something your parents could not provide it for you. So you will accept the man's proposal so that if there is something you will need to buy he can help you buy it. When he buys it for you, you will be happy, even if your parents disagree on your union, you will ignore them and enter into the marriage." – FGD 12-17 Married, Awutu Asubo

> "Some parents don't have, so they are unable to meet the needs of their children. And the children "by force" engage in it and it will result in pregnancy and she will end up entering into marriage." – FGD 18-24 Unmarried, Dosii

In the key informant interviews it also came out that poverty was one of the important drivers of child marriage. Some of the key informants indicated that some parents allow their girls to marry early to get something in return from the man:

> "I will say is poverty, It is poverty, because parents always give the excuse that they are poor because of lack of employment in the system. They will say they do not have money to take care of the child so by the time they think you are of age they should just give you out for marriage; they will get something in return from that man all right, so at the end of the day it is poverty. I see it as poverty." – KII, Social Welfare, Cape Coast

> "Well, I will say maybe poverty. One, like I said religious beliefs and traditional setup is also the cause of it because when there is poverty at home, some parents do not look at the consequences. Some even lure the children into it so that they get monies from their in-laws. So poverty is one of the main issues that drive child marriage." – KII, DOVVSU, Accra

Adolescent girls and young women described how some parents were either aware of or encouraged their relationships borne out of a lack of money/wealth at the family level:

> "Some of the girls' parents don't have money, so when she meets a man who promises to help her in school, she will go and tell her mother that this man says he will help her in school. Then the mum then agrees to it and from there she will be courting with the guy and suddenly she gets pregnant." – FGD 12-17 Married, Awutu Asubo

On the other hand, some parents acknowledged that their children engaged in transactional relationships as a result of family hardship, which leads to marriage:

> "Some are experiencing hardship, so when the girl goes to meet someone who is wealthy, the mother forces her to marry such a person. It is not the time for her to marry, but because of hardship and the wealth of the man, she will be forced to marry him so that he can take care of her." – FGD Parents, Assin Dosii

Despite the family's economic circumstances, not all adolescents pointed the finger at their parents for going into early marriage. Some girls felt that since they did not have money to go to school the best alternative was to marry early:

> "As I am schooling, I don't have anybody taking care of me, my parents are poor, but they did not force me to the man. Because my parents are poor, I have nothing to offer myself. That is why I got married early." – FGD 12-17 Married, Sabare

> "I went into marriage because there was no money. If I look back there is no one, so that is why I had to force <<do what is takes>> to get married." – FGD 18-24 Married, Obidan

> "It's hardship. In my case, my father did not pay my fees when I was about to complete and the man promised to pay but the registration was over. But he was able to help me learn a trade and I got pregnant, so he brought me here that is the reason why I got married so early. But it was not as if somebody forced me." – FGD 18-24 Married, Awutu Asubo

Related to poverty, the pursuit of items of beauty and luxury was another driver of early marriage:

> "Madam, sometimes it is poverty that encourages this child marriage. Like we discussed earlier, ladies of today like beautiful things, example if I have something and a friend of mine has not, she may not know what I did to buy that thing. So she may also use a different way to get money to buy the same thing. Some of the different ways she may use maybe she may come across a man, the man may propose to her, and she will gladly follow the man and be asking him for money. The more she collects money from the man the more the man uses her. So in this case it is poverty that contributes to this child marriage." – FGD 12-17 Married, Awutu Asubo

> "The reason why I had to marry was that, a lot had to do with luxury. Whenever I see my friends, wearing new dresses… my mother was taking care of me at school so I could not overburden her like request that she buys that item for me. Whenever I see a friend in a nice dress, I don't have money so for me I met men who proposed to me and could give me money to buy food and whatever I want, so as I accepted. He buys whatever I need, but he will not do it for free. So I got pregnant and could not continue the school and I could not abort it, because if my mother had done that I would not be alive. So that is how come I found myself in this marriage." – FGD 18-24 Married, Obidan

Pregnancy: nationally representative cross-sectional data such as the GDHS do not permit assessing causal relationship, thus leaving unanswered the question of whether pregnancies

occurred before marriage or that pregnancy led to early marriage. However, it came out in the focus group discussions of the present situational analysis that teenage pregnancy was one of the main drivers of child marriage:

> "Yes, teenage pregnancy can lead to early marriage because we Muslims when you get pregnant you cannot live in your parents' house; you have to move to your husband's house. We do not wish to go into early marriage, but immediately we get pregnant, our parents say that as far as they are concerned, we should move in with the men." – FGD 12-17 Married, Sabare

> "I went in for a boyfriend and whatever I asked him, he give to me. I got pregnant, I stopped school, and I am now living with him. And so it is something that led me into marriage."–FGD 12-17 Married, Obidan

> "What I also know is that some of the girls are in primary or JSS and before you realize the person is pregnant. So this can make the person marry early." –FGD 18-24 Married, Kukpaligu

Parents offered their perspectives on how and why teenage pregnancy usually leads to child marriage. Some parents indicated that when a child falls pregnant, they will let the man responsible for the pregnancy marry the girl even if she does not want to go into early marriage:

> "When she is underage and conceives, they will give her to marry that boy. You the father will be thinking that she is not ready but you will see that she is pregnant so you have to give her out for marriage." – FGD Male Parents, Kukpaligu

> "For us the mothers, we think that if you have a child, the child should live with you until she is ready for marriage. But before you realize the girls will bring pregnancy to you. So the child would be forced to go to <<marry>> whoever impregnated her." – FGD Female Parents, Kukpaligu

In the key informant interviews, it also came out that the practice of parents forcing girls to marry men responsible for their pregnancy was a common phenomenon in their communities.

> "Yes, for some people, if someone impregnated your daughter they will just give her to that boy to marry. Yes to marry." – KII, Opinion Leader-Kukpaligu

> "Yeah, some of them their parents look out for those who put them into such position, who put them in the family way <<pregnant>> and then they see their parents and they marry them." – KII, Opinion Leader-Zabzugu

> "Yes, I'll say yes. Especially in this district, because as at now, what the people in the district are doing is that; when you get a lady pregnant, a teenager, they ask you to come out and pay the bride price to legalize whatever you have done before you can even name the child. So, that is

> really causing more child marriages than before." – KII, Ghana Health Service-Zabzugu

> "[Pauses briefly to think about response to the factors that influence child marriage] Teenage pregnancy too can be one of them." – KII, Teacher at Assin Dosii

Pregnancy is usually a precursor to marriage and in some cases, once a girl falls pregnant they are forced to marry the man who inpregnated her. In the focus group discussions of this study, it was found that young girls used abortion to delay marriage. However, it was also noted that aborting on several occassions could also hinder a woman from getting pregnant in the future:

> "Some of us because we want to delay marriage, we end up causing several abortions so when we delay marriage, we may not conceive because, for all you know, the number of children God has given you is what you have already thrown away during the abortion." – FGD 12-17 Unmarried, Sabare

> "Sometimes, when you wait till about 30 years before getting married, you may not be able to give birth. This is because before this age, you may have caused so many abortions in your earlier ages which can affect you." – FGD 12-17 Unmarried, Sabare

Nevertheless, some adolescents and young women recognized their own role in getting married or being in a union because of teenage pregnancy. They indicated that in some cases, parents could not be blamed for early marriage, as it is the girls who fall pregnant. Indeed, some of the girls insisted on marrying the men who made them pregnant:

> "What I know is that sometimes it is not the will of the parents that the children enter into early marriage. It is from the children themselves. The person will be in school and before you realize she is pregnant. And when she is pregnant, she has to go into marriage. It is not the making of the father and the mother." – FGD 18-24 Married, Kukpaligu

> "When I was in school, a guy proposed to me and I accepted. After some time in the relationship, I got pregnant. When that happened, my parents were unhappy about it and did not agree for me to marry the man. I married the man by refusing to listen to my parents." – FGD, 12-17 Married, Awutu Asubo

Table 6. 1: Predictors of child marriage among young women age 20-24 (GDHS, 2014)

	2003		2008		2014	
	OR	CI	OR	CI	OR	CI
Residence {Urban}						
Rural	1.65+	[1.00,2.72]	2.63***	[1.58,4.37]	1.22	[0.84,1.78]
Ever attended school {Yes}						
No	2.09***	[1.37,3.17]	2.16**	[1.32,3.55]	3.03***	[1.93,4.74]
Region {Greater Accra}						
Western	1.20	[0.56,2.55]	0.69	[0.28,1.71]	0.88	[0.49,1.60]
Central	2.39*	[1.05,5.45]	1.19	[0.51,2.74]	0.90	[0.52,1.56]
Volta	1.26	[0.57,2.75]	1.26	[0.51,3.09]	0.62	[0.28,1.36]
Eastern	1.23	[0.57,2.67]	0.78	[0.34,1.83]	1.13	[0.69,1.88]
Ashanti	1.57	[0.84,2.92]	1.18	[0.55,2.54]	0.66	[0.38,1.15]
Brong Ahafo	1.57	[0.79,3.14]	1.41	[0.61,3.28]	0.70	[0.39,1.24]
Northern	1.66	[0.72,3.84]	1.11	[0.49,2.49]	0.54+	[0.30,0.99]
Upper East	1.04	[0.37,2.90]	2.03	[0.79,5.20]	0.62	[0.30,1.28]
Upper West	0.93	[0.39,2.24]	1.20	[0.48,3.05]	0.81	[0.35,1.88]
Wealth quintile {Lowest}						
Second	1.09	[0.62,1.90]	0.53*	[0.29,0.99]	0.86	[0.47,1.58]
Middle	1.02	[0.58,1.81]	1.04	[0.55,1.98]	0.62	[0.35,1.10]
Fourth	1.06	[0.56,2.02]	0.82	[0.43,1.59]	0.40**	[0.21,0.75]
Highest	0.29**	[0.13,0.66]	0.20***	[0.08,0.49]	0.37*	[0.17,0.80]
Religion {No religion}						
Christian	0.79	[0.36,1.70]	0.83	[0.33,2.10]	0.48+	[0.22,1.07]
Muslim	1.17	[0.51,2.68]	0.72	[0.26,1.99]	0.71	[0.32,1.58]
Traditionalist/Spiritualist	0.88	[0.25,3.05]	0.88	[0.27,2.89]	0.54	[0.15,1.98]
Total (Weighted)	1012		878		1613	
Linktest						
hat	0.00		0.00		0.03	
hatsq	0.07		0.61		0.25	
Exponentiated coefficients; 95% confidence intervals in brackets [ ]						
+ p<.1, * p<.05, ** p<.01, *** p<.001						

6.3.1 Social and cultural drivers of child marriage

Betrothal: Reasons for child marriage vary from one society to the other. In some societies, child marriage is used to build or strengthen alliances between families. The betrothal of young girls was also mentioned as a cultural practice that drives child marriage within the Northern region context (Zabzugu-Tatale):

> "For example, just like I'm having this baby, my husband's mother will call his son and tell him when his child is grown, she would come for her as a wife for a particular man for marriage." – FGD 18-24 Married, Kukpaligu

> "What I also know is that while the children are young their parent will show them their husband. So because of that, the person will be eager to enter into it because she has a husband already." – FGD 18-24 Married, Kukpaligu

Exchange of girls: Aside betrothal of young girls, in the focus group discussions, among the Konkombas of the Northern Region, there was the cultural practice of exchange of girls for marriage by families, which was one of the main drivers of child marriage in that area:

> "Most of us are exchanged, the person will go and bring her sister to your brother and your brother too will give you to that man. The boy too will marry you. Because of that, we are marrying early. You are small and your brother doesn't have a wife, he will use you to exchange like that." – FGD 12-24 Married, Tasundo

> "Your uncles will use you for exchange, so they will like to send you quick so that they get theirs quick." – FGD Female Parents, Kukpaligu

The key informants in the Zabzugu-Tatale district also mentioned the culture of exchange of girls among the Konkomba's as one of the drivers of child marriage in the area. They also indicated that children are sometimes given out for marriage for services a person or family rendered to the girl's family:

> "Yeah, my opinion about this child marriage thing is that, they have a tradition or culture which they believe in, maybe they have this lineage system or they have two families and one would say that I served this man for some time and he promised he will give me his daughter to marry, when the lady is grown. So when the girls grows up to let's say, 10 years, 11, 12, 13, 14, 15 16 years, then the man will be reminding them that this is what you promised me so I have come for the lady and this is their custom." – KII, Police Officer-Zabzugu

> "Yeah, that's why I said it's their traditional norm; they believe in that norm, do you get me. You know in the olden days people do work for women, if you want a woman you have to go and work for that family for some time because it was in the Bible, so actually, I can't cite exactly but it was in the Bible. Somebody worked for a lady whether it is Isaac or I don't know, he worked for some number of years before she was given to him to marry and it is the same thing they are practicing here, they believe in that thing." – KII, Police Officer-Zabzugu

> "The main one is the culture. They don't want to leave the culture that is what causes it. They still exchange and when you marry and you don't have a girl to give them, they will take your wife. So they are compelled to give them. When you give them and is a small girl, they will take it but if you don't have they will take your wife. So sometimes they will remove them from school and exchange." – KII, Religious Leader-Kukpaligu

In describing these de-facto practices, the lack of consent of girls and the forced nature of these marriages were very apparent. Girls have limited say but to marry the man their family members betrothed them to. In some cases, even the mothers of the girls do not have a say when the girls are being exchanged for marriage as some of the participants indicated:

> "When you are young, your father will give you out for marriage so whether you like it or not, you'll have to go. And when it happens like that, you can't do anything than to agree."– FGD 18-24 Married, Kukpaligu

> "When you the mother you are sitting there, the uncle of the child will come and just tell you that they are taking your daughter to this community for a

> wife. If you say no they beat you and the girl and force the girl to the place." – FGD Female Parents, Kukpaligu

Some young women explained the ways in which the cultural practice of exchange could be circumvented, indicating that when you don't want to marry the man you are betrothed or exchanged to, you run away, go, and marry the man you love:

> "We Konkombas … they can give you to one man. That person will come and marry you, you are a small child like that and they give you to that man. So the time that you grow up to 18 years, you will see that they want to force you to that man. So when you have a boyfriend and you love that person, you can run away and go and marry that person by force, since you don't want them to catch you by force and send you to the one that they gave you to." – FGD 12-24 Married, Tasundo

Bride wealth: Bride wealth is another dimension related to the persistence of child marriage. It is a cultural phenomenon in most Ghanaian societies. In the focus group discussions, girls believed that because bride wealth is cheap, men find it easy to pay and ask for the hand of young girls for marriage. Some participants therefore felt that an increase in bride wealth could serve as an incentive to delay the age at which girls get married:

> "They should make the wedding things expensive. If it is expensive, it is like if the man goes and he has not got money, he can wait. Maybe when the girl is 17, he will wait till the girl is 20 before, he will have money then, to buy the things." – FGD 12-17 Unmarried, Dosii

> "I think if the bride price is increased, it will make the men not able to afford it so they will not be able to pay and this will make us wait till we get to the right age of marriage. Because if the bride price is cheap or low, the moment the man pays it, he insists you get married as early as possible, therefore increasing the bride price will make early marriage stop." – FGD 12-17 Unmarried, Sabare

Pressure from significant others

Pressure to get married at an early age comes from multiple sources, namely family, society, peers and self.

Pressure from parents/family: some parents usually encourage or put pressure on their daughters to get married early by always comparing them to their peers who are already married:

> "From parents. They see your colleagues marry, then they tell you that, 'you have seen your colleagues marrying and you are there, so you too hurry up and marry'. So the pressure is from the parents. – FGD 18-24 Unmarried, Zabzugu

> "Sometimes too, the family. You know, you are living with people. You live with your parents, you live with the family members and most of the elders in the family will put pressure [on you] or they will just pressurize

> you to marry. [They will say] look at this person, maybe she is your cousin, [or] she is your this thing [family member], she has married and maybe you are older than her and she is married and you are still there. Through that you can even force someone to marry you. So it is there." – FGD 18-24 Unmarried, Zabzugu

Pressure from society, in the focus group discussions, it was found that marriage is cherished as it is in most African societies and unmarried young girls are usually teased or mocked at because they are not married. Hence, some girls will want to get married early just to conform with the status quo:

> "Some want early marriage to continue simply because of mockery because sometimes, those who get married tend to make mockery of those who are not married, they ask them to accord them the respect simply because they get married early, so sometimes, other people want early marriage to continue just to avoid this mockery." – FGD 12-17 Unmarried, Sabare

Pressure from peers, some young girls go into early marriage because their colleagues are married or when they see their friends doing very well in marriage they also want to get married. In other cases, young girls might go into relationships early for economic gains:

> "When you see that your friends you walk with are getting married, you too you want to get married. That is why we get married early." – FGD 18-24 Married, Kukpaligu

> "It is not because of anything that we Ghana girls are in a hurry to get married, it is because of peer pressure. When we see others like us being treated very well in their marriage, we get attracted and also try to enter in order to be treated well <<laughs>>" – FGD 12-17 Unmarried, Sabare

> "I also think it is bad influence that causes it, we listen to what our friends say. Sometimes a friend may have fancy clothes and you may be envious so that friend will tell you I slept with a man to get them so you can also get a man who will look after you so that you can also get the clothes I have. She will also listen to her friend and go in for a man as her parents cannot provide her with those clothes." – FGD 18-24 Unmarried, Obidan

It was found in the key informant interviews that peer pressure was one of the factors that lead to child marriage as one of the participants indicated:

> "Sometimes it is from the peer group. Peer group influences." – KII, Opinion Leader-Kukpaligu

Pressure from self, in the focus group discussions as well as from the key informant interviews, it came out that some girls decide to go into early marriage, indicating that it was their own will or out of curiosity and in some cases, out of stubbornness (not listening to their parents' advice):

> "Our parents cannot force us to go and marry the men, but we did ourselves as a result of our own curiosity. Even though they advised us against it, we

refused. That is why we are suffering like this. Am not even sure our parents tasted this kind of suffering we are suffering now more than when they got married." – FGD 12-17 Unmarried, Sabare

"Nobody forced me to get married early, I forced myself to marry because I am schooling and nobody is taking care of me that is why I got married." – FGD 12-17 Unmarried, Sabare

"It was as a result of my stubbornness, my parents did whatever they could to cater for me. It was as result of my stubbornness and peer pressure that has landed me in such marriage."– FGD 18-24 Married, Obidan

"Yes, stubbornness because regardless of what you say the children do not listen or take it when mothers talk, they just don't listen. Some also develop early, for instance at thirteen years, they menstruate so by fourteen when they go for a man, they get pregnant. When they get pregnant too, they will have a baby . . . they don't listen to their parents oh! If we try to correct them we are not able to do so at all." – KII, Queen Mother, Central Region]

6.4 Ending Child Marriage

To help curb the practice of child marriage in Ghana, the focus group discussions participants highlighted the role of the police. Participants indicated that reporting cases to the police would help curb the situation. Adding that instead of giving a girl out for marriage because of pregnancy the man responsible should rather be arrested:

"Taking the case to the police station will make it stop." – FGD 12-17 Married, Sabare

"To stop early marriage, when a girl gets pregnant whilst in school, the man responsible should be arrested and this will make it stop." – FGD, 12-17 Unmarried, Sabare

Participants also spoke fervently about the authority of the chiefs in their communities in putting an end to the practice. Participant indicated that the chiefs should be more vocal against child marriage and that women should make it a point to report their husbands to chiefs when they are going to give their girls out for marriage:

"If your husband is to force your children to early marriage, you will call your husband before the chief." – FGD Female Parents, Kukpaligu

"The chief in this village can make this child marriage stop because if he can open his mouth and talk about it, it will stop. But if an elder says it, they will not believe him unless the chief himself says it. If the chief decrees it himself, they will fear him and stop." – FGD 18-24 Unmarried, Obidan

Participants went further to explain the need for community-based laws and policies that should be established specifically by the chief of the community and his elders, which they believe, will help curb child marriage:

> "The chief of this community and his elders can impose their laws and it will stop." – FGD 12-17 Married, Zabzugu

> "The chief can pass the law and it will work because everybody wants it to stop." – FGD Female Parents, Kukpaligu

> "If there is a policy that anytime someone is sending his child into marriage they should call the chief then they won't send the child into early marriage again." – FGD Female Parents, Kukpaligu

> "Madam, they [elders] should bring a rule that tells parents to make sure their children sleep early so if they pay attention to the children and take care of them it can make all the child marriages and teenage pregnancies stop." – FGD 12-17 Unmarried, Obidan

> "All that can be done is that elders and opinion leaders must make laws that any man who impregnates a girl who is in school or under age should be arrested and this will put some fear in them." – FGD 12-17 Unmarried, Sabare

Key informants also indicated that chiefs have an important role to play if child marriage was going to be curbed. They indicated that chiefs should establish laws on child marriage and ensure offenders are punished:

> "Example, for the chiefs they can even establish some laws within the community that whenever you do this these are the punishments that you are going to face and I think no one is ready for a punishment. Through that I think we can reduce the child marriage." – KII, Teacher, Central Region

> "Yeah, the police we have partnered with the UNDP sensitizing the villagers on such issues or activities. They should not involve themselves in it." – KII, Police Officer-Zabzugu

The education of girls was regarded as both a protective factor against early marriage and a means to curbing or ending the practice. Participants in the focus group discussions indicated that when a girl is enrolled in school she cannot be given out for marriage just like that. This was something both parents and girls mentioned during the focus group discussions:

> "When you don't want to marry early, you go to school direct. When you enter school, they won't give you like that." – FGD 12-24 Married, Tasundo

> "No matter how high the bride price, so far the husband is willing to marry the child they will still pay. The only thing is we will bring our heads together and educate the girl on certain things and also advise the girl that if she goes to school it will be better for her in future than if she gets into marriage." – FGD Female Parents, Kukpaligu

> I think the only way to stop early marriage is through education. If the level of educating the girl child is intensified, early marriage will stop. – FGD 12-17 Unmarried, Sabare

> "If you send her to school and you take good care of her she will not marry early. But when you send her to school and you don't care about her, she will go into early marriage." – FGD Male Parents, Kukpaligu

> "Please the youth in this town are mostly not serious about school even if you see that your friend has finished school or come back from Senior Secondary and you see them, you should aspire to be like them. Teenage pregnancy and marriage won't happen if you are in school because you want to do something good. Since our friends have done it and it looks nice, we should also learn so that all these things can help us." – FGD 12-17 Married, Obidan

Key informants also echoed education as a way of ending child marriage among girls, indicating that education will not only help delay marriage but also empower the girls:

> "We must make sure that girls education is enforced at all level and the welfare system." – KII, Head of NGO, Greater Accra

> "We are trying to look at it from every angle, it is education. That is why there are a lot of sayings about girl child education. Before I will make mention of our religion, it is said that when you give education to a girl child, you have much more blessings and that also go with the philosophical sayings of the great men in our society like Aggrey "If you educate a girl, you educate a whole nation." – KII, Muslim leader, Central region

> "It is education that will enable them to take control; and not that man! Not that man! Who gives her certain things like money that you think will help her in future. But then we try to tell them that, the message is that it is education that will help you to take control of yourself and not the man who will try to induce you. Yeah it is helpful, but the concern rather must be the education that will help you, the system that will help you to take control of yourself." – KII, Muslim leader, Central region

In addition, some of the key informants indicated that one of the ways to end child marriage was through awareness creation and advocacy on the consequences of child marriage on girls:

> "Absolutely yes, we have been embarking on sensitizations in the communities, because it is the parents who have to support the children to go school. A child cannot take herself to school even if she can take herself to school there should be support, financially, morally, everything. So we sensitize the parents and we sensitize the girls to errr,….. the girls education unit especially sends me to go out to the schools with my colleagues and then we talk to the girls, we sensitize and inspire them to I mean go high in education and then we tell them the prospect or the benefit in education. So we've been doing a lot of activities, we have *Ahomeka*, here the local FM station, we've been going there to educate the public on the importance of education." – KII, Girl-child Education Officer, Central Region

Some of the key informants also indicated that, there are laws in Ghana to curb the child marriage menace but the problem was enforcement of the laws:

> "The policies are there, because our law is clear on chid marriage, the age of marriage. So if people marry a child at the age of fifteen, it is against our policies or our laws, but there is no punishment, you understand." – KII, Head of NGO, Greater Accra

> "In my opinion, the laws on child marriage are weak. When it comes to child marriage issues, it is like there are no sanctions. I have never witnessed a parent being sanctioned for giving out his or her child for early marriage. I am yet to see that. So I feel stiffer punishment should be there for people who do that. So that it would scare the others from doing it." – KII, Staff of Ghana Health Service, Zabzugu

> "The law is there, it is in the book, the implementation is the problem. You know, many at times, when something happens and you want to follow up, you will end up being like the fool. Because it is like, somebody's issue, you are trying to take it upon yourself to solve it, you see. That is the major problem we are facing, sometimes when you even report at the police station, the parents go there and say that it is their own child, you are not the one who looked after her to this stage. Sometimes they say it is their tradition because she was also given to somebody and somebody was also given to another person. So when it gets to their child's turn, they also have to do the same thing, so at the end you can't do anything about it. Sometimes when the media takes them on, it is the duty of the authorities to follow up and ensure that those people are punished or cautioned that they should leave the child until she is 18 years." – KII, Guidance and Counselling Coordinator, Accra

6.5 The achievements of targets of policies, plans and programs on child marriage

One of the targets in the Adolescent Reproductive Health Policy is

To reduce the proportion of females who marry before age 18 (which at the time was 37%), by 50% by 2010 and by 80% by 2020

Table 6. 2: Selected indicators of age at first marriage (GDHS 1998 & 2014)

	% married by age 15		% married by age 18	
Age group	1998	2014	1998	2014
15-19	3.8	1.6	-	-
20-24	6.8	4.9	35.5	20.7

- Not available in the report

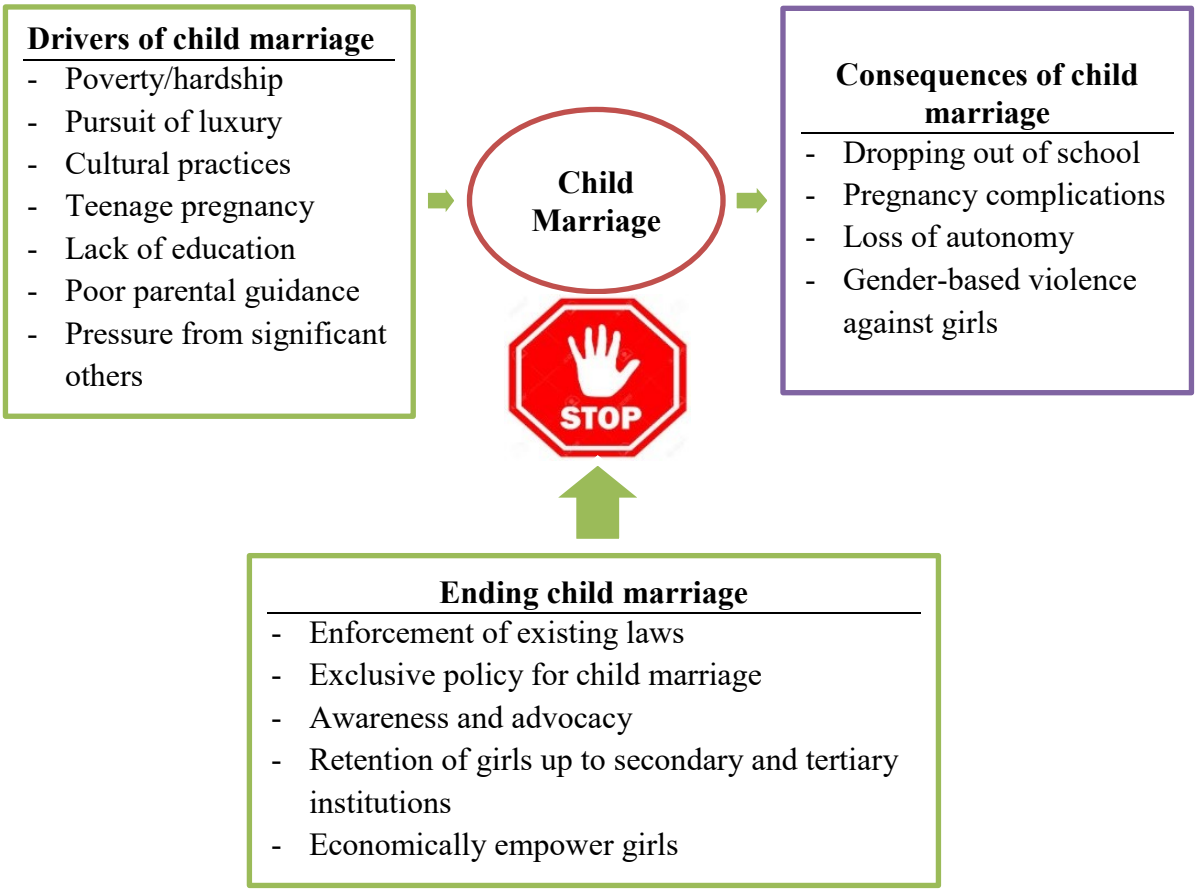
The 1998 and 2014 GDHS are used to assess this target. The proportion of adolescent girls who got married before age 15 declined from 3.8% in 1998 to 1.6% in 2014 (58% decline). Among those aged 20-24 years, the proportion who married before age 15 was 6.8% in 1998 and 4.9 in 2014 (28% decline). Further, there is a decline in the proportion of young women (20-24 years) who married before age 18 from 35.5% in 1998 to 20.7% in 2014 (42% decline). From the data, some success has been made in reducing the proportion of young people who marry before age 18, however, if the 2020 target is going to be met the country will need to put in additional efforts.

6.6 Gaps and barriers in the data

Definitive data in national surveys on the demographic, social and economic characteristics of young girls at first marriage is lacking. This will give a better understanding of the drivers of child marriage.

Figure 6.20 summarizes the findings on child marriage by looking at the drivers and consequences of child marriage as well as how to end child marriage.

Figure 6. 6: Framework of drivers, consequences and ways of ending child marriage in Ghana



7 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

Generally, adolescent girls and young women in Ghana encounter many challenges with respect to reproductive health services and rights, gender-based violence and education. Sexual activities among many adolescent girls and young women begin by age 15. As a result, the proportion of teenagers (15-19 years) who begin child bearing is relatively high. Mostly, pregnancies among these adolescent girls are unplanned; hence, they resort to abortion as an option. However, knowledge of comprehensive abortion care services is low among these adolescents, some of whom indulge in unsafe means of terminating pregnancies.

Furthermore, adolescent girls and young women are disadvantaged with respect to education compared to their male counterparts. Adolescent girls and young women experience several forms of gender-based violence—emotional, physical and psychological. Indeed, the challenges girls face are exacerbated by the overarching problem of child marriage, which has serious implications on girls, their children, family and the society at large.

7.2 Recommendations for consideration by UNFPA

7.2.1 Teenage pregnancy and motherhood

Based on the findings on teenage pregnancy and motherhood in the country, the following recommendations are suggested:

- A multi-sectoral approach is needed to curb teenage pregnancy and motherhood. Hence, the UNFPA in collaboration with the GHS, MOE, National Population Council (NPC), local institutions, donors and development partners should embark on advocacy to raise awareness about causes and consequences of teenage pregnancy and motherhood. Specifically, these advocacy programs should be directed at rural areas, adolescents with no education and those in the Central, Volta and Brong Ahafo regions, which have high prevalence of teenage pregnancy and motherhood cases.

- Modern contraceptive use was found to be consistently low among adolescent girls. UNFPA should work with partners to implement sustainable behavior change interventions in reproductive health and family planning.

- UNFPA and its partners should embark on girls' empowerment programs such as vocational training for those out of school to address the underlying economic challenges that drive girls to engage in early sexual activities.

- UNFPA should engage the Ministry of Education and Ghana Education Service to develop programs that offer incentives to retain girls in school.

- UNFPA should support the government to develop a program that re-integrates girls back into school following childbirth.

7.2.2 Abortion

In view of the fact that adolescent girls and young women still resort to unsafe abortion, the study recommends the following:

- UNFPA in collaboration with the GHS, Ipas, Marie Stopes International, Population Council and relevant local NGOs should embark on educating adolescent girls and young women on their sexual and reproductive rights according to the law.
- UNFPA should collaborate with the GHS and the various development partners including Ipas and Marie Stopes International to provide education and referrals to adolescent girls and young women to access family planning and Comprehensive Abortion Care (CAC) services. This could be done by investing in mass media campaigns as well as increasing both the availability and access to CAC services.
- GHS service providers should be educated, sensitized as well as adhere to the National Reproductive Health Service Policy and Standards for the provision of CAC services.

7.2.3 Gender-based violence

Findings on gender-based violence against young women led to the following recommendations:

- The gender focus of the UNFPA CO should work with the Ministry of Gender, Children and Social Protection and the Domestic Violence and Victims Support Unit (DOVVSU) to develop and/or strengthen programs that will sensitize and educate adolescents on the Domestic Violence Act of Ghana. In addition, the general public should be sensitized on the need to report cases of violence to the appropriate authorities.
- Conscious efforts should also be made to educate the general public especially adolescent girls and young women on the various forms of gender-based violence and the need to report cases of violence to the appropriate authorities.

7.2.4 Education

Recommendations on education are as follows:

- UNFPA should assist Ghana Education Service to strengthen existing national programs on girls' education.
- UNFPA in collaboration with Ministry of Education, GES and other institutions, should devote major efforts to the enrolment and retention of girls at the secondary and tertiary levels of education.
- The Ministry of Education and GES should receive support to collect data on school dropouts and reintegration in the routine school census to facilitate the measurements of progress towards the SDG goal on education.

7.2.5 Child marriage

The analysis of child marriages prompted the following recommendations:

- UNFPA CO Program should assist the Ministry of Gender, Children and Social Protection and the Ministry of Education and other partners to develop tailored advocacy programs for adolescent girls with emphasis in rural areas and the three northern regions (Upper East, Upper West and Northern). This program should focus on educating communities and raising awareness on the consequences of child marriage. This can be done through opinion leaders such as chiefs to influence public opinion.
- UNFPA should work with the Ministry of Gender, Children and Social Protection to initiate a discourse for specific policy on child marriage since the Children's Act does not comprehensively address the issue of child marriage.
- Interventions for reducing child marriage should include a component that aims at improving retention of adolescent girls in schools, since education of girls serves as a protective factor against child marriage.
- Law enforcement agencies should put major focus on implementing and enforcing the existing laws governing child marriage in Ghana.
- UNFPA CO supported efforts should be directed towards curbing teenage pregnancy, which will lead to reducing child marriage particularly in the Central region where teenage pregnancy was found to be a precursor to child marriage. This could be done through working with reproductive health partners, both local and international, to improve access to and utilization of reproductive health services including Family Planning.
- To curb child marriage, out of school adolescents should be economically empowered through vocational skills building.

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ANNEXURES

Annexure 1: Assent Form for Married 12-17 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Your parent/guardian/husband has been informed about the research study and focus group discussion and we have received their permission. However, you do not have to say yes. We have talked to your parent/guardian/husband and he/she agrees that you do not have to say yes.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like you know about child marriage, how it is practiced, how you have experienced child marriage, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking girls like you in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. You have been invited to take part in this study because you got married before you reached 18 years of age.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a discussion with about 6 to 10 other girls who are the same age as you and also married before 18 years old. If you agree to be part of this research study, you will be asked questions about yourself and things you have experienced in your daily life and in your community. For instance, you will be asked about your age, education, housing situation as well as what you know and feel about several topics including child marriage, education, health and how to improve the lives of girls.

Since you will be one of up to ten girls in your age group to join the group discussion, we will ask the same questions to everyone in the group and you will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to leave the

discussion at any time without penalty. A risk may be a breach of confidentiality (something you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. You may find an indirect benefit in knowing that the information you and your peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you and the other girls say. We are also asking you to respect your peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.

Before the group discussion, you can decide to take a nickname or to be called by a number, which we will use to address you during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with organizers of community activities.

Reimbursement: After the group discussion, you will be provided with a drink and a snack to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to

answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print): _____

_____ _____

Date Signature of Interviewer

Annexure 2: Assent Form for Unmarried 12-17 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Your parent/guardian/husband has been informed about the research study and focus group discussion and we have received their permission. However, you do not have to say yes. We have talked to your parent/guardian/husband and he/she agrees that you do not have to say yes.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like you know about child marriage, how it is practiced, how you have experienced child marriage, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking girls like you in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. You have been invited to take part in this study because you are a girl who is under the age of 18 years old.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a discussion with about 6 to 10 other girls who are the same age as you. If you agree to be part of this research study, you will be asked questions about yourself and things you have experienced in your daily life and in your community. For instance, you will be asked about your age, education, housing situation as well as what you know and feel about several topics including child marriage, education, health and how to improve the lives of girls.

Since you will be one of up to ten girls in your age group to join the group discussion, we will ask the same questions to everyone in the group and you will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something

you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. You may find an indirect benefit in knowing that the information you and your peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you and the other girls say. We are also asking you to respect your peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.

Before the group discussion, you can decide to take a nickname or to be called by a number, which we will use to address you during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with organizers of community activities.

Reimbursement: After the group discussion, you will be provided with a drink and a snack to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to

answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print): _____

_____ _____

Date Signature of Interviewer

Annexure 3: Informed Consent Form for Parent/Guardian of 12-17 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. Your child/ward is invited to take part in this research study.

Before you decide whether to allow your child/ward to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you would like your child/ward to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep. Your child/ward will also be asked whether he/she wants to participate in the study.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like your child/ward know about child marriage, how it is practiced, how it is experienced, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking girls like your child/ward in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. Your child/ward has been invited to take part in this study because she is currently under the age of 18 years and may or may not be married.

If you agree to let your child/ward take part in the study, we will ask you to sign this form. Your child/ward will also be asked to participate in a discussion with about 6 to 10 other girls who are the same age as her. If you agree to let your child/ward take part in the study, she will be asked questions about herself and things she has experienced in her daily life and in her community. For instance, she will be asked about her age, education, housing situation as well as what she knows and feels about several topics including child marriage, education, health and how to improve the lives of girls.

Since your child/ward will be one of up to ten girls in her age group to join the group discussion, we will ask the same questions to everyone in the group and she will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact your child/ward again if there is a need to conduct this research again in the future.

Risks: Your child/ward may become embarrassed by or uncomfortable with a few of the questions we ask, but remember she can decide not to answer those questions. Your child/ward is free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something she says is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your child/ward's participation, but the information she gives us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. Your child/ward may find an indirect benefit in knowing that the information she and her peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that your child/ward has participated in the study. The study team will make every effort to protect her privacy and maintain the confidentiality of all the information that she provides. No one, except the people who are conducting the study, will know what she as a person has shared with us. Your child/ward's name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what she and the other girls say. We are also asking your child/ward to respect her peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.

Before the group discussion, your child/ward can decide to take a nickname or to be called by a number, which we will use to address her during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your child/ward's participation in this study is completely voluntary and at her own free will. If she decides not to participate, she will not lose any benefits to which she is entitled. If she agrees to participate in the study, she is free to end her participation at any time without penalty and she will not lose any benefits to which she is entitled. If your child/ward agrees to take part, she is free to skip any questions. Your child/ward is free to withdraw at any time without affecting her relationship with organizers of community activities.

Reimbursement: After the group discussion, your child/ward will be provided with a drink and a snack to compensate for the time she has spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you or your child/ward have a concern about any aspect of the study, you or your child/ward should ask to speak to the study researchers who will to their best to answer your questions. You may call Dr. Dela

Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way your child/ward has been treated during the study or any possible harm she might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You or your child/ward may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

_____

Are you willing to allow your child/ward to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to allow my child/ward to take part in this study. I understand that my child/ward's participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____ _____

Date Signature of Interviewer

Annexure 4: Informed Consent Form for Husband of 12-17 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. Your wife is invited to take part in this research study.

Before you decide whether to allow your wife to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you would like your wife to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep. Your wife will also be asked whether he/she wants to participate in the study.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like your wife know about child marriage, how it is practiced, how it is experienced, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking girls like your wife in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. Your wife has been invited to take part in this study because she is currently under the age of 18 years and may or may not be married.

If you agree to let your wife take part in the study, we will ask you to sign this form. Your wife will also be asked to participate in a discussion with about 6 to 10 other girls who are the same age as her. If you agree to let your wife take part in the study, she will be asked questions about herself and things she has experienced in her daily life and in her community. For instance, she will be asked about her age, education, housing situation as well as what she knows and feels about several topics including child marriage, education, health and how to improve the lives of girls.

Since your wife will be one of up to ten girls in her age group to join the group discussion, we will ask the same questions to everyone in the group and she will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact your wife again if there is a need to conduct this research again in the future.

Risks: Your wife may become embarrassed by or uncomfortable with a few of the questions we ask, but remember she can decide not to answer those questions. Your wife is free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something she says is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your wife's participation, but the information she gives us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. Your wife may find an indirect benefit in knowing that the information she and her peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that your wife has participated in the study. The study team will make every effort to protect her privacy and maintain the confidentiality of all the information that she provides. No one, except the people who are conducting the study, will know what she as a person has shared with us. Your wife's name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what she and the other girls say. We are also asking your wife to respect her peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.

Before the group discussion, your wife can decide to take a nickname or to be called by a number, which we will use to address her during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your wife's participation in this study is completely voluntary and at her own free will. If she decides not to participate, she will not lose any benefits to which she is entitled. If she agrees to participate in the study, she is free to end her participation at any time without penalty and she will not lose any benefits to which she is entitled. If your wife agrees to take part, she is free to skip any questions. Your wife is free to withdraw at any time without affecting her relationship with organizers of community activities.

Reimbursement: After the group discussion, your wife will be provided with a drink and a snack to compensate for the time she has spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you or your wife have a concern about any aspect of the study, you or your wife should ask to speak to the study researchers who will to their best to answer your questions. You may call Dr. Dela Kusi-Appouh who

works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org

What if there is a problem?: Any complaint about the way your wife has been treated during the study or any possible harm she might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 and 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You or your wife may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

_____

Are you willing to allow your wife to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to allow my wife to take part in this study. I understand that my wife's participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____ _____

Date Signature of Interviewer

Annexure 5: Informed Consent Form for Married 18-24 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like you know about child marriage, how it is practiced, how you have experienced child marriage, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking your women like you in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. You have been invited to take part in this study because you got married before you reached 18 years of age.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a discussion with about 6 to 10 other girls who are the same age as you and also married before 18 years old. If you agree to be part of this research study, you will be asked questions about yourself and things you have experienced in your daily life and in your community. For instance, you will be asked about your age, education, housing situation as well as what you know and feel about several topics including child marriage, education, health and how to improve the lives of girls.

Since you will be one of up to ten girls in your age group to join the group discussion, we will ask the same questions to everyone in the group and you will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being

experienced and how it is being continued and/or prevented in communities across the country. You may find an indirect benefit in knowing that the information you and your peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you and the other girls say. We are also asking you to respect your peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.

Before the group discussion, you can decide to take a nickname or to be called by a number, which we will use to address you during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with organizers of community activities.

Reimbursement: After the group discussion, you will be provided with a drink and a snack to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

_____

Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____ _____

Date Signature of Interviewer

Annexure 6: Informed Consent Form for Unmarried 18-24 year olds

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like you know about child marriage, how it is practiced, how you have experienced child marriage, and what can be done to prevent young girls from getting married early and sometimes against their will. We will be asking young women like you in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana. You have been invited to take part in this study because you are a young woman in Ghana.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a discussion with about 6 to 10 other young women who are the same age as you. If you agree to be part of this research study, you will be asked questions about yourself and things you have experienced in your daily life and in your community. For instance, you will be asked about your age, education, housing situation as well as what you know and feel about several topics including child marriage, education, health and how to improve the lives of girls.

Since you will be one of up to ten girls in your age group to join the group discussion, we will ask the same questions to everyone in the group and you will get a chance to hear what other girls have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the

country. You may find an indirect benefit in knowing that the information you and your peers share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you and the other girls say. We are also asking you to respect your peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group.
Before the group discussion, you can decide to take a nickname or to be called by a number, which we will use to address you during the group discussion. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with organizers of community activities.

Reimbursement: After the group discussion, you will be provided with a drink and a snack to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah

Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____ _____

Date Signature of Interviewer

Annexure 7: Informed Consent Form for Parents or Guardians

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in understanding what girls and young women like you know about child marriage, how it is practiced, how you or others have experienced child marriage, and what can be done to prevent young girls from getting married early and sometimes against their will. You have been invited to take part in this study because as a parent, guardian or grandparent, you can provide very useful information. We will be asking parents, guardians, and grandparents like you in this region (mention region) and in (mention second region) to know if there are similarities or differences across Ghana.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a discussion with about 6 to 10 parents, guardians, and grandparents. If you agree to be part of this research study, you will be asked questions about yourself and things you have experienced in your daily life and in your community. For instance, you will be asked about your age, education, housing situation as well as what you know and feel about several topics including child marriage, education, health and how to improve the lives of girls.

Since you will be one of up to ten parents, guardians, and grandparents to join the group discussion, we will ask the same questions to everyone in the group and you will get a chance to hear what others have to say as well. The group discussion will take about one hour. We will ask for the consent of the participants to record the discussion on tape. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to leave the discussion at any time without penalty. A risk may be a breach of confidentiality (something you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. You may find an indirect benefit in knowing that the information you and other parents, guardians, and grandparents share with us will help us to suggest recommendations to develop programs that will improve the livelihood of girls in Ghana.

Confidentiality: The information that is collected during the group discussion will be kept private. No one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the group discussion has been written down, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you and the others say. We are also asking you to respect your peers by keeping everything this is shared in the group discussion confidential (secret) and not to discuss it with anyone who is not part of this group. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with organizers of community activities.

Reimbursement: After the group discussion, you will be provided with a drink and a snack to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah

Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

_____

Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____ _____ _____

Date Signature of participant *(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____ _____

Date Signature of Interviewer

Annexure 8: Informed Consent Form for Key Informants and Key Stakeholders

Good morning/afternoon and thank you for agreeing to talk with us today. My name is _____. I am working with the Population Council, an organization that works to improve the health of all around the world, especially youth. We are currently doing a research on the topic of child marriage in Ghana. You are invited to take part in this research study.

Before you decide whether or not to participate, you need to understand why the research is being done and what it will involve. Please take time to listen as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this Informed Consent Form. You will be given a signed copy to keep.

Purpose: The purpose of this study is to understand the issue of child marriage in Ghana. We are interested in your perspectives on the incidence and prevalence of child marriage Ghana, its underlying causes and consequences, programmes, practices and initiatives against child marriage, gaps in policy and law enforcement on child marriage and your suggestion on how to address this social problem. You have been invited to take part in this study because you are a stakeholder and/or representative of an institution whose activities impact on adolescent girls and young women in Ghana. You are one of approximately 30 key stakeholders and decision-makers in the Central, Greater Accra, and Northern regions who have been identified to participate in the study.

If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in a key informant interview. We may contact you again if there is a need to conduct this research again in the future.

Risks: You may become embarrassed by or uncomfortable with a few of the questions we ask, but remember you can decide not to answer those questions. You are free to end the interview at any time without penalty. A risk may be a breach of confidentiality (something you say is accidentally provided to others), but we will take precautions to see that this does not happen.

Benefits: There are no direct benefits of your participation, but the information you give us will help us to understand better the issues of child marriage in Ghana, how it is being experienced and how it is being continued and/or prevented in communities across the country. You may find an indirect benefit in knowing that the opinions and experiences that you share with us will provide useful information on how to develop effective programme for girls and young women in Ghana.

Confidentiality: The information that is collected during the interview will be kept private. The study team will make every effort to protect your privacy and maintain the confidentiality of all the information that you provide. No one, except the people who are

conducting the study, will know what you as a person has shared with us. Your name and other identifiers will never be used in any research reports that come from this research. After the interview has been transcribed, the recording and the information we collected will be stored in a locked file and computer/hard drive that is only accessible with a password. Only our research team will listen to the tape to be able to write down what you said. There are no right or wrong answers to any of the questions.

Voluntary Participation: Your participation in this study is completely voluntary and at your own free will. If you decide not to participate, you will not lose any benefits to which you are entitled. If you agree to participate in the study, you are free to end your participation at any time without penalty and you will not lose any benefits to which you are entitled. If you agree to take part, you are free to skip any questions. You are free to withdraw at any time.

Reimbursement: After the interview, you will be provided with a token (phone credit) to compensate for the time you have spent with us.

Research Utilization: The results of the study will be presented in a report to be submitted to UNFPA Ghana, the sponsors of this study.

Who has reviewed the research?: The research study has been reviewed by the Ethical Review Committee of the Ghana Health Service as well as the Institutional Review Board (IRB) of the Population Council. These two groups that make sure people in studies are treated fairly and properly informed about all aspects of the study.

For more information and offer to answer questions: If you have a concern about any aspect of the study, you should ask to speak to the researchers who will to their best to answer your questions. You may call Dr. Dela Kusi-Appouh who works at Population Council and is the Principal Investigator. She may be contacted on this number: 050 740 5225 or by email: dkusiappouh@popcouncil.org.

What if there is a problem?: Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact: Ms. Hannah Frimpong who is the Administrator of the Ghana Health Service Ethical Review Committee. She may be contacted on these numbers: 0243 235 225 ad 050 704 1223 or by email: Hannah.frimpong@ghsmail.org.

You may also contact Mrs. Dinah Adiko who is the Head of the Ending Child Marriage Unit at the Ministry of Gender, Children and Social Protection. She may be contacted on these numbers: 0302 688 181/7.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

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Are you willing to participate in the research? ☐Yes ☐No

Participant's Statement

I have listened to and/or read the Informed Consent for this study. I have received an explanation for the planned research, procedures, risks, benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation is voluntary.

Name of participant (print): _____

Age of participant (print): _____

_____	_____	_____
Date	Signature of participant	*(mark)

*In case the respondent is not able to sign this form, this attests that the assent form has been read and explained accurately by a member of the research staff, and that the respondent has marked the space with an 'X.'

Interviewer's statement

I, the undersigned, confirm that I have personally defined and explained to the participant in a language that she/he understands, the nature and extent of the research, study procedures to be followed, potential risks and benefits, and the confidentiality of personal information.

Interviewer Name (Print):_____

_____	_____
Date	Signature of Interviewer

Annexure 9: Focus Group Discussion Guide for Married Adolescents and Young Women (12-24 years)

FGD Details

01. Facilitator's Name: _____

02. Note taker's name: _____

03. Number of FGD participants: _____

04. Age group: _____

05. Location of FGD: _____ Central [ ] Northern [ ]

06. Date of FGD (DD/MM/YYYY): _____/_____/_____

07. Start time: _____End time: _____

08. Notes/Comments:_____

_____

_____

Demographic Information of FGD Participants

P	Age	Age at marriage	Edu. level	Ethnic Group	Religion	Type of marriage	Living Arrangement	Number of children	Age of partner	Occupation of partner
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Legend: ***Education:*** 0= no education; 1= Primary; 2= JHS; 3= SHS; 4= Tertiary ***Type of marriage:*** 1= Monogamous; 2= Polygamous
Living Arrangement: 1= Marital; 2= Parental 3= Duolocal **Religion**: 0 = No religion; 1= Christianity; 2= Islam; 3= Other religion

Focus Group Discussion Guide for Married Adolescents (12-14 & 15-17 year olds) and Young Women (18-24 year olds)

Thank you again for agreeing to participate in this research on child marriage and how you have experienced it, and how it is dealt with in your area. We will start by asking the first question:

01. What are the reasons why girls in this area can get married early? ***Probe: Factors such as poverty, cultural practices, teenage pregnancy, school dropout etc.***

02. Was it you who decided to get married or did someone else decide for you? **Probe: if someone else, probe who? Probe for differences, if any, between who initiates and who makes the final decision.**

    a. If girl herself: what were your reasons for wanting to get married early?

    b. If other: did anyone talk to you about the reasons to get married early? **Probe: parents, grandparents, community elders, teachers**? What were the reasons?

        i. What did you think/feel about the reasons they gave you?
        ii. Did you feel you would be punished if you refused the reasons given to you? Would these punishments be justified?

03. Did any ceremony happen to show that you are now married? **Probe: traditional marriage ceremony with bride price; religious ceremony; verbal family exchange etc.**

04. What has changed in your life because you are now married? What has remained the same in your life because you are now married? **Probe: residence; schooling; societal recognition; empowerment; workload; childbearing; relationship with spouse, parents, community; freedom of movement; decision-making**

05. Among these things that you have mentioned (Q4), which of them have been good for you (benefits)? And which of them have been difficult to manage (challenges)?

06. Are you being given enough support as young married girls and women? Who provides this support? Do you find that it is sufficient enough to handle being young and married?

07. If your sister or your friend want to get married at the same age you got married, what advice will you give them? ***Probe: What have you learned from married early?***

08. For those of you who don't agree with the practice of child marriage,
    a. At what age do you think it is appropriate for a girl to get married?

b. What do you think can be done to stop child/early marriage? **Probe: higher bride price, legal action, educating the girl child.**

c. Who do you think can actually stop child marriage? ***Probe: Girls themselves, family, community, governmental or non-governmental organisation(s)?***

09. Are you aware of any programs, policies or laws in Ghana that focus on the issue child/early marriage***? Probe: which ones and what they entail (if known)***

10. Is there any other issue related to child marriage that we have not brought up in this discussion yet? ***Probe: Encourage further discussions.***

This is the end of the interview. Thank you for your time!

Annexure 10: Focus Group Discussion Guide for Unmarried Adolescents (12-17 year olds)

FGD Details

01. Facilitator's Name: _____

02. Note taker's name: _____

03. Number of FGD participants: _____

04. Location of FGD: _____ Central [ ] Northern [ ]

05. Date of FGD (DD/MM/YYYY): _____/_____/_____

06. Start time: _____End time: _____

07. Notes/Comments:_____
_____
_____

Demographic Information of FGD Participants (Unmarried Adolescents, 12-17 year olds)

Participant	Age	Educational level	Ethnic Group	Religion	Number of children
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Education: 0= no education; 1= Primary; 2= JHS; 3= SHS; 4= Tertiary

Focus Group Discussion Guide for Unmarried Adolescents (12-17 year olds)

Preamble: Thank you again for agreeing to participate in this research on child marriage. As you may know, there are some girls in Ghana and around the world who get married early, either by their own choice or because they are forced to do so.

01. What comes to your mind when we say child marriage? What are the reasons why girls in this area or in Ghana get married early? ***Probe: poverty, cultural practices, teenage pregnancy, school dropout, freedom, etc.***

02. Who normally decides that a girl will get married early?

03. Do you have any friends (or know of anyone) who got married before their 18th birthday?

04. As young girls, do you feel pressure from your community, family, government, church, mosque, and/or school to get married early?

05. What are the benefits of getting married early? ***Probe: Girls themselves, their parents/guardians or significant others, etc.***

06. What are the problems with getting married early? ***Probe: Early child bearing, pregnancy complications, child or mother death, rape, school dropout, controlling husbands (movement, opinions, communication with opposite sex, decision making)***

07. Do you plan on waiting after your 18th birthday to get married?

    a. If yes, what are your reasons for waiting until you pass the age of 18 years?
    b. Around what age do you think you will get married?
    c. If yes, what do you think are the benefits to delaying marriage?
    d. If yes, can there also be problems to delaying marriage?
    e. Who or what has influenced you to delay marriage until you are ready? **Probe: community, family, government, church, mosque, and/or school**

08. Are you being given enough support as young adolescents to delay marriage? Who provides this support? Do you find that it is sufficient enough to successfully delay marriage?

09. If you disagree with the practice of child marriage,
    a. At what age do you think it is appropriate for a girl to get married?
    b. What do you think can be done to stop child/early marriage?
    c. Who do you think can actually stop child marriage? ***Probe: Girls themselves, family, community, governmental or non-governmental organisation(s)?***

10. Are you aware of any programs, policies or laws in Ghana that focus on the issue child/early marriage***? Probe: which ones and what they entail (if known)***

11. Is there any other issue related to child marriage that we have not brought up in this discussion yet? ***Probe: Encourage further discussions***

This is the end of the interview. Thank you for your time!

Annexure 11: Focus Group Discussion Guide for Unmarried Young Women (18-24 year olds)

FGD Details

08. Facilitator's Name: _____

09. Note taker's name: _____

10. Number of FGD participants: _____

11. Location of FGD: _____ Central [ ] Northern [ ]

12. Date of FGD (DD/MM/YYYY): _____/_____/_____

13. Start time: _____End time: _____

14. Notes/Comments:_____
_____
_____

Demographic Information of FGD Participants (Unmarried Young Women, 18-24 year olds)

Participant	Age	Educational level	Ethnic Group	Religion	Number of children
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Education: 0= no education; 1= Primary; 2= JHS; 3= SHS; 4= Tertiary

Focus Group Discussion Guide for Unmarried Young Women (18-24 year olds)

Preamble: Thank you again for agreeing to participate in this research on child marriage. As you may know, there are some girls in Ghana and around the world who get married early, either by their own choice or because they are forced to do so.

01. What comes to your mind when we say child marriage? What are the reasons why girls in this area or in Ghana get married early? ***Probe: poverty, cultural practices, teenage pregnancy, school dropout, freedom, etc.***

02. Who normally decides that a girl will get married early?

03. Do you have any friends (or know of anyone) who got married before their 18th birthday?

04. As young women, do you feel pressure from your community, family, government, church, mosque, and/or school to get married?

05. Did you plan purposely not to get married before your 18th birthday?

    a. If yes: what were your reasons/motivations/influences for delaying marriage?
    b. If yes: at what age do you plan on getting married? Why?
    c. If no: at what age would you have wanted to get married? Why?

06. As things are now, do you feel you have benefitted from waiting to get married? If so, how have you benefitted? What would your life look like if you had gotten married earlier?

07. Have you faced any problems because you have delayed marriage? ***Probe: Delayed child bearing, pregnancy complications, shrinking marriage market, etc.***

08. Are you being given enough support as young women to get married at the age you desire? Who provides this support? Do you find that it is sufficient enough to successfully delay marriage?

09. If you disagree with the practice of child marriage,
    a. At what age do you think it is appropriate for a girl to get married?
    b. What do you think can be done to stop child/early marriage?
    c. Who do you think can actually stop child marriage? ***Probe: Girls themselves, family, community, governmental or non-governmental organisation(s)?***

10. Are you aware of any programs, policies or laws in Ghana that focus on the issue child/early marriage***? Probe: which ones and what they entail (if known)***

11. Is there any other issue related to child marriage that we have not brought up in this discussion yet? ***Probe: Encourage further discussions***

This is the end of the interview. Thank you for your time!

Annexure 12: Focus Group Discussion Guide for Parents/Guardians/Gatekeepers

FGD Details

01. Facilitator's Name: _____

02. Note taker's name: _____

03. Number of FGD participants: _____

04. Location of FGD: _____ Central [ ] Northern [ ]

05. Date of FGD (DD/MM/YYYY): _____/_____/_____

06. Start time: _____End time: _____

07. Notes/Comments:_____

_____

_____

Demographic Information of FGD Participants (Parents/Guardians/Gatekeepers)

P	Sex	Age	Age at first marriage	Educational level	Marital status	Ethnic Group	Religion	Occupation	Number of children
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Legend: ***Education:*** 0= no education; 1= Primary; 2= JHS; 3= SHS; 4= Tertiary ***Marital status:*** 1= Married; 2= Single; 3=divorced/separated

Thank you again for agreeing to participate in this research on child marriage and how you have experienced it, and how it is dealt with in your area. We will start by asking the first question:

01. In this community, who is considered a child?

02. What comes to your mind when we say child marriage? Is child marriage commonly practiced in this area?

03. Who usually decides or allows for girls to get married at an early age?

04. What are the reasons why girls in this area can get married early? ***Probe: poverty, cultural practices, teenage pregnancy, school dropout, etc.***

05. What are the benefits that come from early/child marriage for a girl and her family? ***Benefits for girls themselves, their parents/guardians or significant others, etc.***

06. What are the problems that come from early/child marriage for a girl and her family? ***Early child bearing, pregnancy complications, child or mother death, rape, school dropout, controlling husbands (movement, opinions, communication with opposite sex, decision making)***

07. What happens when a girl and/or her family if they refuse early marriage? Are these consequences justified?

08. How do parents/guardians/community members usually encourage or promote child marriage? ***Probe: Are there any incentives?***

09. How do parents/guardians/community members usually discourage or prevent child marriage?

<u>To Married participants in the group</u>

10. Did anyone in this group get married before 18 years of age?
11. Did you decide to get married at an early age or was it someone else's decision? **Probe: if someone else, probe who? Probe for differences, if any, between who initiates and who makes the final decision.**

12. What circumstances led to the decision for you to get married?

13. What have been the benefits of getting married at an early age?

14. What have been the problems with getting married at an early age?

Perspectives on Laws, Policies and Programmes to address Child Marriage

16. Are you aware of any programs, policies or laws that focus on the issue child marriage***?***
    Probe: which ones and what they entail (if known)

17. For those of you who don't agree with the practice of child marriage,
    - ***a.*** At what age do you think it is appropriate for a girl to get married?
    - ***b.*** What do you think can be done to stop child/early marriage?
    - ***c.*** Who do you think can actually stop child marriage? ***Probe: Girls themselves, family, community, governmental or non-governmental organisation(s)?***

18. Is there any other issue related to child marriage that we have not brought up in this discussion yet? ***Probe: Encourage further discussions.***

This is the end of the interview. Thank you for your time!

Annexure 13: Key Informant Interview Guide for Focal Persons & Key Stakeholders

Informant's Name: _____
Informant's Title: _____
Informant's Organization/Institution: _____
Organization/Institution primary area of focus: _____
Length of time focal person/stakeholder has worked with institution (in years):_____
Interview Date: _____
Interviewer's Name: _____

Thank you again for agreeing to participate in this research on child marriage and how you have experienced it, and how it is dealt with in your area. We will start by asking the first question:

01. What activities/programs is your ministry/department/organization engaged in to address the health of adolescent girls and young women in Ghana?

02. In your opinion, how widespread is the practice of child marriage in Ghana? In this region? In this area? [**Probe: in regions, probe higher or lower than national average?**]

03. What has your ministry/department/organization found to be the main drivers of or reasons for child marriage in Ghana? In this region? In this area? ***Probe: Factors such as poverty, cultural practices, teenage pregnancy, school dropout, etc.***

04. What specific actions has your ministry/department/organization taken to address the problem of child marriage in Ghana? In this region? In this area? ***Probe: Please describe these action in detail.***

05. Has your ministry/department/organization partnered with another to address the problem of child marriage in Ghana? In this region? In this area? ***Probe: If yes, describe collaboration; if not, describe reasons.***

06. How is your ministry/department/organization addressing child marriage with stakeholders and gatekeepers are keen on promoting child marriage?

07. Who have your your ministry/department/organization found to be community champions for ending child marriage? How are they being equipped to support the cause?

Perspectives on Laws, Policies and Programs to address Child Marriage

08. What is your opinion on the current programs, policies, and/or laws in Ghana that are aimed to end child marriage? Which ones are effective and which need strengthening/revision? **Probe: please discuss your reasons**.

09. Is there any other issue related to child marriage that we have not brought up in this interview yet?

This is the end of the interview. Thank you for your time!

The UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage in Ghana