

Rethinking the circumstances surrounding the first sexual experience in the era of AIDS in Ghana*

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Abstract

With heterosexual intercourse as the main source of HIV/AIDS transmission in sub-Saharan Africa, understanding the context of sexual experience has become important in research. The sexual debut and the circumstances surrounding that experience, although important, are rarely discussed. This paper examines the circumstances surrounding the first sexual experience, and their implications for the transmission of STDs in Ghana.

Data for the study are derived from a survey of both the general population and a few persons with HIV/AIDS in Ghana. About two-thirds of first sexual experiences were voluntary, sometimes in the context of mutual consent with a prospective spouse. A small number of first sexual experiences were through coercion. That the main participants are prospective marital partners points to overt or covert acceptance of premarital sex within the study communities. The level of premarital sex reported by both groups carries with it an inherent individual and collective vulnerability to STD infection, including HIV/AIDS.

After nearly two decades of research into the transmission and effect of HIV/AIDS in sub-Saharan Africa, a number of socio-demographic features associated with the disease have emerged. Among them is the recognition that HIV transmission is beginning to stabilize in some countries while still rising in others. Furthermore, the pattern and dynamics of spread are not uniform throughout the region. Rather, there are various strands of the epidemic on the sub-continent, reflecting the phases of the epidemic and the diversity of STD-prone behaviour. Some practices have contributed to the spread of HIV in some areas (UNAIDS 1998).

Studies also point to individual and collective vulnerability to HIV infection, found to be related to the decline of the economies of some countries in the last three decades; the collapse of some aspects of the traditional social support systems as an unintended consequence of modernization; inadequate health care systems; and poor nutrition (Ainsworth and Over 1994; Sahn 1994; Mann and Tarantola 1996; Anarfi 1997). Finally, the advent of AIDS has intensified the quest for understanding of aspects of sexual behaviour which emerged from studies in family planning in the 1970s and 1980s (Standing and

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Kisekka 1989; Dixon-Muller 1993). Among the issues explored are sexual networking, non-marital sex and various sexual practices that have implications for the spread of STDs, condom use and the interface between family planning and STD prevention (Awusabo-Asare 1996).

This paper discusses age at first sexual experience and the circumstances under which this occurs for a group of HIV/AIDS patients and a sample of the general population in Ghana. The aim is to analyse the circumstances of some of these first sexual experiences and the implications for STD, including HIV infection. With heterosexual contact as the main source of HIV transmission in sub-Saharan Africa, understanding the context within which sexual exchange takes place is important. Focusing on behaviour has the advantage of extending the discussion of HIV from the 'risk' groups which dominated earlier studies to some of the individual and collective sources of vulnerability to infection (Mann and Tarantola 1996). The targeting of younger females for sex because 'they have not been contaminated', as observed in some parts of Eastern and Central Africa (Schoepf 1988), could be one of the factors in the spread of HIV among young females. Some of these encounters may be the first sexual experience for the girls involved and may occur under circumstances such as coercion or rape which are rarely discussed openly in Ghana.

Discussion of the conditions in which STDs, including HIV, spread has become important because in spite of the publicity given to AIDS, some Ghanaians still believe it is for other people, in particular prostitutes, foreigners and Ghanaians who have travelled outside the country. This misconception is partly due to the fact that initially over 80 per cent of the diagnosed cases were international return migrants, most of whom were women associated with commercial sex in neighbouring countries (Anarfi 1990). Although the proportion of return migrants has declined, the view persists among some Ghanaians that HIV affects sexually active return migrants. But a number of Ghanaians could be at risk, particularly young people, because of changing perceptions of sexual behaviour and the varying circumstances under which sexual encounters can take place (Anarfi and Antwi 1995).

Background

Moral regimes

Adolescents in sub-Saharan Africa entering sexual life now are confronted with at least four moral regimes: traditional, Christian-Muslim, administrative-legal and 'romantic love' (Ahlberg 1994). The preferred sexual behaviour of the traditional, Christian and Islamic regimes is sex within marriage; that is, there should be no sex before marriage. However, at the moment the traditional regime seems to 'operate in a vacuum or lack sufficient regulatory and control mechanism' in some areas (Ahlberg 1994:234). This is because the traditional system has been undermined by formal education, Christianity or Islam and new administrative and legal structures established with colonialism and continued after independence. On the other hand, these new structures have not been able to completely replace the previous ones with new enforceable codes of sexual ethics within and outside marriage, creating ambivalence for some people (Kirby 1994). For instance, prohibition of pregnancy when initiation rites have not been performed under the traditional system has not been replaced by any viable alternative (Sarpong 1977).

The last regime, 'romantic love', tends to permit premarital sex as long as the people involved 'are in love' (Ahlberg 1994). This is especially the case for young people, particularly the educated and those in urban areas, through images from the school system

and the media. People starting new relationships, irrespective of age, seek intimacy and love; neither of the two people involved wants to wreck a new relationship. In such circumstances they may be under pressure to satisfy one another sexually. Females in particular are likely to be under pressure from their lovers to have sex as a demonstration of their love. The wish to satisfy a partner in such situations often outweighs any fear of acquiring a sexually transmitted disease or becoming pregnant. Moreover where convenient, people adopt one regime or the other. For instance, Preston-Whyte (1994) observed that young males in KwaZulu (South Africa) invoked traditional polygyny to justify their multiple sexual activities. Some of these practices are likely to increase the spread of STDs in sub-Saharan Africa.

Network of social obligations and interactions

The nature of sexual relations in any society forms part of a connected web of social relations. Mason (1994) has identified four kinds of socially binding network obligations with implications for the construction of gender relations that have existed over time. These are the development of (1) social identity through shared rituals; (2) mutual dependence based on exchange of gifts and services; (3) sense of social obligations through the exchange of gifts, which may or may not be economically valuable; and (4) system of obedience and cohesion through overt or covert force, and in some cases, by a central authority. These types of social obligation define the interactions between and within groups. Paraphrasing Levi-Strauss (1969), Mason (1994) noted that

although gifts of pigs, cowrie shells [or] food... may be highly valued and can create strong ties of obligation among men, women make the best gifts because they provide... children ... it is women who produce people ... it is the 'circulation of women' among groups of men that creates human society (p. 220).

Historically, such networks of social obligations have defined gender constructs and manifest themselves in the different sexual standards set for men and women. For instance, in the Ghanaian tradition of marriage and sexual relationships, adultery occurs only when the woman involved in an extramarital relationship is married (Amoah 1990). Thus, sex between a married man and an unmarried woman (never married, divorced or widowed) does not constitute adultery. As a sign of respect for his wife or wives, a married man may keep such a liaison secret but when it is known, he is expected to pacify his wife or wives, and in some instances marry the woman involved if she is not already married. Some of these practices inform premarital sexual relations for both males and females and influence the age and the circumstances under which first sexual experience occurs, especially for females. For instance, the sexual debut for a female may be within marriage after she has been offered as a bride, or the outcome of a liaison with a man as a prelude to marriage whether or not the man is married.

Source of data

In 1992, a study was conducted in Ghana on the social dimensions of HIV/AIDS infection. The objectives were to collect basic data on socio-cultural and economic issues which have implications for the transmission of HIV/AIDS; to assess the knowledge and attitudes of the general population towards STDs and people with AIDS; to study the demographic and socio-economic background of some people with AIDS and their relatives; and to examine some of the coping strategies adopted by infected persons.

For the study of infected persons and their relatives, eight of the ten administrative regions in the country were covered. Two of the regions, Upper East and Upper West, were left out, partly because there were few officially reported AIDS cases and partly because of problems of cost and supervision. In each region one researcher interviewed infected persons and their relatives, except in the Eastern Region where two interviewers were used because at the time of the survey nearly a quarter of all officially reported HIV sero-positive persons were in that region. Each interviewer was allocated a minimum number of infected persons and their relatives based on recorded cases from the regions and from a reconnaissance survey.

Prospective respondents were identified through regional AIDS counsellors and medical officers of health of the eight selected regions, and district medical officers of health of some districts. For some of the persons with AIDS, permission was also sought from their relatives. During the fieldwork some regional counsellors were given training on the interviewing schedule when it was realized that some of the infected persons and their relatives were prepared to talk to the counsellors instead of our trained interviewers. Respondents were interviewed at health centres, in their homes or at prearranged places. A few people who had agreed to be interviewed cancelled their appointments, possibly through fear of stigmatization. Thus, respondents were infected persons who agreed to be interviewed.

The data on the general population were derived from a three-stage sample of six districts. First, the 10 administrative regions in Ghana were zoned into high, medium and low reported HIV/AIDS areas. One administrative region was then selected from each zone through simple random sampling. In the next stage the selected regions were further classified into high-infection and low-infection districts within the region. Two districts were then selected from each region representing low- and high-infection districts. The procedure and the selected districts are described in Awusabo-Asare and Anarfi (1995). For the general population two instruments, interviewing schedule and Focus Group Discussion guide, were used. This paper reports some of the findings from the two surveys.

Various studies of human sexual behaviour have alluded to the problem of the reliability and validity of responses, because questions on sex touch on the intimate aspects of people's lives. It is rarely possible to cross-check responses on issues such as sexual networking which are not amenable to observation or other forms of research. In their evaluation of the WHO/GPA-sponsored studies on sexual behaviour related to HIV and AIDS, Dare and Cleland (1994) noted that 'It is extremely difficult to present clear-cut conclusions concerning the trustworthiness of survey information on sexual behaviour and related matters' (p. 106). However, studies matching responses of couples in rural Senegal found surprising agreement in their responses (Enel, Lagarde and Pison 1994). In general, the reliability of survey data on human sexual behaviour is influenced by factors such as the design of the study, the terms used, gender and age of the interviewers *vis-à-vis* the respondents, the interviewing environment and recall lapse time (Caldwell, Orubuloye and Caldwell 1994; Dare and Cleland 1994).

The first sexual experience as retrospective information has the potential of being misreported, through recall lapse error or because it happened under such unpleasant circumstances that respondents would like to suppress the experience. Furthermore, AIDS has generated mass hysteria in Ghana, as elsewhere (National Research Council 1993), leading to shame and isolation. It is necessary to be aware of these constraints when interpreting the data. Nonetheless, the survey provides information on sexual debut which is worth examining.

Findings

Background of respondents

In the survey, 141 persons with AIDS, 40 men and 101 women, were interviewed out of a targeted population of 150. The highly skewed sex ratio was partly due to the high proportion of diagnosed HIV-positive females in the country and partly due to the fact that more female patients than males were willing to be interviewed. From the general population, 2398 people, 1364 men and 1034 women, were interviewed in the three regions sampled.

The modal ages for the persons with HIV/AIDS were 25-29 years for the women and 30-35 years for the men. Of the general population interviewed, a third of the men were over 40 years compared to a quarter of the women, with modal ages 20-24 years for the women and 25-29 for the men (Table 1). The pattern of age distribution for the women, with the peak period of infection at ages 20-34 years, is similar to the pattern for all reported cases in the country. That of the men, however, is skewed because of the small numbers involved.

Table 1
Age of respondents

Age	Infected persons		General population	
	Males	Females	Males	Females
15-19	2.5	5.9	3.1	9.1
20-24	2.5	16.8	12.4	20.7
25-29	17.5	30.7	20.5	19.5
30-34	40.0	16.8	15.8	15.6
35-39	7.5	15.8	15.3	10.3
40+	30.0	13.9	32.9	24.9
Number	40	101	1364	1034

Age at first sexual experience

Because of the heterosexual transmission of AIDS in Ghana, understanding the context within which sexual experiences start and continue forms part of the general wish to understand aspects of the society which are likely to contribute to the spread of STDs, including HIV. Societies have always defined some of the conditions under which sexual activity can occur, such as within or outside recognized marital unions. However, the reality is sometimes different from the ideal. The first sexual experience and the circumstances in which it occurs can have implications for the individual involved.

Among the HIV-infected persons the reported minimum age of first sexual experience was 12 years and the median was around 18 years for both males and females. For the general population, the reported minimum age was nine years and the maximum was 32 years for the female and 49 years for the male respondents; the medians were 19.2 years (s.d. 4.024) for males and 17.9 years (s.d. 3.012) years for females, which compares with the reported median age of first sexual experience of 17 years for females in the second Ghana Demographic and Health Survey of 1993 (Ghana 1994). The reported minimum age of nine years is also the same as was observed in an experimental survey on sexual networking undertaken in Ghana in 1990 (Anarfi and Awusabo-Asare 1993).

Circumstances of first sexual experience

The circumstances under which the respondents experienced their first sex are shown in Table 2. About 75 per cent of the HIV-positive respondents but 55 per cent of the general population reportedly had their first sexual experience voluntarily. The first experience of another 15 per cent of the general population (12% for males and 16% for females) occurred as a prelude to marriage. This was not reported by the HIV-infected respondents. The response could be a rationalization of past events. Another four per cent of the general population reportedly had sex as a sign of friendship. On the other hand, among the women about a quarter of the infected persons and 13 per cent of the general population indicated that they were either forced or deceived by the men with whom they had their first sexual experience. Only one per cent of the general population reported rape. A further six per cent of the females lost their virginity at the request of their male partner. Two male patients had sex for the experience. It could be observed that first sexual experience in Ghana occurs under various circumstances: through coercion, deceit, and mutual consent or for other reasons.

The proportion reporting first sexual experience as a prelude to marriage or sign of friendship may have had sex in accordance with expected traditional behaviour. This may be particularly so with the female respondents; but it is uncertain whether even some of these experiences were voluntary or coerced. The 21 per cent of the infected females and 13 per cent of the females in the general population reporting 'forced' sex might have used the term as a synonym for rape, since in Ghanaian society rape is rarely mentioned.

Table 2
Circumstances of first sexual experience

Circumstance	AIDS patients				General population			
	Males		Females		Males		Females	
	No.	%	No.	%	No.	%	No.	%
Forced	3	7.5	21	20.8	112	8.7	124	12.9
Raped	0	0.0	0	0.0	0	0.0	11	1.1
Enticed/deceived	0	0.0	2	2.0	11	0.9	9	0.9
Willingly/mutual	30	75.0	74	73.3	720	56.1	489	50.7
Prelude to marriage	0	0.0	0	0.0	158	12.3	162	16.8
Sign of friendship	0	0.0	0	0.0	56	4.4	35	3.6
Requested	0	0.0	0	0.0	37	2.9	60	6.2
Instincts	0	0.0	0	0.0	78	6.1	24	2.5
For experience	2	5.0	0	0.0	0	0.0	0	0.0
Other	1	2.5	0	0.0	111	8.6	50	5.2
Not stated/don't know	4	10.0	4	4.0	0	0.0	0	0.0
Total	40	100.0	101	100.0	1283	100.0	964	100.0

Persons involved

The majority of the respondents knew the persons with whom they had their first sexual experience (Table 3). Seventy-three per cent of the infected respondents first had sex with people they classified as a 'friend'; seven per cent of the women reported 'a prospective spouse' as the person with whom they had their first sexual experience. In the case of 13 per cent of both men and women the partner was a school-mate or a casual friend. The 'others' category includes a prostitute and a 'stranger'.

The pattern of reporting for the general population is similar to that for the infected persons. For instance, over two-thirds of both the male and female respondents in the general population reported having had their first sexual experience with a 'friend'. Another quarter of the women, but 14 per cent of the men, reported prospective spouse as the person with whom they first had sex. About seven per cent of the men and two per cent of the women reported school friend or playmate.

First sexual experience with school-friends or playmates reported by both the patients and the general population point to the existence of sexual activities among adolescents. People classified as 'strangers' were reported by both groups. The term 'stranger' as used in most areas of Ghana does not necessarily mean a person unknown to the respondent; it also refers to a non-indigene in any area, who may, however, be known to the respondent.

Table 3
Person with whom respondent had first sexual experience

Person	Infected persons				General population			
	Males		Females		Males		Females	
	No.	%	No.	%	No.	%	No.	%
Friend	31	77.5	72	71.3	935	71.6	678	69.1
Proposed spouse	0	0.0	7	6.9	177	13.6	244	24.8
Play/classmate/casual	5	12.5	15	14.8	89	6.8	21	2.1
Other	4	10.0	7	6.9	104	8.0	39	4.0
Total	40	100.0	101	100.0	1305	100.0	982	100.0

Although the information is retrospective, the responses indicate some of the known pressures on young people, especially girls, during adolescence. These observations are not unique to Ghana. Helitzer-Allen, Makhamera and Wangel (1994) have similarly observed among girls in Malawi 'that their boy friends begged them to have sex and sometimes they were forced to do it' (p. 78).

Conclusion

The Ghanaian traditional system has always supported early marriage and childbearing. Traditionally, girls were married off immediately after menarche partly to avoid the temptation of early premarital sex (Sarpong 1977). Biological maturity, defined by menarche, also meant social maturity for marriage (Udry, Talbert and Morris 1986). This traditional regime limited the period between physical and social maturity for marriage and childbearing. However, the expansion of formal education for females, urbanization and migration, have changed the traditional system of social and sexual maturity. Girls no longer marry at puberty, at least in urban areas, a situation that increases the gap between physical maturity and age at first marriage. This gap creates conditions for premarital sex.

In general, Ghanaian societies, especially in the urban areas, are transitional in socio-political, cultural and economic structures. Traditional systems co-exist with modern ones in such diverse areas as definition of prestige and social status, moral behaviour, marriage, inheritance and sexual activity in both rural and urban areas. Traditional rulers and elders are no longer the ultimate authority, even in rural communities, because of changes in the socio-economic and political structures (Nukunya 1992; Dei 1994). Thus, a young person in Ghana is always confronted with one or another of the four moral regimes. Occasionally the ideologies clash and lead to open conflict. The reported circumstances of first sexual experience reflect some of the changes taking place. First sexual experience outside marriage of one's own volition, with a prospective husband, schoolmate or stranger would have been unheard of in the 1940s. Of course, the 'gate-keepers' of traditional morality are not happy with some of the changes taking place. Thus, in 1994 the traditionalists protested and succeeded in stopping the advertisement of condoms on television during prime time with the excuse that it would corrupt the young, who were, however, already sexually active.

The fairly high proportion of first sexual experience with a prospective spouse points to possible pressure on girls to show their interest in a relationship through sex and also to prove their fertility. Such premarital sex appears to be tacitly permitted. At one of the focus-group sessions with men aged 50 years and above, a participant said:

The society accepts premarital sex among people contemplating getting married. It is a necessary prelude to marriage for those yet to marry for the first time and those wishing to marry another wife.

However, there was a distinct difference between male and female attitudes to premarital sex. While the men accepted it as 'normal', older women (35-49 years) disapproved of it, lamenting its high incidence among the young. There was a general consensus among the female participants that premarital sex and pregnancy did not carry the stigma that existed in the past; consequently there was a high incidence of premarital sex.

Sex with a prospective husband indirectly contributes to sexual networking. When the relationship did not end in marriage the two people involved repeated the same process with other people. Such people do not consider themselves to be at risk of STD infection, let alone HIV, since they feel that they have sex with somebody they know. As part of preventive messages it will be important to stress that familiarity does not mean safety. Those who think that a sexual partner is a prospective spouse and therefore safe are exposing themselves to unnecessary risks of infection or unplanned pregnancy.

Furthermore, in spite of the socio-economic changes in Ghana over the last 50 years, some sexual acts are rarely discussed openly as they were in the traditional system. Rape and incest are rarely discussed; only one per cent of the females in the general population reported that their first sexual experience was through rape. Thirteen per cent of the females reported that they were forced but did not classify their experience as rape. Some of the forced sex may have been with relatives and, especially in the case of domestic servants, with employers and sons of employers..

Secondly, incest is rarely disclosed because it is against the moral code and is also an offence against ancestors and the gods. Previously, incestuous relationships carried very stiff penalties and included rituals to cleanse the offending parties (Rattray 1929; Sarpong 1977). The matrilineal Akan have a long list of sexual offences which include sex with maternal and paternal parallel cousins. Incest, if it occurs, is not likely to be reported and it is, therefore, not surprising that none of the respondents mentioned it as the circumstance of the first sexual experience.

Even the social and political system is yet to recognize the magnitude of such problems

as rape and incest and their implications for the spread of AIDS. In July 1993, during a debate in Parliament to amend parts of the Criminal Code dealing with sexual offences, female members of Parliament moved to increase the penalties for rape. However, the motion was not supported by the male-dominated Parliament and was defeated (Mensa-Bonsu 1995). However, one outcome of the debate and the subsequent defeat was that it created uproar in the country and helped to bring rape onto the political agenda. Another aspect of the debate was that 'AIDS did not feature in the discussion of the sexual offences', a situation which Mensa-Bonsu (1995:287) has called a 'denial syndrome' in the politico-legal system of Ghana. Such attitudes towards rape, incest and HIV infection at the highest level point to political under-reaction to the epidemic. Some of the circumstances surrounding sexual debut such as rape need to be publicized and discussed thoroughly since they put some people, especially young females, into avoidable risk of STD, including HIV.

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