QUALITY HEALTH: MY RIGHT, MY RESPONSIBILITY PROJECT

DOCUMENTATION OF BEST PRACTICES AND LESSONS LEARNT

PRESENTED TO YOUTH ALIVE

BY

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LIST OF ACRONYMS

APRRM - Annual Participatory Review & Reflections Meetings

CHPS – Community-based Health and Planning Services

CSE – Comprehensive Sexuality Education

FGM – Female Genital Mutilation

GES – Ghana Education Service

GHS – Ghana Health Service

HIV/AIDS – Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome

JHS – Junior High School

NGO – Non Governmental Organisation

SRHR – Sexual and Reproductive Health and Rights

STDs – Sexually Transmitted Diseases

STIs – Sexually Transmitted Infections

USAID – United States Agency for International Development

WHO – World Health Organisation

YA – Youth Alive

YAP – Youth Alive Programme
Foreword

It is common knowledge that the young people of today are tomorrow’s adults. It is also a truism that their fertility behaviour is a potential determining factor for future population growth in a country. It is of paramount importance that an environment be created and adequate support provided to enable adolescents develop their full potential and to enjoy a healthy and responsible adulthood.

While adolescence is a period of great opportunity and growth for young people it is also a period of adventure and high risks. Of all other groups, adolescents are one of the sizable groups that are hardly consciously thought of and targeted in terms of sexual and reproductive health service needs. Particularly in a culture, like what pertains in Northern Ghana, where it is difficult to discuss sex even among adults, sexual and reproductive health discussions with the youth is almost a taboo. Yet this is the group that needs sexual health education the most, given how curious and adventurous they are and, hence, the likelihood of being misinformed and getting themselves in trouble. However, they are usually very energetic and receptive to information that pertains to them and are anxious to become more autonomous in their decision-making. Such curiosity and interest in learning offers great opportunities for improving adolescent health and development.

All these informed Youth Alive’s choice of strategies in the implementation of its adolescent sexual and reproductive health project ‘Quality Health: My Right, My Responsibility’ as documented in this booklet. Key to this was the empowerment of the youth with correct, age appropriate and current information and skills to develop and practice responsible behaviours, protect themselves from risks as well as help them seek appropriate services. Information for parents, teachers and traditional authority was equally important as they play key roles in adolescent health and development. Once again, the youth demonstrated that with a little support they can redirect their energies to productive ventures, assume and provide very effective and innovative leadership to their peers/communities. It is thus, my pleasure, to share with you the Youth Alive experience in working with the communities, chiefs, elders, and particularly, the youth on issues bordering on the sexual and reproductive health rights of young people.

I would like to thank Star Ghana for funding this project. All our constituents are grateful to you. I also thank our collaborators and partners for helping to make this project a success. Again, the youth are energized; their self-esteem and confidence levels have increased and are poised to take on greater responsibilities. This needs to be consolidated, sustained and harnessed for further community and national development. We look forward to the fulfilment of the promise of GHS in the participating districts to replicate this project in all their communities.

Finally I want to acknowledge and congratulate the young people we worked with for their cooperation and their sterling work in reaching out to various youth groups in schools and communities, some of which were originally not part of the project. To them we say ‘yeyaane, yaane’, ‘tumatuma’ ‘daale’.

Agnes Chiravira
Director
EXECUTIVE SUMMARY

Youth Alive (YA) is a local Non-Governmental Organization (NGO) working with street and vulnerable children/youth in the poorest parts of Ghana, i.e. the Northern, Upper East and Upper West Regions. In February 2013, YA sourced funding from STAR Ghana, a multi-donor funding mechanism, to implement a project on adolescent Reproductive & Sexual Health.

The project was meant to:

1. Increase the number of youth accessing reproductive and sexual health facilities by 5%
   - increase youth awareness of their rights and responsibilities to access reproductive/sexual health services
   - reduce STIs
   - reduce teenage pregnancies

2. Increase the number of youth participating in health care delivery by 10%
   - increase youth awareness on their rights/responsibilities to participate in health care delivery
   - encourage GHS to hold planning meeting with the youth so their concerns can be captured in their (GHS) plans
   - Support youth to organize health related activities
   - Support youth to hold meetings with traditional authorities to discuss traditional issues that affect health/development

The following were the activities/methods carried out to meet the above objectives of the programme:

1. The formation of school clubs and training of peer educators (as well as teachers) who teach their peers on adolescent reproductive health.
2. Organizing seminars/workshops where health professionals are invited to train school clubs and peer educators on adolescent health. This involves the use of demonstration materials such as condoms and a dummy of the male genital organ.
3. Organizing community durbars where health and other professionals are invited to sensitize the youth as well as adults on reproductive health and other health matters such as cleanliness. During these sections plays are also enacted to further educate people on the same issues.

4. The use of community radios to educate listeners on sexual reproductive health

5. Distribution of posters on adolescents’ reproductive health to further educate the youth.

The programme started in February 2013 and was expected to end in January 2015. However, the project had to end in December, 2014 as there were considerations and preparations for a phase two of the STAR Ghana programme. It was implemented in the communities 20 communities in the Upper East and Upper West regions of Ghana.

The objectives of this current study were to:

- Analyse the appropriateness and effectiveness of processes and strategies adopted to facilitate the achievement of key project results/outcomes.
- Document best practices of the project implementation;
- Document Lessons learnt (positive, negative);
- Document Challenges;
- Provide video recording evidence; and
- Recommend future direction of Youth Alive.

Out of the 20 operational communities, multi-stage sampling technique was employed to select 13 for the study. These are Vunania, Biu and Tampola-Kapania in the Kassena-Nankana Municipality, Kayoro, Katiu and Saa in the Kassena-Nankana West and Yikene in the Bolgatanga Municipality all in the Upper East region. The rest are Loggu, Sagu and Baaleyire in the Wa East and Kpongo, Charia, Busa and Kejetia in the Wa Municipal, also in the Upper West region. A total of 230 school club members as well as community members (20 from each community) were interviewed, aside some key informants.

A number of data collection methods were used in the study, namely; individual questionnaire administration, focus group discussions, key informant interviews, observations as well as video recording. The method of data analysis was basically descriptive, using mean ranks.
The following were some of the very best practices:

- The establishment of five youth centres and the furnishing of existing ones in the operational areas of YA (except Yikene in the Bolgatanga district of the Upper East region).
- The establishment of a CHPS compound in Saa/Katiu through the instrumentality of the Assembly women, the roofing of which was done by Youth Alive.
- Video show on sexually reproductive health in the participating communities, especially Yekini in the evenings, which was highly patronized by the youth. In the case of Yekini, the high patronage was partially as a result of the absence of electricity in the community. The programme is, in a way, also a source of entertainment. The two nurses there had been very instrumental.
- A locally made video on adolescent health in Busa (in the local dialect and involving local youth). Two nurses were a good model to the youth.
- A replacement of a night club with a local dance called “Dugu” in Busa.
- The peer educators in Baaleyire and Tampola had been so hard working that the pupils preferred confiding in them to confiding in the teachers.
- The impact of Youth Alive’s Programmes (YAPs) had extended beyond the moral life of the students to their academic life.
- A nurse in Charia had been a role model to the community members, especially the young girls who were all aspiring to be nurses.
- There had been a cordial relationship between YA and other stakeholders such as chiefs, GHS and GES in the programme areas. A good monitoring of the programmes (i.e. regular quarterly visits, use of visitors books to check staff visits, health personnel visits, etc.).
- The YAPs had served as a wake-up call to existing institutions to do better, their core mandate.
Challenges

The problems/challenges were as follows:

- The promotion of condom use among the youth, especially those in the primary school, did not go down well with the parents at the initial stages. At the latter stages some of them still had their reservations.
- While in some quarters the (school) peer educators were celebrated, in other places they were a laughing stock; they were stigmatized as being spoiled. “if you can do this at this stage then I bet you, you will not finish school” (A man said this to a peer educator after he drew a male sex organ).
- Some youth were shy of going to buy condoms because they were being sold by adult nurses.
- The timing and venue for the workshops were a problem for some of the pupils in the rural communities.
- The meeting place (and furniture) and times of some of the school clubs were a problem for some school clubs.
- It was reported that sometimes YA did not keep to their time of meeting with them (community members).
- It was reported that some school girls and women found the contraceptives to be expensive.
- Some people argued that poverty was the root cause of promiscuity on the part of youth, especially the girls. YA should help to address this. This point was buttressed by one of the leaders of Kejetia (a street youth), who said that YA should step up their efforts in addressing the unemployment problems of the youth.
- The life span of the project had been criticised to be too short.
General recommendations by respondents

In the light of the above the following recommendations were made by the respondents

- Supply of T-Shirts and Identification cards for peer educators to help publicize the programme.
- Supply of simple manuals on reproductive adolescent health teaching of adolescent health in schools to be stepped up.
- The sale of condoms should be handled by the youth themselves.
- There should be more community durbars.
- Means of transport to be provided for community peer educators.
- Sponsorship for some of the brilliant but needy pupils. Some of them do those bad things because of poverty. They can buy books and pad. (School club patron at Katiu).
- Create opportunities for those who are not good academically to continue in vocational institute when they finish.
- Provision of logistics such as veronica buckets (e.g. in Yikene), benches and tables.
- Provision of a library facility to engage the school children.
- The programme to continue for some time. “Most of these programmes are laudable but the life spans are short. If we do it for a short time this current group will pass out and what about the rest?” Assembly man at Busa.

Recommendations for future implementation

For a more successful implementation of the programme in future the following recommendations are also made:

- Enough education and sensitization of community and religious leaders as well as parents is done before the school children are brought in. These would mean that parents would understand their children and also play a complementary role.
- The use of condoms is a bit sensitive. Education on this should be discriminatory so the very young ones in the primary school are not exposed to its use.
• Funding should be sourced to support some needy students who feel compelled to marry or pick a boyfriend. At a school club meeting we were shown a fifteen year old girl who is forced to marry because she has nobody to take care of her.
• Incentives should be given to peer educators to motivate them to work hard.
• We also reiterate the suggestion by the respondents that YA create opportunities for those who are not good academically to continue in vocational institute when they finish.

Conclusion

In conclusion, YA has made a good impact on the reproductive health of the people in their operational zones. All the methods were deemed efficient and complementing one another in addressing the reproductive health problems of the people. Essentially, the health professionals were instrumental in the workshops, school clubs, radio stations and the community durbars. Once the school clubs had been educated they also performed drama to complement the education by the health professionals at the community durbars. In future implementation though, it may be useful for YA to source funding for or seek partnership in addressing the poverty situation of the target population (e.g. young girls). It may also be necessary for the organisation to step up its skill training programme to absorb the youth who may not have the opportunity to further their education.
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1. INTRODUCTION

At the United Nations International Conference on Population and Development in Cairo in 1994, it was agreed by the international community that reproductive health care be made universally accessible by 2015. After a 5-year review of progress towards implementation of the Cairo programme of action, that commitment was extended to include sexual, as well as reproductive health and rights (Fathalla et al, 2005). Fathalla, et al (2005) noted that although progress has been made towards this commitment, much still need to be done to meet the original goal.

Against this backdrop, at the Rio+20 conference on sustainable development, one of the key outcomes was a call on governments to commit themselves and integrate into national policies strategies and programmes that will lead to the promotion on protection of all human rights with more emphasis on sexual and reproductive health including family planning and sexual health. Sexual and Reproductive Health and Rights (SRHR) incorporate the right of all individuals to make decisions concerning their sexuality and free from discrimination, intimidation, and violence (PartnersForum 2014: Soundari, 2012). Access to SRHR ensures that people (women, men, adolescent girls and boys) are able to choose what, whether, when, and with whom to engage in sexual activity; to choose whether and when to have children; and have access to general and specific information on the how to do so (Soundari, 2012). However, the Universal Access Project Report in 2014, indicates that about 60% of adolescents in Sub-Saharan Africa and South Central and Southeast Asia, who wish to prevent pregnancy rarely have access to modern contraception for the reason that such programmes are unavailable in most of these countries leading to increased percentages in teenage pregnancy, unsafe abortions and maternal mortality.

Sexual and reproductive health right has not been effectively promoted in the past. However in recent times the issue of sexual and reproductive health and human rights have become quite popular but needs a lot of resources to garner support for effective and efficient campaign. It is common knowledge that adolescents are particularly vulnerable to sexual and reproductive ill health as they often have unanticipated sex and find access to services very challenging, thus resorting to crude methods of pregnancy and unsafe abortion. It is therefore incumbent on governments and civil society organisations to ensure that women have access...
to sound reproductive health services, planned pregnancies that can prevent needless deaths among women and newborns (Grimes et al, 2006).

In terms of adolescent pregnancy and unsafe abortion, approximately 11 per cent of births worldwide are to women between 15–19 years old, and 95 per cent of these are in developing countries (Gibbs et al, 2012). Adolescent pregnancy and childbearing is more prevalent in sub-Saharan Africa, especially in rural communities where education levels for girls and women are very low. Thus the persistence of adolescent parenting among the poorest populations continues to be a cause for concern. This has often led to increases in unsafe abortions, as many of the girls have no intention of keeping pregnancies (Gibbs et al, 2012). Studies around the world indicate a higher magnitude of unsafe abortion than do health statistics. Thus high proportions of women (20–50%) who have unsafe abortions are hospitalised for complications. Unsafe abortion is preventable if information and access to reproductive health services are made available (Grimes et al, 2006). Unsafe abortion mainly endangers women in developing countries where abortion is highly restricted by law and countries where, although legally permitted, safe abortion is not easily accessible. In such situations, women faced with an unplanned pregnancy often self-induce abortions or obtain clandestine abortions from medical practitioners, paramedical workers, or traditional healers (Grimes et al, 2006).

Sex education is based on internationally and nationally agreed rights of the child, of women and of human beings in areas of sexual and reproductive health. A review of 87 studies of comprehensive sexuality education (CSE) programmes around the world showed that CSE increased knowledge, and two-thirds had a positive impact on behavior. Many programs delayed sexual experience, reduced the frequency of sex and number of sexual partners, increased condom or contraceptive use, or reduced sexual risk-taking. However, in most countries, such programs are unavailable (Lamb, 2010).

Fathalla, et al (2005) argued that sexual and reproductive health for all is achievable if certain measures are put in place as follows: if cost effective interventions are properly scaled up; political commitment is revitalized and financial resources are mobilized, rationally allocated and more effectively used. In developing countries other stakeholders whose roles are also important include the donor community, inter-governmental organisations, non-governmental organisations, civil society groups, the women’s health movement, philanthropic foundations,
the private for-profit sector, the health profession, and the research community. The research community particularly has a role in documenting “best practices” of reproductive health programmes for easy replication in other communities to save cost and time.

2. LITERATURE REVIEW

2.1 Definition of Best practice

WHO (2008; p2) defined Best Practice as “a technique or methodology that, through experience and research, has proven reliably to lead to a desired result.” In the context of health programmes and services, a practical definition of a Best Practice, according to WHO, is knowing what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts. The organization stressed that “best practice does not necessarily mean that the practice is perfect or of golden standards. Neither is it only about the aspects of a programme that have been successful. Rather it is about documenting and applying lessons learned on what does not work and why it does not work so that mistakes would not be repeated by other programmes and projects.

2.2 Benefits of Sharing Best Practices

USAID (2005) identified the benefits to an organization of sharing best practices as follows: raising the overall quality of services; improving operations at poorly performing units so that their performance more closely approaches that at the best units; avoiding duplication of effort or “reinventing the wheel”; minimizing the need to redo work because poor methods led to poor quality and save money through increased productivity and efficiency.

2.3 Criteria for Best Practices

WHO (2008) identified the following criteria for best practices:

Effectiveness: The practice must work and achieve results that are measurable.

Efficiency: The proposed practice must produce results with a reasonable level of resources and time.
Relevance: The proposed practice must address the priority health problems

Ethical soundness: The practice must respect the current rules of ethics for dealing with human populations.

Sustainability: The proposed practice must be implementable over a long period of time without any massive injection of additional resources.

Replicability: It must be possible to repeat the practice elsewhere without difficulty

Concluding, WHO (2008) noted that a best practice does not necessarily need to meet all the above criteria. What is important is that the practice has chalked up some successes with reasonable resources such that it can be replicated elsewhere.

2.4 Empirical Literature review on best practices in adolescent reproductive health

Advanced Africa (2003) has observed that as adolescent reproductive health programmes become more prevalent, implementing best practices will help to reduce duplication and improve overall service delivery. Advance Africa (2003) categorized best practices under (i) school based programmes, (ii) Mass media programmes and (iii) community-based programmes. The key best practices identified in school based programmes were as follows: building on existing services and social structures; adaptation of existing educational curricula; use of existing institutions to implement adolescent programmes; participation of school administrators and parents; and utilization of drama for delivering messages. Under mass media programmes the key best practices identified were also as follows: use of popular youth culture; creating links to medical schools; utilizing local institutions; use of branding/logos; and use of drama and music for education and entertainment. Lastly, in the case of community-based programmes, the following were the key best practices: use of youth to educate community as a whole; multi-intervention approach to address comprehensive adolescent reproductive health; use of existing services and social structures; and peer education and promotion.

Similarly, the US Office of Family of Family Planning has identified nine best practices for teenage pregnancy prevention as follows; comprehensive sexuality education; clinical service linkages; information presentations; youth leadership development; life skills education; male
involvement; education and support for teen mothers and fathers; education and support of significant adults, parents and other caregivers; and community awareness and mobilization.

Furthermore, the JSI Research & training Institute of the Centres of Disease Control and Prevention in the USA outlined the best practices also with respect to teenage pregnancy prevention as follows; community mobilization; educating and engaging stakeholders; evidence-based and evidence-informed prevention programme implementation; increasing youth access to client-centred contraceptive and reproductive health care;

Lastly Cornel University (2003) outlined some best practices for youth development programmes in general as follows: comprehensive, long-term programmes that involve all aspects of a young person’s life (i.e. home, school and community); strong relationship with parents and other adults; new roles and responsibilities for the youth; attention to specific youth needs in a physically and psychologically safe environment; highly qualified and diverse staff who are well trained and committed to the youth development philosophy; opportunities for critical thinking and active, self-directed learning; programmes that motivate and convey high expectations for the youth; and teach specific skills using interactive teaching methods.

3. YOUTH ALIVE AND REPRODUCTIVE HEALTH PROGRAMMES

Youth Alive (YA) is a local Non-Governmental Organization (NGO) working with street and vulnerable children/youth in the poorest parts of Ghana, i.e. the Northern, Upper East and Upper West Regions.

Youth Alive’s approach to youth development is holistic and embraces five thematic programmes: Formal Education, Vocational Skills Training, Health Care, Youth in Governance and Women’s Economic Empowerment & Participation. The organization believes that reproductive health is a crucial aspect of overall health which is central to human development and affects everyone: individuals, families and communities alike. Unfortunately hundreds of teen girls, in and out of school, including those on the street and in rural communities, are unable to realize their full potential and live full lives due to early pregnancy before they mature into adulthood. In several pre-project stakeholders’
consultations held in the participating communities/districts, this was largely attributed to the lack of reproductive, sexual and contraceptive knowledge, along with difficulty in accessing contraceptives resulting in high teenage pregnancy, unsafe abortions, STIs and consequently school drop-out, low academic performance and death in some cases. The findings of a baseline survey commissioned, among other factors, confirmed the revelations of the pre-project stakeholders’ consultation meetings.

In February 2013, YA sourced funding from STAR Ghana, a multi-donor funding mechanism, to implement a project on adolescent Reproductive & Sexual Health.

The project was meant to:

3. Increase the number of youth accessing reproductive and sexual health facilities by 5%
   - increase youth awareness of their rights and responsibilities to access reproductive/sexual health services
   - reduce STIs
   - reduce teenage pregnancies

4. Increase the number of youth participating in health care delivery by 10%
   - increase youth awareness on their rights/responsibilities to participate in health care delivery
   - encourage GHS to hold planning meeting with the youth so their concerns can be captured in their (GHS) plans
   - Support youth to organize health related activities
   - Support youth to hold meetings with traditional authorities to discuss traditional issues that affect health/development

3.1 Implementation of the Practice

From the above objectives, the specific elements of the YA’s Sexual & Reproductive Health programmes (YAP) were as follows:

1. Family planning, including prevention of pregnancy and treatment of infertility
2. Prevention of STDs, RTIs including HIV/AIDS
3. Prevention and treatment of unsafe abortion
4. Human sexuality, sexual health, responsible sexual behaviour
5. Adolescent reproductive health and sexuality
6. Gender equity
7. Harmful traditional practices (such as FGM) and issues based on gender

The following were the activities/methods carried out to meet the above objectives of the programme:

6. The formation of school clubs and training of peer educators (as well as teachers) who teach their peers on adolescent reproductive health.
7. Organizing seminars/ workshops where health professionals are invited to train school clubs and peer educators on adolescent health. This involves the use of demonstration materials such as condoms and a dummy of the male genital organ.
8. Organizing community durbars where health and other professionals are invited to sensitize the youth as well as adults on reproductive health and other health matters such as cleanliness. During these sections plays are also enacted to further educate people on the same issues.
9. The use of community radios to educate listeners on sexual reproductive health
10. Distribution of posters on adolescents’ reproductive health to further educate the youth.

The programme started in February 2013 and was expected to end in January 2015. However, the project had to end in December, 2014 as there were considerations and preparations for a phase two of the STAR Ghana programme. It was implemented in the communities listed in table 1 below.

Table 1: Operation Areas of Youth Alive

<table>
<thead>
<tr>
<th>Region</th>
<th>District</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper east</td>
<td>Kassena Nankana Municipal</td>
<td>Vunania, Bui, Gaani, Janania, Tampola-Kapania</td>
</tr>
<tr>
<td></td>
<td>Kassena Nankani West</td>
<td>Kayoro, Katui, Saa, Abulu</td>
</tr>
<tr>
<td></td>
<td>Bolga Municipality</td>
<td>Yikene</td>
</tr>
<tr>
<td>Upper west</td>
<td>Wa East</td>
<td>Loggu, Sagu, Karisaga, Baaleyire, Wawa</td>
</tr>
</tbody>
</table>
Objectives of the study

The objectives of this current study were to:

- Analyse the appropriateness and effectiveness of processes and strategies adopted to facilitate the achievement of key project results/outcomes.
- Document best practices of the project implementation
- Document Lessons learnt (positive, negative)
- Document Challenges
- Provide video recording evidence
- Recommend future direction of Youth Alive

3.2 Study Area, Sample Size, Methods of Data Collection and Analysis

Out of the 20 operational communities listed above, simple random sampling was employed to select 13 for the study. These are Vunania, Bui and Tampola-Kapania in the Kassena-Nankana Municipality, Kayoro, Katui and Saa in the Kassena-Nankana West and Yikene in the Bolgatanga Municipality all in the Upper East region. The rest are Loggu, Sagu and Baaleyire in the Wa East and Kpongo, Charia, Busa and Kejetia in the Wa Municipal, also in the Upper West region. A total of 230 school club members as well as community members (20 from each community) were interviewed, aside some key informants. In Yikene, the team could not interview the club members and peer educators because of the GNAT strike action which commenced at beginning of the data collection exercise.

A number of data collection methods were used in the study, namely; individual questionnaire administration, focus group discussions, key informant interviews, observations, voice and video recordings. The method of data analysis is purely descriptive, using mean ranks of the mode of delivery of the programs and processes, which will be shown in the main report. In this preliminary draft report only findings from the some focus group discussions and the key informants are presented.
4. RESULTS

4.1 Respondents’ levels of awareness on reproductive health before and after joining YAP

Respondents were asked to indicate their levels of awareness before and after joining YAP. They were to score the awareness level with a score ranging from 1 (lowest) and 5 (highest).

From Figure 1 below, we observe that on average, the respondents’ levels of awareness after YAPs were at least twice the levels before. A paired sample t-test was used to assess whether there is significant difference in the level of awareness before and after the training programmes from Youth Alive. All the analyses indicate that there was statistically significant difference in the level of awareness before and after the training programmes from Youth Alive. Thus, Youth Alive has been effective in generating or enhancing the level of awareness on health and health related issues in their operational zones.

Figure 1 Respondents’ levels of awareness on reproductive health before and after joining YAP.
4.2 **Source of Awareness and Subject of Discussion**

Having indicated their levels of awareness before and after YAPs, respondents were then asked to mention their source of awareness as well as the subject of discussion when they first got to know about YAPs. The commonest source was workshops and educational fora organized by YA officials (32.1%), followed by school clubs and group discussions in the schools (23.1%) , community durbars (15.4%) and education by the school teachers (10.9%). The rest are as indicated in Figure 2 below. With respect to the subject of discussion when they first got to know about YA, education on family planning, abstinence and prevention of STDs, sexual reproductive health, responsible sexual behaviour as well as adolescent and youth reproductive health emerged as the most important (75.2%), followed by personal hygiene (10.2). the rest are as shown in Table 3. Reproductive health related issues dominating the discussions at first contact with YA did not come as a surprise to us, considering the fact that they are the core messages of YAPs.

Table 2: Source of knowledge about Youth Alive Programmes

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>workshop / educational forum organized by officials</td>
<td>50</td>
<td>32.1</td>
</tr>
<tr>
<td>/facilitators of Youth Alive Programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>community durbars</td>
<td>24</td>
<td>15.4</td>
</tr>
<tr>
<td>radio discussions</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>school clubs and group discussions in school</td>
<td>36</td>
<td>23.1</td>
</tr>
<tr>
<td>through teachers of master</td>
<td>17</td>
<td>10.9</td>
</tr>
<tr>
<td>through peer educators</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>community clean-up exercises</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>community nurses</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>through research work at the community</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Opinion leaders/religious leaders</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>seminars</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>156</strong>*</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Excludes respondents who had not much information about YA
Table 3: Subject of Discussion at First Encounter with Youth Alive Programmes

<table>
<thead>
<tr>
<th>Subject of discussion</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal hygiene/ how to prevent oneself from diseases</td>
<td>16</td>
<td>10.2</td>
</tr>
<tr>
<td>Education on family planning, prevention of unwanted / teenage pregnancy, abstinence and prevention of STDs</td>
<td>63</td>
<td>40.1</td>
</tr>
<tr>
<td>Education on sexual reproductive health/ Education on responsible sexual behaviour</td>
<td>42</td>
<td>26.8</td>
</tr>
<tr>
<td>Education on youth and girl child education</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>Education on proper child care</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Education on prevention of communal violence and how to maintain peace and build a stronger society</td>
<td>8</td>
<td>5.1</td>
</tr>
<tr>
<td>Education on adolescent and youth reproductive health</td>
<td>13</td>
<td>8.3</td>
</tr>
<tr>
<td>Education on child or individual rights and responsibilities</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong>*</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Excludes respondents who had not much information about YA

4.3 Reasons for not having Access to Reproductive and Health Programmes

Before the introduction of YAPs, as high as 41% of the respondents did not have access to any reproductive health services in their respective communities, the reasons being that they lacked health personnel to educate and train them (29.5%), they lacked access to information on reproductive health issues (26.2%), and they lacked clinics/health centres (16.4%) (See Table 4). Another reason that they came up was the fact that training was considered as premature for the youth. This reason is important and underscores the importance of YAPs. Over the years, parents and adults in general, find it uncomfortable to discuss sex issues with their children, let alone offer them any form of training to protect themselves. Consequently, when the youth, especially the females, are confronted with any challenge they are at a loss as to how best they can surmount it. The relevance of YAPs in this case, has been the education and training that have benefitted the youth which have gone a long way to empower them. Less than two years after the inception of YAPs, as high as 96.1% of the respondents indicated they were involved in the programmes.
We have seen a lot of improvement. A parent can now take the female child to the health centre for her to be educated. **Assembly women at Katui/Saa**

At first the boys used to worry me but now I am something else; now I am like a lion to them”  

**A JHS girl at Katiu**

Table 4: Reasons for Not Having Access to Reproductive and Health Programmes

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigmatisation</td>
<td>3</td>
<td>4.9</td>
</tr>
<tr>
<td>Lack of personnel/nurses were not around to train us</td>
<td>18</td>
<td>29.5</td>
</tr>
<tr>
<td>Low level of awareness and lack of access to information on reproductive health issues</td>
<td>16</td>
<td>26.2</td>
</tr>
<tr>
<td>Lack of clinic or health centre in our community</td>
<td>10</td>
<td>16.4</td>
</tr>
<tr>
<td>Unfavourable timing of community forums or meetings on health issues</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>Training was considered as premature for the youth/training were meant for adults</td>
<td>8</td>
<td>13.1</td>
</tr>
<tr>
<td>I was not interested</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61</strong>*</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Only those who had no access to reproductive health services prior to YAPs

4.4 **Respondents’ Levels of Participation**

After asking them about their levels of awareness, the respondents were then asked to rate their levels of participation in the elements of the reproductive health programme before and after the interventions by YA. Like the levels of awareness, respondents were to score their levels of involvement before and after with a range of 1(lowest) and 5(highest). The idea was to find out the extent to which YA had helped to raise the respondents’ adoption of the services. To know this, we have computed the **difference** between the levels of participation **before** and **after** as shown in Table 5 below. A high value of the **difference** implies a high impact by YA. From the pooled data in the last column we observe that, in general, YA’s impact in the two regions was 1.8. Between them however, the impact in the Upper West region (2.1) was greater than in the Upper East region (1.5). Across the communities, the greatest impact was recorded in Baaleyiri (3.0), followed by Kpongo (2.3), Loggu (2.2),
Vunania (2.2) and Katui (2.0). The rest are as shown in the table. Baaleyiri recording the greatest level of impact does not come as a surprise. In this community the peer educators, and for that matter the school club is so effective that the pupils said they prefer confiding in them to confiding in their teachers. We also understand from the YA Coordinator that this is one community in which they faced resistance at a point but latter they overcame with the support of the chief.

Per the ‘after’ figures (last but one column), Busa emerges as the strongest community (5.0) However, the value for the difference is only 1.7 because the ‘before’ value is 3.3. Busa is one community that we found to be very innovative and receptive to development, no wonder their involvement in the services was comparably high even before the coming of YA. This is a community that had come out with a local video on adolescent reproductive health, not only in their local dialect but also involving some youth in the community. They had also replaced night clubs with a local dance called ‘Dugu’ because they said the former made the youth promiscuous. At a focus group discussion, when we asked about the sustainability of YAPs after YA withdraws they said it would not be a problem at all because they had been involved in a lot of self-help activities, including a water and a school building project which they had just completed. In terms of best practices, we find that an innovative community like Busa which would readily accept a development project to build on what they already have is as commendable as the one who starts with very little but ends big.
Table 5: Respondents’ Level of Participation in reproductive health before and after Youth Alive Programme

| Region     | Community | FP Before | FP After | DIFF | STDs Before | STDs After | DIFF | UA Before | UA After | DIFF | HS Before | HS After | DIFF | GE Before | GE After | DIFF | ARH Before | ARH After | DIFF | HTP Before | HTP After | DIFF | POOLED Before | POOLED After | DIFF |
|------------|-----------|-----------|----------|------|-------------|------------|------|-----------|----------|------|-----------|----------|------|-----------|----------|------|-----------|-----------|------|----------------|-------------|------|
| Upper West | Loggu     | 2.7       | 5.0      | 2.3  | 2.3         | 4.7        | 2.4  | 3.7       | 5.0      | 1.3  | 2.0       | 4.7      | 2.7  | 2.3       | 4.7      | 2.4  | 2.7       | 4.7      | 2.0  | 2.3       | 4.7      | 2.4  | 2.6       | 4.8      | 2.2  |
|            | Charia    | 2.8       | 4.4      | 1.6  | 3.2         | 4.2        | 1.0  | 2.6       | 4.0      | 1.4  | 2.4       | 3.8      | 1.4  | 2.6       | 4.6      | 2.0  | 2.6       | 4.4      | 1.8  | 2.4       | 3.6      | 1.2  | 2.7       | 4.1      | 1.5  |
|            | Kpongou   | 2.0       | 4.5      | 2.5  | 2.2         | 4.5        | 2.3  | 1.8       | 4.5      | 2.7  | 2.0       | 4.3      | 2.3  | 2.0       | 4.0      | 2.0  | 2.0       | 4.2      | 2.2  | 2.2       | 4.5      | 2.3  | 2.0       | 4.4      | 2.3  |
|            | Busa      | 3.0       | 5.0      | 2.0  | 4.0         | 5.0        | 1.0  | 4.0       | 5.0      | 1.0  | 2.0       | 5.0      | 3.0  | 4.0       | 5.0      | 1.0  | 3.0       | 5.0      | 2.0  | 3.0       | 5.0      | 2.0  | 3.3       | 5.0      | 1.7  |
|            | Baaleyiri | 1.0       | 4.0      | 3.0  | 1.0         | 4.0        | 3.0  | 1.0       | 4.0      | 3.0  | 1.0       | 4.0      | 3.0  | 1.0       | 4.0      | 3.0  | 1.0       | 4.0      | 3.0  | 1.0       | 4.0      | 3.0  |
| SUB-       |           | 2.3       | 4.6      | 2.3  | 2.5         | 4.5        | 1.9  | 2.6       | 4.5      | 1.9  | 1.9       | 4.4      | 2.5  | 2.4       | 4.5      | 2.1  | 2.3       | 4.5      | 2.2  | 2.2       | 4.4      | 2.2  | 2.3       | 4.5      | 2.1  |
| TOTAL      |           |           |          |      |             |            |      |           |          |      |           |          |      |           |          |      |           |          |      |           |          |      |
| Upper East | Bui       | 1.0       | 1.0      | 0.0  | 5.0         | 5.0        | 0.0  | 3.0       | 3.0      | 0.0  | 4.0       | 4.0      | 0.0  | 3.0       | 3.0      | 0.0  | 3.0       | 5.0      | 2.0  | 4.0       | 4.0      | 0.0  | 3.3       | 3.6      | 0.3  |
|            | Katui     | 3.0       | 5.0      | 2.0  | 4.0         | 4.0        | 0.0  | 1.0       | 4.0      | 3.0  | 1.0       | 3.0      | 2.0  | 1.0       | 3.0      | 2.0  | 2.0       | 4.0      | 2.0  | 1.0       | 4.0      | 3.0  | 1.9       | 3.9      | 2.0  |
|            | Kayorowura| 3.0       | 4.6      | 1.6  | 2.6         | 4.0        | 1.4  | 1.9       | 3.7      | 1.8  | 2.0       | 4.4      | 2.4  | 1.4       | 2.3      | 0.9  | 2.7       | 4.3      | 1.6  | 2.0       | 3.1      | 1.1  | 2.2       | 3.8      | 1.5  |
|            | Saa       | 3.0       | 4.5      | 1.5  | 3.5         | 4.5        | 1.0  | 2.5       | 4.5      | 2.0  | 3.0       | 3.5      | 0.5  | 2.0       | 3.0      | 1.0  | 2.5       | 4.5      | 2.0  | 2.0       | 4.0      | 2.0  | 2.6       | 4.1      | 1.4  |
|            | Tampola   | 2.7       | 4.0      | 1.3  | 2.3         | 4.5        | 2.2  | 2.2       | 3.7      | 1.5  | 2.2       | 4.0      | 1.8  | 2.0       | 3.8      | 1.8  | 2.3       | 4.0      | 1.7  | 2.0       | 4.2      | 2.2  | 2.2       | 4.0      | 1.8  |
|            | Vunania   | 2.7       | 5.0      | 2.3  | 2.3         | 4.7        | 2.4  | 3.7       | 5.0      | 1.3  | 2.0       | 4.7      | 2.7  | 2.3       | 4.7      | 2.4  | 2.7       | 4.7      | 2.0  | 2.3       | 4.7      | 2.4  | 2.6       | 4.8      | 2.2  |
| SUB-       |           | 2.6       | 4.0      | 1.5  | 3.3         | 4.5        | 1.2  | 2.4       | 4.0      | 1.6  | 2.4       | 3.9      | 1.6  | 2.0       | 3.3      | 1.4  | 2.5       | 4.4      | 1.9  | 2.2       | 4.0      | 1.8  | 2.5       | 4.0      | 1.5  |
| TOTAL      |           |           |          |      |             |            |      |           |          |      |           |          |      |           |          |      |           |          |      |           |          |      |           |          |      |
| GRAND TOTAL|           |           |          |      |             |            |      |           |          |      |           |          |      |           |          |      |           |          |      |           |          |      |           |          |      |

DIFF: Before - After
4.5 Respondents’ evaluation of the methods and services

Another important element of the questionnaire was for the respondents to evaluate the methods used by YAP against certain criteria of best practices. These criteria include accessibility, consistency with culture, ability to address reproductive sexual behavioural challenges, sustainability and cost effectiveness as outlined by WHO (2008). Again, they were to do the scoring on the scale 1 to 5 (I being the lowest and 5 being the highest). This means that the higher the score the greater the effectiveness of the method. From the pooled data (last column) in Table 5 it can be observed that community durbar was judged the most effective method (32.9), followed by school clubs (21.4), seminars & workshops (14.6) and teachers (6.8). The lowest score was demonstrations (0.6). With the same set of criteria the services were also evaluated and the results provided in Table 6 below. The pooled results show that apart from gender equity and adolescent reproductive health and sexuality which scored 3.4 and 3.6 respectively, all the rest scored 3.8, implying that there is not much difference among the services. Across the criteria, the highest score was by culture (3.9) and effectiveness (3.9), followed by sustainability (3.8), accessibility (3.7) and cost effectiveness (3.3). Culture recording the highest score comes as a surprise to us considering the thinking that some of these services (e.g. family planning, gender equity and elimination of FGM) are at variance with most traditional beliefs and practices. Turning to the services, we also find in Table 7 that those that made the greatest impact were HS (2.0), ARH (2.0) and HTP (2.0). The lowest impact was recorded by STDs (1.6).

Table 6: Methods used in delivering services

<table>
<thead>
<tr>
<th>Method</th>
<th>HS</th>
<th>ARH</th>
<th>FP</th>
<th>STDs</th>
<th>GE</th>
<th>FGM</th>
<th>Pooled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seminars / Workshop</td>
<td>16.5</td>
<td>13.5</td>
<td>12.1</td>
<td>13.3</td>
<td>14.0</td>
<td>18.2</td>
<td>14.6</td>
</tr>
<tr>
<td>Community durbars</td>
<td>33.0</td>
<td>30.6</td>
<td>27.7</td>
<td>27.4</td>
<td>41.0</td>
<td>37.4</td>
<td>32.9</td>
</tr>
<tr>
<td>Radio</td>
<td>6.8</td>
<td>5.4</td>
<td>2.9</td>
<td>3.7</td>
<td>8.0</td>
<td>8.1</td>
<td>5.8</td>
</tr>
<tr>
<td>School clubs</td>
<td>20.4</td>
<td>27.9</td>
<td>16.8</td>
<td>28.9</td>
<td>18.0</td>
<td>16.2</td>
<td>21.4</td>
</tr>
<tr>
<td>Focus group discussions</td>
<td>3.9</td>
<td>3.6</td>
<td>4.6</td>
<td>4.4</td>
<td>6.0</td>
<td>3.0</td>
<td>4.3</td>
</tr>
<tr>
<td>demonstrations</td>
<td>0</td>
<td>0.9</td>
<td>1.2</td>
<td>1.5</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Teachers</td>
<td>10.7</td>
<td>8.1</td>
<td>1.7</td>
<td>8.1</td>
<td>4.0</td>
<td>8.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Peer educators</td>
<td>5.8</td>
<td>7.2</td>
<td>4.0</td>
<td>5.2</td>
<td>7.0</td>
<td>7.1</td>
<td>6.1</td>
</tr>
</tbody>
</table>
Table 7: Respondents’ Evaluation of Services

<table>
<thead>
<tr>
<th>Service</th>
<th>CU</th>
<th>A</th>
<th>E</th>
<th>CO</th>
<th>S</th>
<th>Pooled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>3.9</td>
<td>3.9</td>
<td>4.0</td>
<td>3.1</td>
<td>4.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Prevention of STDs, STIs &amp; HIV/AIDS</td>
<td>4.1</td>
<td>4.0</td>
<td>3.9</td>
<td>3.2</td>
<td>3.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Prevention and treatment of unsafe abortion</td>
<td>4.0</td>
<td>3.8</td>
<td>4.0</td>
<td>3.5</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Responsible sexual behaviour</td>
<td>4.0</td>
<td>3.9</td>
<td>4.1</td>
<td>3.3</td>
<td>3.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Gender Equity</td>
<td>3.6</td>
<td>3.2</td>
<td>3.4</td>
<td>3.2</td>
<td>3.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Adolescent reproductive health &amp; sexuality</td>
<td>4.1</td>
<td>3.0</td>
<td>3.9</td>
<td>3.2</td>
<td>3.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Harmful traditional practices</td>
<td>3.9</td>
<td>3.8</td>
<td>3.9</td>
<td>3.3</td>
<td>4.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Pooled</td>
<td>3.9</td>
<td>3.7</td>
<td>3.9</td>
<td>3.3</td>
<td>3.8</td>
<td>3.7</td>
</tr>
</tbody>
</table>

CU=Culture; A=Accessibility; E=Effectiveness; CO=Cost; S=Sustainability

4.6 Respondents’ Evaluation of key processes

Evaluating a method includes evaluating the processes involved in the method. In this light, the respondents were asked to score some vital processes of the methods used by YA. The responses are indicated in the Table 8 below. On a whole, the responses were favourable. The best processes are indicated as follows: teachers’/facilitators’ level of understanding (4.5) and friendliness (4.5); learning from peers (4.4), friendliness of peers (4.3); relevance of lessons (4.3); school club members’ level of participation (4.3); venue (4.2) and time of meetings/training (4.1).

Table 8: Respondents’ evaluation of key processes

<table>
<thead>
<tr>
<th>Aspect of Method</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers’/facilitators’ level of understanding</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Rating</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Teachers/facilitators’ level of friendliness</td>
<td>4.5</td>
</tr>
<tr>
<td>Usefulness of relevant materials</td>
<td>3.8</td>
</tr>
<tr>
<td>Use of teaching aid</td>
<td>3.8</td>
</tr>
<tr>
<td>Timing of meetings/ training</td>
<td>4.1</td>
</tr>
<tr>
<td>Venue for meetings/ training</td>
<td>4.2</td>
</tr>
<tr>
<td>Relevance of lesson</td>
<td>4.3</td>
</tr>
<tr>
<td>School club members’ participation</td>
<td>4.3</td>
</tr>
<tr>
<td>School clubs members’ level of friendliness/ openness</td>
<td>4.1</td>
</tr>
<tr>
<td>Focus groups are based on sex and age group</td>
<td>3.9</td>
</tr>
<tr>
<td>Focus group discussions are open and frank</td>
<td>3.5</td>
</tr>
<tr>
<td>Ownership of radio</td>
<td>3.0</td>
</tr>
<tr>
<td>Time of radio discussions</td>
<td>3.4</td>
</tr>
<tr>
<td>Traditional/ opinion leaders advice and share ideas with youth</td>
<td>3.6</td>
</tr>
<tr>
<td>The number of community durbars are adequate</td>
<td>3.4</td>
</tr>
<tr>
<td>Discussions on reproductive behaviours at durbars are detailed</td>
<td>3.9</td>
</tr>
<tr>
<td>Peers are friendly</td>
<td>4.4</td>
</tr>
<tr>
<td>Learning from peers</td>
<td>4.5</td>
</tr>
</tbody>
</table>

5. DISCUSSION

From our interviews and interactions with the community members we gathered that the programme has been very beneficial to the people. Statistics given to us by the District public health nurse at Navrongo for instance gives the half year trend of teenage pregnancy cases in Kasena Nankana Municipality as follows: 2011(19.2%); 2012 (16.9%); 2013 (15.1%) and 2014 (14.9%). Clearly, from 2011 to 2014 there has been a reduction of teenage pregnancies in the municipality by 4.3%. The nurse also disclosed that prior to YA Project, they had only one youth centre giving adolescent health services in the whole district but with the coming of YA, five more youth centres have been opened in their (YA) operational areas. Also, with “their example and motivation, we have been able to extend it to other non-operational areas of YA in the district”. YA also helped (roofed) Saa/Katui community to build a CHPS compound. Also in Busa, the nurses told us that before YA they used to top the teenage pregnancy cases in the district, but now the cases have dropped considerably. YAPS have also led to a reduction in the school drop-out rate and improved the academic performance of
the school children. The exposure acquired through the participation in training workshops, drama performance, meeting and interacting with elderly people has also made the children, particularly the peer educators, very confident and assertive. The following are some of the comments made with respect to the achievements of YAPs:

*Adolescent problems have gone down by 80%. Now the kids are educating themselves. The kids have changed. I schooled with married people, some with kids. In my JSS time a whole class could be married. “Chief of Saa/ Katui

This was iterated by a peer educator at Baaleyire:

*Teenage pregnancy has reduced because, when we were in JHS 1 twelve girls dropped out of school because of teenage pregnancy but in JHS 3 only two dropped out and these are girls who were not serious with our talks.

5.1 Extent of partnership/collaboration

As is indicated earlier, one of the criteria of best practice is the extent to which the change agent partners with local/existing institutions on the ground. This does not only ensure that the intervention is well embraced and owned by the community, but also ensures sustainability of the programme. External funding of the programme is definitely not going to be forever; a time would come when funding would cease and the communities must be weaned off. If existing institutions are not brought into the picture and strengthened, then the programme will come to a halt as soon as funding ceases. Among the best practices identified by Advanced Africa (2003), ‘building on existing services and structures’ was identified as the most important in school-based programmes. JSI-CDC (undated) also argued that community mobilisation empowers individuals and groups to take action to facilitate change. They stressed that with respect to preventing teenage pregnancy, mobilising the sectors of the community where youth live, learn, work and play is essential in bringing together all relevant stakeholders to identify and understand underlying issues related to teen pregnancy and build community cohesion to address teen pregnancy prevention. It was against this backdrop that we sought to investigate the extent to which YA collaborated with existing institutions such as health professionals (GHS), teachers (GES), parents, chiefs and elders as well as community members in general. We noted that even though adolescent reproductive health is part of the school curricula and is supposed to be taught at the schools, not much
was done until the introduction of YAPS in the communities. Similarly, health professionals at the clinics as well as the municipal offices were not going to the schools to educate the school children because of logistical and staff challenges. The coming of YA however had made a change; not only had they strengthened the health institutions with logistics, YA had been a source of awakening and motivation to these institutions. YA had been a unifying body, bringing the other partners together for mutual strengthening and motivation. For instance, the capacity of teachers (patrons of clubs and adolescent health teachers) who participated in the workshops were strengthened in the same way that the community durbars were a source of knowledge-gain to the parents, community leaders and members in general.

Support from YA was not only in the area of capacity building, but also logistics such as establishing social centres, roofing a CHPS compound, financing workshops and durbars (providing refreshments and transport fares) and providing tables, chairs and benches to adolescent corners/clinics, among others. The following were some comments from some of the professionals and peer educators:

*We are into adolescent health. We don’t have the funding and the means. We had only one youth centre. Since they (YA) came we have taken 5 communities. YA did training in those five communities. YA is organizing inter schools talks and drama. We were doing it but because of funding it was not effective.* District public health nurse at Navrongo

*The youth were coming for advice but YA has brought more awareness* a staff nurse at St Martin’s clinic at Bui.

*YA laid the foundation for us to enact bye-laws. If you allow your school child to go and marry you will face sanctions. If you push your daughter into marriage, the elders of the community will invite you and make sure you bring your daughter back and pay back whatever you might have picked from the man. If you refuse they charge you. If you refuse to pay, we will send you to the Police station….We accepted it from YA to educate our own children. Before the YA Project most of the girls were getting pregnant, now it has reduced. They used to dress so that the guys would be attracted; now they have been taught to dress decently. A lot of them were dying through unsafe abortion, now it has reduced* Assembly man at Busa.
This finding is consistent with a case study in Ibadan, Nigeria, where a six week multimedia course presented during the school resulted in significant increases in knowledge and attitude toward HIV/AIDS. Advance Africa (2003) revealed that HIV prevention behaviours were improved after six months, including a decreased number of sexual partners and consistent use of condoms. Educational sessions were comprised of a variety of techniques including lectures, films, role plays, debates, stories, songs and essays. Lastly, a demonstration on the proper use of condoms was presented after receiving approval from the school principal and teachers. This key success factors, according to Advance Africa were support and involvement of the school principal and teachers.

5.2 Extent of Accessibility

The results in Table 5 shows that among the methods community durbars was the most important, followed by the school clubs, workshops and teachers. Demonstrations was the least important. However, another important finding we made, with respect to best practice, was the fact that the methods and programmes adopted by YA are complementary, rather than substitutes. For instance, it was at the workshop that teachers and peer educators were trained to also counsel and be mentors of their peers in both the schools and communities. Thus, in terms of accessibility, not everybody was invited, yet it remains about the most effective tool of empowering the peer educators. Without the workshops, the school clubs and the peer educators (both at the school and community levels) would only be a lame duck, existing in name but ineffective in delivery. It was also at the community durbars that the peer educators are able to educate the community leaders and members through drama on what they had been taught at the workshop. Also, at the community durbars, professionals have the opportunity to further educate parents, with demonstrations on what their children had been taught. This is very helpful so that the parents would also understand and appreciate the issues and play a complementary role in reinforcing what had been taught their wards.

Similarly, we found the health and the educational programmes of YA to be complementary. The educational project is a Dfid funded project titled “Reducing violence in school and home for 5601 children in 22 schools (4 districts) in Upper East and Upper West Regions (Ghana). This had increased enrolment, retention and educational performances of the pupils, as revealed in group presentations at YA’s APRRM. For example it was reported by Biu
peer educators that learning child rights, among others, had led to significant reduction violence in school and at home. This was corroborated by Katiu/Saa peer educators. In the case of Tampola community, “It has helped us to know our rights/responsibilities, children now obey parents, better relationship between parents/children”. Lastly, the educational project had led to a good relation between husbands and wives as well as parents now allowing children more time for studies in Janania community. This is a clear case of an educational project impacting and complementing the health project.

The ACT Centre for Youth Centre Development (2003) noted that involvement of parents and caregivers reinforces what the youth are learning and creates opportunities for family communication on teen issues. OFP (undated) also observed that having a prominent/influential speaker and mentors to promote vital messages would not only help raise the awareness level of the youth but motivate them to make better choices which would eventually enable the youth to change their high risk behaviours. In terms of accessibility, the community durbars commanded larger crowds than the workshops. However, the community radios stood even a better chance of reaching out to more people than the durbars. The challenges, however, were that not every household had a radio, and besides, the transmission time did not favour some people. This notwithstanding, there was the possibility of such disadvantaged people hearing the programme from their colleagues who might have listened to them. This is normally done while going to fetch water or going to the market.

5.3 Extent of sustainability

The problems with the workshops particularly, had to do with the meeting times and the means of transportation. While in nearby communities these were not much of a problem in the remote areas (e.g. Kayoro, Katiu, Saa, Biu, Loggu, Baaleire), concerns were raised with respect to having to leave home/school early to Navrongo or Wa and the programme not starting at the stipulated time. A community leader also raised concerns that normally they (leaders) would pre-finance the transportation of the school children to the workshop, after the money is reimbursed by Youth Alive; it becomes difficult to claim the money from the pupils. However, at the APRRM community representatives and leaders recognize the availability and accessibility of the nurses and health teachers in various schools as a great advantage that will enhance the programme to live on. Each community outlined the
steps/strategies (ref. fourth quarter report) being put in place to ensure sustainability. An opinion leader in Bui community in Navrongo district had this to say when the question of sustainability was asked, “we don’t need to go to Navrongo necessarily to incur cost on transportation, we can organize it here in the community and invite the professionals to speak to us. All communities agreed on implementation of community bylaws to protect the girl child. It was observed during the interactive session of the APRRM that while some communities have already started the implementation of some of the strategies, others are yet to begin.

In connection with the school clubs, a way forward towards sustainability, which YA had put in place, is to select leaders (among both staff and students) to understudy those who might be completing school or going on transfer before they leave. Also, in the absence of YA, an avenue has been created to the effect that the health professionals can be invited to the school premises to train the peer educators. With respect to radio discussion one suggestion that came from a health teacher and an opinion leader in Bui that is relevant for community ownership, and for that matter, the sustainability of the programme was “the need to go to the (radio) station with people residing in the community.”

The sustainability of a programme sometimes depends on numbers, i.e. the extent to which the programme is able to attract new members on a regular basis. At a point we were wondering why majority of the student in school were not members of the school club and so at Loggu JHS in the Upper west region, we interviewed some students who were not members of the club on why they had not joined. Their answer was that they did not come to school on the day that they were writing names. We probed further to find out if they knew of any benefits that the members were enjoying. Their response was that the members were keeping themselves well and were even doing better in exams, because some of the things they are taught at the club meetings come in the examinations. We concluded that perhaps, these non-members had simply not been motivated to join the trail. There is the need to ‘evangelize’ these students, who despite the fact that they knew about the good things that the programme could offer, were sitting on the fence. A discussion with the YA Director, however, revealed that the directive to the school clubs that membership should not exceed 30 had been misconstrued. She explained that for effective discussion she had directed that a particular club should not have more than 30 members, but that did not mean that they could not form more clubs in a particular school to accommodate those who may want to join later.
It also came to our attention that the churches and mosques had not been well-partnered with, compared with the health personnel and the traditional leaders. The influence of religious bodies in matters of sexuality cannot be downplayed. It came to our attention that the Catholic Church prohibits the use of contraceptives, and for that matter, family planning. If this is true, then given that majority of the community members are Catholics it would be important that the leadership of the church is targeted for them to appreciate the programme before any meaningful gain is achieved. We can take a cue from a statement that the chief of Saa/Katui made when we asked him about the extent to which YAP were at variance with their culture. He said “at first it was, but once the chief endorses it the members will agree because they know that the chief would not ask them to do what is bad.” This means that the best way to ensure that a programme is embraced by the people is to first educate the leadership, both traditional and religious. Once they accept it, the members are likely to also buy into it. Talking about leadership, one tool that also emerged as a best practice is how YA alive had facilitated the concept of role modelling. For instance, in Busa we were told that after a video show one day they “brought out all the technical people-nurses, teachers etc. and asked them won’t you like to be like these people”? According to the elders this has gone a long way to challenge the youth to aspire to be like their mentors. The nurses—a man and a woman in the Busa community, according to the Assembly man, are not only efficient, they are “youth friendly nurses”. He stressed that “if a school girl has a problem she comes to see them and discusses with them. They organize games, such as ludo, “oware”, film show, poem recitals and dictation to make the youth happy.”

The sustainability of a programme, also perhaps depends on the life span of that programme. In all the communities, the people wished that YAP will continue for some time. According to them, the programme is now gaining roots and if it phases out now it may affect its sustainability. “Most of these programmes are laudable but the life spans are short. If we do it for a short time this current group will pass out and what about the rest” the Assembly man at Busa commented.
Refreshments at workshops and durbars came up as one of the limiting issues with respect to the sustainability of the programme, but in Busa community, it should not be a problem at all; in a focus group discussion, they stressed that they would contribute to provide refreshments in their durbars when YA is no more; “when YA is no more, we will sell our goats and chicken to continue the programme” an elder retorted. The respondents cited water and a JHS projects, which they said the community members contributed their quota to make it a success. Largely, in all the communities, sustainability of community durbars was not in doubt at all. The health professionals also gave the assurance that they would continue to play their role stressing that “it is our job, Youth Alive only came to wake us up; we shall surely continue if they are no more with us.” Again, on the issue of refreshment, the Director of YA disclosed that in the spirit of sustainability they had stopped providing refreshments at durbars since the last quarter of the first year of operation and that it was rather GHS who had been providing the refreshment.

5.4 Ethical consideration

Another way by which we are evaluating the YAP is the extent to which the methods or activities were ethical and do not conflict with culture. Largely from the findings, YAP does not conflict with culture. It was only at the initial stages, that in some communities, parents were not in support of the use of condoms by the school children, however, with time, after evaluating the programme in totality, they came to the realization that the programme was good. Similarly, while the majority had come to accept family planning, concerns were raised by some men at a focus group discussion (in Kpongo) that their wives were “over planning” their families and were preventing them from having the number of children they wanted. Furthermore, while some women complained of bleeding, some had fears that after sometime they may not be able to give birth. Some health professionals in Busa, Charia and Yikene however, said they were constantly educating and correcting the misconceptions. According to the health professionals they advised and guided the women to choose the options that were most suitable to them. In Busa, some of the contraceptives were Nourigyuon, Depo-Provera and condoms. We found very innovative ways by which some communities (e.g. Busa), with the support of YA were going about the programmes. They had come out with a movie in their local dialect (“waale”) on teenage pregnancy and maternal health, using some of their own youth. This, according to the community members, had been very effective in
reversing the teenage pregnancy trend in the community. This movie had been shown in other communities. The good thing about this, in terms of sustainability, is not just the use of the local dialect but the use of the target group in the community. At a focus group meeting, the Assembly man who could not hide his joy was proudly pointing to some of the youth who acted in the movie.

In Yikene, in the Upper East region, a video on adolescent reproductive health was also a powerful tool, but not in the sense that it was local. The community has no electricity, and so video shows which the nurses at the CHPS compound occasionally showed was not only a source of vital information on their reproductive health, but a source of entertainment. In Busa, another innovation was the banning of night clubs and the replacement of a local dance, called “Dugu” on Friday nights, that the community members said they enjoyed more than the night clubs. Thus, with respect to video show, and for that matter entertainment for the youth, the best practice is a local alternative to the modern form of entertainment that exposed the youth to promiscuous living. In Yikene, one traditional practice that appears to be a threat, needs mentioning; we were told by the mid-wife at the CHPS compound that the people have a traditional practice where if there is a funeral at an aunt or uncle’s house, the girl (should be single) goes to pick a man (married or single), stays with him as a wife for the three days. This tradition, if not checked, can defeat the YAP objective of keeping the young girls pure and healthy. Also in Katui, there is normally a one month ban on drumming prior to harvesting millet. During this month the school children are not able to do their drama:

“They tell us we are making noise” a JHS peer educator lamented.

Furthermore, with the sale of condoms, the Assembly women at Katui/Saa made the following observation “women are those selling the condoms and women can talk. Some of the students feel shy. They should let their colleagues sell the condoms.” Lastly, at Charia, a recommendation was made by respondent that before a programme comes out openly, there is the need for talks with the community leaders if that programme is to be accepted. However, this was discounted by the Director of YA, stressing that before the launch of the project, they had a lot of talks with the chiefs and elders in each community.
5.5 **Extent of cost effectiveness**

The issue of cost is another important area in terms of evaluating the best practices of a programme/project. The methods and activities of YAPS were judged to involve some costs, even though not too much. From the findings (Table 6) cost effectiveness of YAPs scored the least (3.3), among the criteria. Needless to say, the production of posters on adolescent health cannot continue without sponsorship. In terms of the activities, family planning was a bit expensive to some users. In particular, at the Reproductive and Child health Division of the St Martins Clinic at Biu in the Upper east region, the midwife in charge noted that most of the women and girls want to patronize family planning but they find it to be expensive. Also, some men complained that the condoms were now expensive. Some of the youth also complained of not having radio in their homes, which meant that they were not able to listen to YAP. Lastly, the supply of YAP T-shirts and ID cards was another motivating way that the students, and even some adults, stressed as important in publicizing the programme, and for that matter ‘keeping the vision alive.’

6. **SUMMARY, RECOMMENDATIONS AND CONCLUSION**

6.1 **Summary of findings**

By way of summary, the following were some of the very best practices:

- The establishment of five youth centres and the furnishing of existing ones in the operational areas of YA (except Yikene in the Bolgatanga district of the Upper East region).
- The establishment of a CHPS compound in Saa/Katui through the instrumentality of the Assembly women, the roofing of which was done by Youth Alive.
- Video show on sexually reproductive health in the participating communities, especially Yekini in the evenings, which was highly patronized by the youth. The high patronage was partially as a result of the absence of electricity in the community. The programme is, in a way, also a source of entertainment. The two nurses there had been very instrumental.
- A locally made video on adolescent health in Busa (in the local dialect and involving local youth). Two nurses were a good model to the youth.
• A replacement of a night club with a local dance called “Dugu” in Busa.
• The peer educators in Baaleyire and Tampola had been so hardworking that the pupils preferred confiding in them to confiding in the teachers.
• The impact of YAPs which had extended beyond the moral life of the students to their academic life.
• A nurse in Charia had been a role model to the community
• The cordial relationship between YA and other stakeholders such as chiefs, GHS and GES in the programme areas. A good monitoring of the programmes (i.e. regular quarterly visits, use of visitors books to check staff visits, health personnel visits, etc.).
• The YAPs which have served as a wake-up call to existing institutions to do better, their core mandate.

6.2 Challenges

The problems/challenges were as follows:

• The promotion of condom use among the youth, especially those in the primary school, did not go down well with the parents at the initial stages. At the latter stages some of them still had their reservations.
• While in some quarters the (school) peer educators were celebrated, in other places they were a laughing stock; they were stigmatized as being spoiled. ”if you can do this at this stage then I bet you, you will not finish school” (A man said this to a peer educator after he drew a male sex organ).
• It was remarked that the sale of the condoms should not be done by adults because the youth feel shy to patronise it. It should be handled by the youth themselves.
• The timing and venue for the workshops were a problem for some of the pupils in the rural communities.
• The meeting place (and furniture) and times of some of the school clubs were a problem for some school clubs.
• It was reported that sometimes YA did not keep to their time of meeting with them (community members).
• It was reported that some school girls and women found the contraceptives to be expensive.
• Some people argued that poverty is the root cause of promiscuity on the part of youth, especially the girls. YA should help to address this. This point was buttressed by one of the leaders of Kejetia, who said that YA should step up their efforts in addressing the unemployment problems of the youth.

• The life span of the project has been criticised to be too short.

6.3 General recommendations by respondents

In the light of the above the following recommendations were made by the respondents.

• Supply of T-Shirts and Identification cards for peer educators to help publicize the programme
• Supply of simple manuals on reproductive adolescent health teaching of adolescent health in schools to be stepped up.
• More community durbars should be organized
• Means of transport to be provided for community peer educators.
• Sponsorship for some of the brilliant but needy pupils. Some of them do those bad things because of poverty. They can buy books and pad. (School club patron at Katiu).
• Create opportunities for those who are not good academically to continue in vocational institute when they finish.
• Supply Logistics such as veronica buckets (e.g. in Yikene), benches and tables
• Provision of a library facility to engage the school children.
• The programme to continue for some time. “Most of these programmes are laudable but the life spans are short. If we do it for a short time this current group will pass out and what about the rest?” Assembly man at Busa.

6.4 Recommendations for future implementation

For a more successful implementation of the programme in future the following recommendations are also made:
- Enough education and sensitization of community and religious leaders as well as parents is done before the school children are brought in. These would mean that parents would understand their children and also play a complementary role.
- The use of condoms is a bit sensitive. Education on this should be discriminatory so the very young ones in the primary school are not exposed to its use.
- Funding should be sourced to support some needy students who feel compelled to marry or pick a boyfriend. At school club meeting we were shown a fifteen year old girl who is forced to marry because she has nobody to take care of her.
- Incentives should be given to peer educators to motivate them to work hard.
- We also reiterate the suggestion by the respondents that YA create opportunities for those who are not good academically to continue in vocational institute when they finish.

6.5 Conclusion

In conclusion, YA has made a good impact on the reproductive health of the people in their operational zones. All the methods were deemed efficient and complementing one another in addressing the reproductive health problems of the people. Essentially, the health professionals were instrumental in the workshops, school clubs, radio stations and the community durbars. Once the school clubs had been educated they also performed drama to complement the education by the health professionals at the community durbars. In future implementation though, it may be useful for YA to source funding for or seek partnership in addressing the poverty situation of the target population (e.g. young girls). It may also be necessary for the organisation to step up its skill training programme to absorb the youth who may not have the opportunity to further their education.

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