FINAL REPORT

CONSULTANCY FOR THE ASSESSMENT OF THE INTEGRATED ASRH PROGRAM FOR SELECTED GIRLS IN SIX REGIONS IN GHANA

MAY 2019

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LIST OF ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
DOVVSU	Domestic Violence and Victim Support Unit
FA	Framework Analysis
FGDs	Focus Group Discussions
GES	Ghana Education Service
GHS	Ghana Health Service
GSS	Ghana Statistical Service
IDIs	In-Depth Interviews
IEC	Information, Education and Communication
JHS	Junior High School
LSD	Livelihood Skills Development
MGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
MoU	Memorandum of Understanding
PPAG	Planned Parenthood Association of Ghana
RAs	Research Assistants
SDGs	Sustainable Development Goals
SHS	Senior High School
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UCC	University of Cape Coast
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund

EXECUTIVE SUMMARY

Introduction

Many adolescents struggle with the consequences of teenage pregnancy, early and forced marriage, sexual harassment, rape, unsafe abortion and other forms of domestic violence. They face increased risk of complications from pregnancy, childbirth, unsafe abortion and sexually transmitted infections (STIs), which cause the death of many. Globally, there is comparatively a large proportion of adolescents in low and middle-income countries and related high rates of STIs, unwanted pregnancy, unsafe abortion and early parenthood. As a result, promoting adolescent sexual and reproductive health (ASRH) has become a global endeavor, which has forced many countries to pursue strategies aimed at addressing the sexual and reproductive health (SRH) needs of adolescents. As part of efforts contributing to minimize the incidence of child marriage, teenage pregnancy and unsafe abortion and to secure a healthy future for adolescents, the United Nations Population Fund (UNFPA), through its office in Ghana, partners with other United Nations Agencies (particularly the United Nations Children's Fund [UNICEF]), Government of Ghana, civil society, and youth-serving organisations to implement adolescent sexual and reproductive health-related education to both in-school and out-of-school young people. One of such programs is the Integrated ASRH program (referred to as the SISTAs' Club Initiative) for girls in six selected regions, nine districts and 27 communities of Ghana. Through strategic behavior change communication (BCC) interventions, SRH service delivery, advocacy, and mentorship, the Program was designed to empower young girls to acquire some health and socio-economic assets that build their agency and ensure a higher chance of fulfilling their potentials. The Planned Parenthood Association of Ghana (PPAG) facilitated the Program implementation. This report presents an assessment of the Integrated ASRH program in Ghana.

Aim and objectives of the study

The aim of this study was to assess the overall effectiveness and benefits of the SISTAs' Club Initiative and identify appropriate approaches to assure a robust programming model.

Specifically, the study was to:

- Profile the background characteristics of the SISTAs' Club members;
- Assess Club members' health-seeking behaviors relative to sexual and reproductive health, contraceptive use/family planning, coping strategies against rape, adolescent pregnancy, and abortion;
- Analyze the gender dynamics, social relations and factors that influence the vulnerabilities of the girls to disempowerment, rights abuses, unwanted pregnancies, child and forced marriages and other harmful practices;
- Ascertain the processes employed in the establishment and functioning of the SISTAs' Clubs;

- Assess available partnerships, collaborative or coordination mechanisms adopted by the various strategic agencies/structures to strengthen referrals to adolescent-and youth-friendly health services;
- Examine the effectiveness, impact, and benefits of the SISTAs' Club Initiative; and
- Recommend measures that could be employed to strengthen and replicate the SISTAs' initiative.

Methodology

The study adopted the constructive response evaluation methodological framework to guide the evaluation process. It used the concurrent triangulation strategy of mixed-methods to collect both quantitative and qualitative data for the evaluation. The main beneficiaries of the SISTAs' Club Initiative were adolescent girls aged 10-19 in six (6) regions, nine (9) districts, and 27 communities. The total sample size was 530. Simple random sampling was used to sample the 12 communities, accidental sampling was employed for the selection of the adolescent girls (242), while purposive sampling technique was used to select key informants (50) and focus group discussants (238). Accordingly, questionnaire, indepth interview (IDI) and focus group discussion (FGD) guides as well as simulation checklist were used as instruments for data collection. Descriptive statistics were used to analyze the survey data, while framework analysis (thematic analysis) was adopted for the qualitative data.

Main findings

The respondents were between the ages of 10-19 years with a slight majority (51.7%) within the age group 10-14 years (younger adolescents). All the respondents had received at least formal basic education; more than 80 percent were at Junior High School (JHS). All the respondents were never married. The expectation was that some of the members in the community-based clubs would have out-of-school and married adolescents. This was not the case on the ground in all the sampled clubs. However, in the Volta Region where there were out-of-school clubs, all of them were above 19 years.

The evaluation affirmed the existence of adolescent-and-youth-friendly health services in some of the communities surveyed. The respondents admitted the key attributes of adolescent-friendly health services and the various services they provide. However, their utilization was being hampered by challenges, principally, negative attitude of gatekeepers and other adolescents in relation to comprehensive adolescent sexuality education.

The adolescents were generally challenged mainly because of a number of factors, including parental neglect, economic poverty, and peer influence. These, coupled with challenges associated with accessing adolescent sexual and reproductive health and rights services, explain the vulnerability of adolescent population in the study area within the context of teenage pregnancy and child marriage.

SISTAs' Clubs have been established in all study sites. The Clubs can be categorized into two, based on composition and context. With regard to composition, there were mainly two types – in-school Clubs and mixed (both in-school and out-of-school) Clubs. The context was either school-based or community-based. Largely, the purpose of the SISTAs' Initiative which is to

introduce knowledge, and equip and empower adolescent girls to control their sexuality, has been achieved.

Four key partner categories were directly involved in the SISTAs' Club Initiative – development partners, implementer, stakeholder, and the beneficiary categories. The collaborative mechanism allowed for participation which, to a large extent, promoted the implementation of the Initiative. However, some gaps and challenges were identified. These include the unavailability of a memorandum of understanding (MoU) to serve as guide and also spell out responsibilities of the notable key stakeholders (PPAG, the District Assemblies, Ghana Health Service, Department of Gender, and the Traditional Council), as well as the absence of succession and follow-up plans and strategies.

As regards the sustainability of the initiative, the respondents almost unanimously asserted that the SISTAs' Initiative ought to be sustained.

Recommendations

The study agrees to the sustainability and replication of all the component parts of the Initiative. It requires that the partnership and ownership structures must be conceptualized, developed and well defined. These should be guided by a holistic MoU which will specify responsibilities, roles, and commitments of each stakeholder as well as sources of resources. The model of implementation should also be integrative to include parents as well. The SISTAs' Club Initiative could be scaled up to include boys-only and mixed programs in order to empower more adolescents to make informed decisions that relate to their SRH.

CHAPTER ONE

INTRODUCTION

Background to the Study

Teenage pregnancy, early marriage, sexual harassment, rape, unsafe abortion and other forms of gender based violence continue to hamper the growth and development of women and girls in some parts of the world. At the international level, it has been estimated that about 21 million girls aged 15 to 19 and 2 million girls aged under 15 become pregnant in developing regions every year (Darroch, Woog, Bankole & Ashford, 2016; United Nations Population Fund [UNFPA], 2015a). It has also been reported that 16 million of these pregnancies end up in childbirth (UNFPA; Neal, Matthews & Frost, 2012). In the same vein, the global number of child brides was estimated at 650 million with an average of 12 million marriages being contracted every year (Cappa, 2018). Although this represents a continued decline in child marriages, sub-Saharan Africa has the highest prevalence of child brides with modest declines during the past decade (Cappa, 2018). It must also be noted that about 15 million adolescent girls (aged 15 to 19) worldwide have been reported as having experienced forced sexual intercourse at some point in their life (United Nations Children's Fund [UNICEF], 2017).

Clearly, these have some negative consequences on the growth and development of adolescents. For instance, adolescent child-bearing has been associated with complications during pregnancy and delivery (Ganchimeg *et al*., 2014; Ghana Statistical Service [GSS], Ministry of Health (MoH), & ICF, 2018; Mukhopadhyay, Chaudhuri & Paul, 2010). Aside the complications associated with teenage pregnancy, it also leads to other detrimental human development challenges such as an increase in the rate of school dropout (Grant & Haslam, 2008). Early or child marriage also constitutes a threat to national efforts to combat teenage pregnancy. Sexual violence, on the other hand, can also affect the social wellbeing of victims such as stigmatization and health complications.

Global attempts have been demonstrated, particularly in recent times, to promote the development of women and girls in developing countries. For instance, the Millennium Development Goals two and three, and to a large extent, four and five, focused on the wellbeing of women and girls. Currently, the Sustainable Development Goals (SDGs) have also emphasized obviously and inherently in the first five goals, as well as the eighth goal, targets and indicators, which when achieved, will enhance the human development of females in general and young girls in particular (United Nations, 2000, 2015). In Ghana, various policies and interventions have been adopted and are being implemented to enhance the wellbeing and welfare of the girl-child. For instance, in July 2015, as a means of strengthening Ghanaian children protection system, the Ministry of Gender, Children and Social Protection (MoGCSP) adopted a policy dubbed Child and Family Welfare Policy (MoGCSP, 2015). Among other targets, the Policy is intended to address and prevent harm to children and recognize the integral position of the family in children upbringing. The Policy aims at designing child and family welfare programs and activities that will effectively protect children from all forms of violence, abuse, neglect and exploitation as well as ensuring effective coordination of the child and family welfare services at all levels (MoGCSP). Furthermore, various social intervention programs, including the implementation of the Child Health Policy (2007-2015), Child Health Strategy (2014-2018), Comprehensive Antenatal Clinic Program, introduction of the National Health Insurance Policy and Free Maternal Delivery Services are some of the factors that have been

implemented in Ghana to generally promote the health and wellbeing of the population and women/children in particular (GSS *et al*., 2015; MoH, 2007, 2014; United Nations Development Program [UNDP], 2013). The enactment of the Children's Act (Act 560) in 1998 in Ghana has further provided the legal framework that would enjoin courts, persons, institutions or other bodies to secure the best interest of children in all matters that relate to them (Government of Ghana, 1998). In addition, the MoGCSP with its partners has developed the Adolescent Pregnancy Strategy and Child Marriage Framework (2017-2026). Other policies include the Revised National Gender Policy (Working Draft) (2012), the FAO Policy Document on Gender Inequalities in Rural Employment in Ghana (2012), Gender and Child Policy (2004) and the Domestic Violence Act (DVA Act 732) (2007).

Notwithstanding the adoption and implementation of these policies and interventions in Ghana, results, especially in the areas of reducing or eliminating teenage pregnancies, child marriages and rape, have not been encouraging. In Ghana, some 14 percent of adolescents aged 15-19 have begun childbearing (GSS, MoH, & ICF International, 2018). In terms of rural-urban variations, the percentage of women aged 15 to 19 (18%) who reside in rural communities had begun childbearing (GSS *et al.*, 2015). At the regional level, the percentage of teenage pregnancy was highest for Central region (21%) and lowest in Greater Accra region (8%) in 2014 (GSS, Ghana Health Service [GHS], & ICF International, 2015). However, in 2017, the percentage for teenage pregnancy was highest in the Western region (19%) with Greater Accra still maintaining the lowest percentage (GSS *et al.*, 2018).

Rates of early marriage in the country are not so different from what pertains at the global level. Findings from the Ghana Maternal and Health Survey (GSS *et al*., 2018) indicate that eight percent of women aged 25-49 first married at exactly age 15, which is before the acceptable legal marriage age of 18 years. Although abortion is illegal in Ghana (but permitted, if pregnancy was due to defilement, incest or rape, or if the life or health of the woman is in danger, or if there is a risk of foetal abnormality), it continually becomes one of the two outcomes of sexual intercourse, especially among adolescents.

Results from the 2017 Ghana Maternal Health Survey showed that seven percent of women between ages 15-49 years and a little above three percent of adolescents less than 20 years have ever had an induced abortion in the past five years prior to the survey. The report also asserted that women in the Greater Accra region recorded the highest number of induced abortions in the country. The percentage of induced abortion was high among women with secondary school education and above as well as for those living in urban communities. According to Ghana's Criminal Offences Act 1960 (Act 29), section 98, rape is the carnal knowledge of a female of 16 years or above without her consent. Aside from rape being a criminal offence in Ghana, it is also classified as a breach of the sexual rights of the female victim. According to the Domestic Violence in Ghana Report (2016), 10 percent of women aged 15-19 were physically forced to have sex in Ghana (Institute of Development Studies, GSS & Associates, 2016). In terms of regional spread, the Volta region recorded the highest percentage of rape (9%), while the Northern region recorded the least (3%).

It was, therefore, not only imperative, but also timely, when UNFPA implemented the Integrated Adolescent Sexual and Reproductive Health Program for selected girls in six regions in Ghana

dubbed the SISTAs Club Initiative intervention, and facilitated by the Planned Parenthood Association of Ghana (PPAG). This model is implemented by the PPAG with support from UNFPA. The Initiative is being implemented in UNFPA Ghana operational areas under the UNFPA-UNICEF Global Program to Accelerate Action to End Child Marriage, which commenced operations in Ghana in 2015.

SISTAs Club Initiative: Purpose and Focal Areas

The SISTAs Club Initiative is an all-girls program that provides a platform for young girls (10-19 years) to be empowered with health and socio-economic assets in order to build their agency and ensure a higher chance of fulfilling their potentials (UNFPA, 2018). The Program employs strategic behavior change communication (BCC) interventions, Sexual and Reproductive Health (SRH) information and service delivery, advocacy, mentorship and Livelihood Skills Development (LSD) to address pertinent issues concerning adolescent girls, which will empower them to make informed decisions on their SRHR. It also covers the general wellbeing of the members, including awareness-raising and consciousness building on gender equality.

It is being designed to provide an integrated, rights-based, and gender-responsive approach to directly reach both married (or in a union) and unmarried adolescent girls to reduce unwanted pregnancies and child marriage as well as other harmful socio-cultural practices that disproportionately affect girls. So far, the SISTAs' Club Initiative has been implemented in six regions, nine districts and 27 communities (see Table 1) in the UNFPA Ghana operational areas.

Table 1: Region, District and Communities Implementing SISTAs' Club Initiative

Region	District	Communities
Northern	Sagnarigu Municipal	Kalpohini, Sagnarigu, Gurugu, Kunyegula
Upper East	Bolgatanga Municipal	Yarigabisi, Zaare, Kumbosco, Tindonseo, Gambibgo, Yipala, Atulbabisi
Upper West	Wa Municipal	Suriyri, Jengbeyiri, Kabanye, Danko, Kambali, Konta
Ashanti	EjisuJuabeng	Apromase
Ashanti	AsokoreMampong	Asawase, Dagombaline
Central	Cape Coast Metropolis	Amessakyire, Abura, Apewosika
Volta	Central Tongu	Adidome
Volta	North Tongu	Mepe
Volta	South Tongu	Sogakope, Dabala

Source: UNFPA-Ghana, 2018

The target beneficiaries are mainly the most marginalized in-school and out-of-school adolescent girls in rural and deprived communities. As an integrated model, the Initiative comprises various intervention areas, including:

- The formation of SISTAs' Clubs to create safe spaces for adolescent girls;
- Provision of Sexual and Reproductive Health Information and Services (outreach and facility-based levels);
- Holding of Life Planning Skills (LPS) sessions to equip leaders of SISTAs' Clubs with skills in providing Sexual and Reproductive Health information to Club members;

- Provision of BCC interventions, including interpersonal discussions, radio panel discussions, film shows at health facility level and communities, reading skills, interactive theatre and distribution of Information, Education & Communication (IEC) materials;
- Mentorship and LSD sessions to equip and inspire the girls to know and learn motivational, leadership and livelihood development skills through engagement with reproductive health advocates, entrepreneurs, and experts from various other fields;
- Undertaking Parent-Child Communication (PCC) sessions to foster greater communication and dialogue between parents and adolescent girls on issues such as child marriage, teenage pregnancy and related topics; and
- Forming partnership with various strategic agencies/structures to strengthen referrals to adolescent-and youth-friendly health services and other complementary social services to protect and empower adolescent girls.

The SISTAs'Club Initiative has been implemented since 2015 collaboratively by all the partners. This evaluation was commissioned by the UNFPA Ghana Office to assess the workability, relevance, effectiveness, gaps, implementation challenges and remedial actions of the SISTAs' Club Initiative. This will then inform decisions and strategies of upscaling the project in Ghana and replicating it in other countries where UNFPA and its partners such as PPAG are operating.

Aim and Objectives of the Study

The aim of this study was to assess the overall effectiveness and benefits of the SISTAs' Club Initiative and identify appropriate approaches to assure a robust programming model. Specifically, the study was to:

- Profile the background characteristics of the SISTAs'Club Initiative members;
- Assess Club members' health-seeking behaviors relative to SRH, contraceptive use/family planning, coping strategies against rape, adolescent pregnancy and abortion;
- Analyze the gender dynamics, social relations and factors that influence the vulnerabilities of the girls to disempowerment, rights abuses, unwanted pregnancies, child and forced marriages and other harmful practices;
- Ascertain the processes employed in the establishment and functioning of the SISTAs' Clubs;
- Assess available partnerships, collaborative or coordination mechanisms adopted by the various strategic agencies/structures to strengthen referrals to adolescent-and youth-friendly health services;
- Examine the effectiveness, impact, and benefits of the SISTAs' Club Initiative; and
- Recommend measures that could be employed to strengthen and replicate the SISTAs' Club Initiative.

Organization of this Report

This report has been organized into nine sections. Following this introductory chapter is a chapter on the methodology which outlines how the assessment was organized and data were sourced for analysis. The third chapter presents the profile of the respondents, while the next four chapters share the findings and discussion of the study. Chapter Eight covers the gaps identified, challenges encountered and lessons learnt. The last chapter is on sustainability and replicability, as well as key recommendations for improving future roll out of the SISTAs'Club Initiative.

CHAPTER TWO

METHODOLOGY

Introduction

The methods that were adopted to carry out the assessment are presented in this chapter. Four main activities were conducted. These are desk activity, pre-field activity, fieldwork, and data analysis. The desk activity provided methodological direction to both the pre-field activity and fieldwork.

Desk Activity

Evaluation design

This study adopted the constructive response evaluation technique methodological framework to guide the implementation of the evaluation. The technique, as applied in project evaluation, assesses program interventions from the basis of policymaker's (in this instance, the UNFPA) goals and the engagement of stakeholders (in this context, girls, facilitators, community leaders/members, etc.) about the relevance and effectiveness of the intervention and their practice (Abma, 2005) towards the theory of change. The technique also prescribes the triangulation of data to ensure validity.

The concurrent triangulation strategy of mixed-methods was employed during the data collection phase of the evaluation. This strategy allowed for both quantitative and qualitative data to be gathered concurrently by research investigators with equal priority placed on both. The data is integrated during the analysis and interpretation stage to confirm, validate or corroborate responses. This strategy makes it possible to collect data at short durations (Terrell, 2012).

Population

The SISTAs' Club Initiative targeted adolescent girls aged 10-19 in six (6) regions, nine (9) districts, and 27 communities. This assessment focused on 12 communities spread across six (6) regions and nine (9) districts. The study anticipated a total of 30 members per Club in each community selected. As a result, 720 SISTAs' Club members were targeted for a survey. Others, including non-member boys and girls as well as stakeholders who played diverse but active roles in the SISTAs' Club Initiative were also targeted. The stakeholders comprised UNFPA and PPAG focal persons, as well as officials of partner organizations such as the GHS, Ghana Education Service (GES), Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service and community leaders/gatekeepers.

Sampling procedure and sample size

The total sample size was 530. Simple random sampling was used to sample 12 out of 27 communities where SISTAs' Clubs are functional. To ensure representativeness, at least one community was randomly selected from each of the district/municipal or region. However, two communities were selected (randomly) from Districts/Municipals (except Cape Coast Metropolis) that had more than two functional Clubs (Table 2). Although two communities were selected from the Cape Coast Metropolis, one was used for the pre-testing of the research instruments. Additionally, four communities were randomly sampled to replace four already

sampled communities. This was conducted because the project facilitators in the already sampled communities were not available during the time of the data collection.

Table 2: Sampled Distribution per District and Community

Region	Municipality/District	Number of Communities	Sampled Communities	Sampled Communities
Northern	Sagnarigu Municipal	4	2	Sagnarigu, Gurugu
Upper East	Bolgatanga Municipal	7	2	Tindonseo (replaced with Gambibigo), Atulbabisi (replaced with Yarigabisi)
Upper West	Wa Municipal	6	2	Suriyri, Jengbeyiri (replaced with Kabanye)
Ashanti	AsokoreManpong	2	1	Dagombaline (replaced with Asawase)
	EjisuJuaben	1	1	Apromase
Central	Cape Coast Metropolis	3	1	Amessakyire
Volta	Central Tongu	1	1	Adidome
	North Tongu	1	1	Mepe
	South Tongu	2	1	Sogakope
	Total	**27**	**12**	

Source: Consultant's Desk Review, 2018

Since there was no proper sampling frame for the adolescent girls under the Program, accidental sampling was employed to select 242 Club members. Purposive sampling technique was also used to select key informants (50) and focus group discussants (238). With respect to the key informants, all those who were engaged directly and actively on the Program were purposively selected. They include the Program Officers of PPAG at the implementation sites, facilitators of SISTAs' Clubs, officials from the partner organizations, opinion leaders and parents from the communities sampled. The study also purposed to select a male and female parent/guardian each from every community selected. The involvement of this category of respondents was because they were either responsible or played instrumental roles in the implementation of the Initiative, and also are well positioned to assess the impact of the SISTAs' Club on the members.

Additionally, six to eight members of the Clubs from each sampled community were selected for focus group discussion (FGDs). The reason was to accumulate adequate data to complement and explain responses from the survey data. Similarly, FGDs were organized for adolescent non-Club members (girls) and non-Club members (boys) at each sampled community. The purpose was to assess the extent to which knowledge gained by the Club members 'spilled' into the non-member population.

Instruments

Eight different sets of instruments were developed to collect primary data. These comprised one structured questionnaire, four in-depth interview (IDI) guides, two FGD guides and one simulation checklist. Contents of the instruments mirrored the objectives of the study, intended outcomes of the SISTAs'Club Initiative, identified gaps, sustainability, recommendations for upscaling and lessons learnt. The questionnaire was administered to only the Club members. Aside from eliciting comprehensive data on the respondents' socio-demographic background, the instrument also contained both open and closed-ended questions on sexual and reproductive health, child marriage, program implementation design, challenges and the way forward.

The IDI guides were administered on focal persons from UNFPA, UNICEF and PPAG as well as officials from partner organisations and community leaders. The key issues in the guides touched on community-based information on teenage pregnancy, child marriage, rape, access to adolescent reproductive health, the formation of the Clubs, implementation design, effectiveness (output and outcome) of the initiative and the sustainability of the Clubs. The FGD guides also elicited data from both Club members and non-members (boys and girls). The issues on the FGD and IDI guides were similar. The simulation checklist was used to assess how facilitators provide information to the Club members, how precise and accurate the information is and the knowledge acquired by the Club members. The physical environment was also assessed. Copies of all the evaluation instruments have been attached to this protocol as Appendix 1.

Pre-field Activity

Reconnaissance

The first activity was the reconnaissance exercise. The research team contacted all the Zonal Managers of PPAG to provide contacts of the Program Officers who implemented the SISTAs' Club Initiative in the selected regions, districts and communities. The Zonal Officers also informed the Program Officers in detail about the extent of work to be conducted and the specific roles they (Program Officers) had to play to facilitate activities before and during the fieldwork. The research team shared with the Zonal Managers and the Program Officers information about the sampled communities (Table 3), respondent categories (Table 4) and fieldwork itinerary (Table 5). The Program Officers conducted all the community entry protocols and this facilitated the completion of the fieldwork as scheduled.

Table 3: Sampled Distribution per District and Community

Region	Municipality/District	Number of Communities	Sampled Communities	Sampled communities
Northern	Sagnarigu Municipal	4	2	Sangnerigu, Gurugu
Upper East	Bolgatanga Municipal	7	2	Tindonseo, Atulbabisi
Upper West	Wa Municipal	6	2	Suriyri, Jengbeyiri
Ashanti	AsokoreManpong	2	1	Dagombaline
	EjisuJuaben	1	1	Apromase
Central	Cape Coast Metropolis	3	1	Amessakyire
Volta	Central Tongu	1	1	Adidome
	North Tongu	1	1	Mepe
	South Tongu	2	1	Sogakope
Total		**27**	**12**	

Source: Consultant's Desk Review, 2018

Table 4: Respondent Categories per Selected Community

Respondent Category	Data Collection Method			
	Survey	Interview	FGD	Simulation
PPAG Program Officers		1		
SISTAs' Club Facilitators		2		1
SISTAs'Club members	All by Census		1 (6-8 discussants)	
Non-SISTAs' Club members (Girls)			1 (6-8 discussants)	
Non-SISTAs' Club Members (boys)			1 (6-8 discussants)	
GHS		1		
Department of Gender		1		
GES		1		
Police Service		1		
Parents		2		

Source: Consultant's Desk Review, 2018

Table 5: Work Itinerary

Region	Municipality/District	Sampled Communities	Date for Fieldwork
Northern	Sagnarigu Municipal	Sagnarigu,	13th – 14th December, 2018
		Gurugu	15th – 16th December, 2018
Upper East	Bolgatanga Municipal	Tindonseo (replaced with Gambibigo)	17th – 18th December, 2018
		Atulbabisi (replaced with Yarigabisi)	19th – 20th December, 2018
Upper West	Wa Municipal	Suriyri	13th – 16th December, 2018
		Jengbeyiri (replaced with Kabanye)	17th – 19th December, 2018
Central	Cape Coast Metro	Amessakyire	11th – 16th December, 2018
Ashanti	AsokoreManpong	Dagombaline (replaced with Asawasi)	12th – 13th December, 2018
	EjisuJuaben	Apromase	14th – 15th December, 2018
Volta	Central Tongu	Adidome	18th December, 2018
	North Tongu	Mepe	19th December, 2018
	South Tongu	Sogakope	20th December, 2018
Total		**12**	

Source: Consultant's Desk Review, 2018

Recruitment and allocation of field staff

Initially, the plan was to engage 10 Research Assistants (RAs) consisting of eight Field Assistants and two Field Supervisors. However, the number was increased to 12 in order to facilitate the completion of the field data collection within a relatively short duration (see Appendix 2 for details of RAs). Apart from their academic qualifications, the RAs were selected based on their experience in data collection within the context of sexual and reproductive health, knowledge and familiarity with, and ability to speak languages commonly spoken in the sampled communities.

Three RAs were assigned to each region except in the Central, Northern and Upper East regions where variations were made. All the RAs collected data in the Central region. The rationale was to practically have a fieldwork experience with all the instruments to enhance the familiarisation of issues as well as to understand other protocol arrangements. One RA was then assigned to the Central region to do a mop-up in the region. Also, five RAs were assigned to the Northern and Upper East regions. However, they were tasked to begin the data collection in the Northern Region. This was because the Program Officer at the Upper East region was not available at the time data collection was to commence.

Training, ethical clearance, and pre-testing

A two-day participatory training and pre-testing exercises were organized on 10th and 11th December, 2018 at the University of Cape Coast (UCC), Cape Coast. The team of facilitators comprised the Lead Investigator (Prof. Samuel Kobina Annim) and two Team Leaders (Dr. Kobina Esia-Donkoh and Dr. Samuel Asiedu Owusu). The assessment protocol was also subjected to an ethical clearance review process and subsequently, approved by the University of Cape Coast Institutional Review Board (UCCIRB) before the commencement of the fieldwork.

On the first day, the training focused on the background, aim, and objectives of the assessment. The theory of change, as a methodological approach, was discussed as the underpinning framework that guided the implementation and the assessment study. Participants were charged to adhere to the work itinerary. Lastly, the sampling processes, research instruments (questionnaire, FGD and IDI, and simulation guides), ethical considerations and data collection procedures were all discussed. Three role-plays were conducted with the IDI and FGD guides as well as the questionnaire to increase the understanding of the concepts in the instruments and also sharpen the translation skills of the RAs.

The morning session of the second day was used to recap the previous day's activities. Two role-plays were also conducted to reinforce understanding of the issues and deepen translation skills. The afternoon session was used to pre-test the data collection instruments. The Apewosika community (one of the implementation sites) in the Central Region was the site selected for the pre-test. The community was selected because it was not part of the sampled communities for the actual assessment. In all, 16 survey questionnaires were administered to members of the SISTAs' Club, and three FGDs comprising one FGD with members of SISTAs' Club, non-member boys and girls were conducted. The exercise enabled the assessment team (Resource Persons and RAs) to translate the theory into practice.

The two-day training ended with a plenary discussion on feedback from the pre-testing which led to a revision of aspects of the study instruments as well as the arrangement of logistics and allocation of Team Members to their assigned study communities. The Statistical Product for Service Solutions (SPSS) (version 23) was used to develop the survey template. The pre-test survey data was screened and entered for subsequent analysis. Appendix 3 is a copy of the program outline for the training and pre-testing.

Fieldwork

Data gathering

The fieldwork began as scheduled (see Table 5 above) and simultaneously in the Ashanti, Northern and Upper West regions in the respective sampled districts and communities. The data collection began on 11th December, 2019 at Emisaekyir in the Cape Coast Metropolis (Central region) and ended at Sogakope in the South Tongu District (Volta region) on 20th December, 2018. In all, 10 days were used to collect both quantitative and qualitative data from the respondents. In all, a total of 242 questionnaires were administered to members of the SISTAs' Club to comprise the quantitative data. In addition, 53 IDIs comprising three focal persons from UNFPA (2), and PPAG, five Program Officers, 12 facilitators, 19 parents, and 14 partner organization officials were conducted. Again, 34 FGDs were organized with 11 Club member groups, 12 non-member girls groups, and 11 non-member boys groups. Finally, six simulations were performed (see Table 6 and Appendix 3).

Table 6: Data Collected in each Region

Respondent Category	**Region**						**Total**
	Ashanti	Central	Northern	Upper East	Upper West	Volta	
IDI Facilitator	2	2	2	1	2	3	12
IDI Program Officer	1	1	1	1	0	1	5
IDI Parent	2	1	4	4	2	5	19
IDI Stakeholder	3	2	2	2	3	2	14
FGD Members	2	1	1	2	2	3	11
FGD Non-members Boys	1	1	2	2	2	3	11
FGD Non-member Girls	2	1	2	2	2	3	12
Survey	33	27	28	44	34	76	242
Simulation	1	1	1	1	1	1	6

Source: Fieldwork, 2018

On average, the duration of 40 minutes was used to administer a questionnaire. The IDI and FGD interviews generally lasted longer comparatively. Interviews with the stakeholders and the facilitators lasted between 50 and 70 minutes, while that of the Program Officers lasted between 75 and 90 minutes. However, the duration of IDIs with parents was almost the same as that of the questionnaire administration.

Two sitting arrangements were adopted during the FGDs. These are the linear structure and the arc structure (Sarantakos, 2013). The linear structure was adopted during the in-school/school-based FGDs. This is because each school desk that was used accommodated two participants, which made it easy to adopt this structure. On the other hand, the arc structure was adopted during the community-based FGDs. This is because the seats (plastic chairs or stools) that were provided made its use appropriate. Both sitting arrangements made it easy for the interviewers to reach the participants easily. Again, non-verbal communications were easy to be seen to enable the interviewers to probe for meanings.

Quality assurance
Four steps were adopted during the fieldwork to ensure that the survey data that were collected met the desired and expected quality standards to enhance appropriate, precise and accurate analysis.

1. The RAs ensured that all the questions in every instrument were asked and answered except, if the respondents declined to answer. At the end of every interview, the RAs went through the questionnaire or recorded interviews (IDIs and FGDs) immediately after the interview to make sure that all the responses were accurately recorded.
2. The RAs did a re-check of all the questionnaires administered and interviews recorded on a daily basis after work to address any errors that could not be identified on the field.
3. Questionnaires administered and interviews recorded were re-distributed to partner RAs for a peer review process.
4. The field supervisor finally vetted all the questionnaires administered to certify that data entry could commence. All the recorded interviews were vetted as well.

During and post-field discussion
Three main WhatsApp platforms were created. The composition of the first comprised all the research team members. The composition of the second was made up of members of RAs and supervisors at each region. The last platform that was created comprised the research team facilitators and an official of UNFPA. The main reasons for the creations of these platforms were to share ideas, disseminate information, address challenges and provide a daily report from the field.

At each implementation site, the research team also met after a day's fieldwork for a post-field discussion. Pertinent issues (both general and specific) that influenced the fieldwork process were discussed. Reflections on the day's activities were also made and plans for the subsequent day's work were drawn.

Data entry and transcription
The survey data entry and the audio interviews were transcribed on the field. This was to ensure that any error identified could easily be addressed because of quality memory recall and proximity advantage. The survey data were subsequently merged after the fieldwork. Specifically, the survey data were cleaned, coded, re-cleaned, filed and stored on a computer with a password to prevent access by a third party. The interview transcripts were also typed, cleaned, filed and stored similarly. All the transcriptions were, however, completed a week after the fieldwork.

Data Analysis
The survey data were analyzed with the use of the SPSS. Descriptive statistics, simple frequency, and cross-tabulations were used to analyze the data to draw out commonalities, differences and interpret how views and ideas relate. Tables and percentages were used to present the analysis. On the other hand, the framework analysis (FA) (also known as the thematic analysis) was adopted to analyze the qualitative data. The analysis followed four main stages. The first stage comprised the familiarisation of the transcripts by thoroughly reading them. The second stage constituted the organization of thoughts and ideas in the transcripts to identify the differences

and commonalities. The third stage involved the mapping and interpretation of patterns, associations, linkages, and variations that exist. The last stage entailed the triangulation of data available to validate ideas and interpretations. The FA is one of the commonly used frameworks, and it allows the inclusion of emergent concepts (Lacey & Luff, 2009). Specific and relevant quotes were used to support and interpret concurrent and divergent ideas.

Challenges

Two main challenges were encountered. The first was the unavailability of the Program Officer in the Upper West region as well as facilitators at sampled communities such as Dagombaline (Ashanti region), Tindonseo and Atulbabisi (Upper East region) and Jengbeyiri (Upper West region). The second challenge was the hospitalisation of one of the RAs (who was assigned the Volta region) immediately after the fieldwork. Although the former challenge did not affect the quality and schedule of the fieldwork, the latter affected the completion and submission of transcription of the data from the Volta region on time.

CHAPTER THREE

DEMOGRAPHIC PROFILE OF RESPONDENTS

Introduction

The results from the analysis reflected the purpose of the study according to the terms of reference for this evaluation. This section, therefore, focuses on the demographic profile of the respondents, especially the members of SISTAs' Club, formation and implementation of SISTAs' Clubs, collaborative mechanisms among partner organizations, effectiveness, and impact as well as the sustainability of SISTAs' Club Initiative.

Demographic/Background Profile

Among the demographic characteristics analyzed are age, marital status, educational background, religion, length of stay in community and type of parent/guardian living with (Table 7). The girls were aged 10-19. From the results, the majority (51.7%) fell within the age group 10-14 years, while a little over 48 percent were within the age group 15-19. About 24 percent of the young adolescents aged 10-14 were in the Ashanti region, while less than 10 percent of the same age group were in the Upper East region. Conversely, close to half (47.2%) of the older adolescents were in the Volta region, while the Central region had the least of respondents in the same age category.

Across the regions, the findings showed that all the respondents had attained some form of formal education. More than 80 percent were at junior high school (JHS). The rest were in primary (17.8%) and senior high schools (SHS: 2.1%). It was also found that there was a sharp contrast with respect to religious affiliation. For instance, all the respondents in Central and Volta regions and the majority (95.5%) in Upper East region were Christians, while all the respondents in Upper West and the majority in Northern (75%) and Ashanti (63.6%) regions were Muslims.

All the respondents were never married. Almost half (49.2%) stayed with both biological parents, while a little (21 percent) and about five percent lived with their biological mothers and fathers, respectively. Thus, more than 25 percent stayed with their relatives with less than three percent staying with both guardians. It was only in the Central (40.7%) and Volta (30.3%) regions where less than half of the respondents stayed with both biological parents. In all, close to half (48%) of the adolescent girls stayed with a single parent/guardian (Table 8).

Table 7: Demographic Profile 1

Variable		Frequency	Percentage
Age			
10-14		117	48.3
15-19		125	51.7
Total		***242***	***100.0***
Educational background			
No education		0	0
Primary		43	17.8
Middle/JSS/JHS		194	80.2
SHS		5	2.1
Total		***242***	***100.0***
Religion			
Christians		164	67.8
Muslims		78	32.2
Total		***242***	***100.0***
Length of stay in the community			
0-4		30	12.4
5-9		38	15.7
10-14		112	46.3
15+		62	25.6
Total		***242***	***100.0***
Type of parent/guardian			
Biological mother		51	21.0
Biological father		11	4.5
Both biological parents		119	49.2
Male guardian		8	3.3
Female guardian		46	19.0
Both guardian		7	2.9
Total		***242***	***100.0***
Region/Community			
Ashanti	Apromase	12	13.6
	Asawase	21	5.0
	Total	***33***	***8.7***
Central	Amisaekyir	27	11.2
	Total	***27***	***11.2***
Northern	Gurugu	20	8.3
	Sagnarigu	8	3.3
	Total	***28***	***11.6***
Upper East	Gambibig	20	8.3
	Yargabisi	24	9.9
	Total	***44***	***18.2***
Upper West	Kabanye	21	8.7
	Suuririyi	13	5.4
	Total	***34***	***14.0***
Volta	Adidome	23	9.5
	Mepe	21	8.7
	Sogakope	28	11.6
	Total	***76***	***31.4***

Source: Fieldwork, 2018

Table 8: Demographic Profile 2

Region	Community	Who do you stay with?						Total % (N)
		Biological mother % (N)	Biological father % (N)	Both Biological Parents % (N)	Male guardian % (N)	Female guardian % (N)	Both guardians % (N)	
Ashanti	Apromase	33.3 (4)	8.3 (1)	25 (3)	0.0 (0)	25 (3)	8.5 (1)	100.0 (12)
	Asawase	9.5 (2)	0.0 (0)	85.7 (18)	0.0 (0)	4.5 (1)	0.0 (0)	100.0 (21)
	Total	***18.2 (6)***	***3.0 (1)***	***63.6 (21)***	***0.0 (0)***	***12.1. (4)***	***3.0 (1)***	***100.0 (33)***
Central Northern	Amissaekyir	44.4 (12)	3.7 (1)	40.7 (11)	0.0 (0)	11.1 (3)	0.0 (0)	100.0 (27)
	Gurugu	0.0 (0)	0.0 (0)	55.0 (11)	30.0 (6)	15.0 (3)	0.0 (0)	100.0 (20)
	Sagnarigu	0.0 (0)	0.0 (0)	100.0 (8)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (8)
	Total	***0.0 (0)***	***0.0 (0)***	***67.9 (19)***	***21.4 (6)***	***10.7 (3)***	***0.0 (0)***	***100.0 (28)***
Upper East	Gambibigo	10.0 (2)	0.0 (0)	60.0 (12)	0.0 (0)	25.0 (5)	5.0 (1)	100.0 (20)
	Yarigabisi	12.5 (3)	16.7 (4)	50.0 (12)	4.2 (1)	8.3 (2)	8.3 (2)	100.0 (24)
	Total	***11.4 (5)***	***9.1 (4)***	***54.5 (24)***	***2.3 (1)***	***15.9 (7)***	***6.8 (3)***	***100.0 (44)***
Upper West	Kabanye	9.5 (2)	4.8 (1)	61.9 (13)	0.0 (0)	9.5 (2)	14.3 (3)	100.0 (21)
	Suuriyiri	23.1 (3)	15.4 (2)	61.5 (8)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (13)
	Total	***14.7 (5)***	***8.8 (3)***	***61.8 (21)***	***0.0 (0)***	***5.9 (2)***	***8.8 (3)***	***100.0 (34)***
Volta	Adidome	43.5 (10)	0.0 (0)	17.4 (4)	0.0 (0)	39.1 (9)	0.0 (0)	100.0 (23)
	Mepe	20.8 (7)	0.0 (0)	24.0 (6)	4.0 (1)	44.0 (11)	0.0 (0)	100.0 (25)
	Sogakope	21.4 (6)	7.1 (2)	46.4 (13)	0.0 (0)	25.0 (7)	0.0 (0)	100.0 (28)
	Total	***30.3 (23)***	***2.6 (2)***	***30.3 (23)***	***1.3 (1)***	***35.5 (27)***	***0.0 (0)***	***100.0 (76)***

Source: Fieldwork, 2018

There were two categories of IDI participants. These were adolescent and adult participants. The demographic profile of the IDI and FGD adolescent participants were not different from the survey respondents. Three adolescent facilitators (one in the Upper East region; two in the Volta region) participated in the IDIs. One was aged 14 and the rest 18 and 19 years. On the other hand, 211 adolescents participated in the 34 FGDs comprising members of SISTAs' Club (72), and non-members girls (71) and boys (68). Seventy-one were within the age range of 10-14 years, while 70 fell within the age range of 15-19 years. Only three persons were aged less than 10. All the participants were attending school (primary: 18%; JHS: 80%; and SHS: 2%). All the participants were never married. The majority (68%) were Christians, while 32 percent were Muslims. Most (71.9%) of the adolescent participants have lived in their community of residence between 10-15 years, while others have lived in the community for more than 15 years. A considerable number (108) lived with both biological parents and single parents (biological female parent: 39).

The adult category participated in only the IDIs. In all, 47 adults were involved. The youngest was aged 20, while the oldest was aged 76. Most of them were Christians and have lived in their respective communities for more than 15 years. At least, one of the daughters of each parent was a member of SISTAs' Club.

Conclusion

All the respondents attended formal education. More than 80 percent were at JHS. All the respondents were never married. Almost half (49.2%) stayed with both biological parents.

CHAPTER FOUR

HEALTH SEEKING BEHAVIOR

Introduction

This chapter reports on the health-seeking behavior of adolescents and youth who participated in this evaluation. It presents findings related to availability and accessibility of adolescent-and-youth-friendly health services. It also covers challenges with access to adolescent-and-youth-friendly health services.

Availability of Adolescent-and youth-friendly Health Services

Meeting the sexual and reproductive health needs of Ghanaians is among the key challenges confronting policymakers and implementers (Owusu, Blankson & Abane, 2011), which require improved policy formulation and implementation strategies to address. Access to sexual and reproductive health services was one of the key focal arms of the SISTAs' Club Initiative. It was, therefore, pertinent to assess the various sexual and reproductive health services available to adolescents in the project implementation communities to determine their availability, accessibility, and affordability. To this end, all the SISTAs' Club members, various key informants and focus group discussants were asked varied questions that centered on youth-friendly health services in the study communities, services offered at the facilities, referrals, challenges, and proposed improvement measures.

As shown in Table 9, 55 percent of the SISTAs' Club members indicated the existence of adolescent-and-youth-friendly health services in their communities. All Club members (100%) in the Yaragabisi community in the Upper East region, as well as 92 percent in Mepe community of the Volta region, affirmed the availability of these health services in their respective communities. Conversely, the greater percentage (92% and 88% in Apromase of the Ashanti region and Sagnarigu of the Northern region, respectively) averred that they did not have adolescent-and-youth-friendly health services in their communities.

Some key informants and focus group discussants also affirmed the availability or access to adolescent-and-youth-friendly health services in their communities. On the contrary, there were a few who reported of non-availability of such services. Where available, the respondents indicated that they were operated in hospitals, PPAG facilities, temporal clinics mounted by Community Health Nurses and at CHPS compounds. The variation in the responses is generally due to factors such as the existence or non-existence of the service and, where available, the differences in the mode and services being provided by the facilities. Clearly, adolescents living in communities without youth-friendly health services will be constrained in their quest to access and utilize these services which could negatively affect their access to sexual and reproductive health. For health facilities that provide these services, the respondents indicated that separate or dedicated sections have been made available to attend to the sexual and reproductive health needs of adolescents as illustrated in these two narratives:

> *Yes! There are about four Centres that I know of, one at Bagabaga and in the other three communities… From our interaction with some adolescents who access these services, they admitted that the services are always available and it is also affordable to them.* **[42 years old SHEP Coordinator, Sagnarigu Municipal, Northern Region]**

Yes! If you look at most of the CHPS compounds, they have created Adolescent corners…we encourage them to go to the center to be attended to by Nurses or health professionals. **[42 years old, GES, Upper West Region]**

Table 9: Availability of Adolescent-and-youth-friendly Health Services in Communities

Region/ Community	Yes		No		Total
	Frequency	Percentage	Frequency	Percentage	(n)
Total	**132**	**55.0**	**108**	**45.0**	**240.0**
Central region					
Amessakyire	11	40.7	16	59.3	27.0
Total	***11***	***40.7***	***16***	***59.3***	***27.0***
Ashanti region					
Apromase	1	8.3	11	91.7	12.0
Asawase	2	9.5	19	90.5	21.0
Total	***3***	***9.1***	***30***	***90.9***	***33***
Upper East region					
Yarigabisi	24	100.0	0	0.0	24.0
Gambibgo	10	50.0	10	50.0	20.0
Total	***34***	***77.3***	***10***	***22.7***	***44***
Northern region					
Sagnarigu	1	12.5	9	87.5	8.0
Gurugu	11	55.0	7	45.0	20.0
Total	***12***	***42.9***	***16***	***57.1***	***28***
Upper West region					
Kabanye	7	33.3	14	66.7	21.0
Suuriyiri	6	50.0	6	50.0	12.0
Total	***13***	***39.4***	***29***	***60.6***	***33***
Volta region					
Adidome	14	60.9	9	39.1	23.0
Mepe	23	92.0	2	8.0	25.0
Sogakope	22	81.5	5	18.5	27.0
Total	***59***	***132***	***16***	***108***	***240***

Source: Fieldwork, 2018

Adolescent-and-youth-friendly Health Services

The views on how freely and conveniently adolescents could access adolescent-and-youth-friendly health services are presented in Table 10. Generally, more than three-quarters of the

SISTAs' Club Initiative members indicated that adolescents could freely and conveniently access adolescent-and-youth-friendly health services in their communities.

Table 10: Accessibility ofAdolescent-and youth-friendly Health Services

Community	**Yes**		**No**		**Total**
	Frequency	Percentage	Frequency	Percentage	(n)
Total	105	66.5	53	33.5	158.0
Central region					
Amessakyire	9	81.8	2	18.2	11.0
Total	***9***	***81.8***	***2***	***18.2***	***11.0***
Ashanti region					
Apromase	1	100.0	0.0	0.0	1.0
Asawase	2	100.0	0.0	0.0	2.0
Total	***3***	***100***	***0.0***	***0.0***	***3.0***
Upper East region					
Gambibgo	7	35.0	13	65.0	20.0
Yarigabisi	24	100.0	0	0.0	24.0
Total	***31***	***70.5***	***13***	***29.6***	***44***
Northern region					
Gurugu	11	55.0	9	45.0	20.0
Sagnarigu	1	12.5	7	87.5	8.0
Total	***12***	***42.9***	***16***	***57.1***	***28***
Upper West region					
Kabanye	4	57.1	3	42.9	7.0
Suuriyiri	5	100.0	0	0.0	5.0
Total	***9***	***75***	***0***	***25***	***12***
Volta region					
Adidome	8	57.1	6	42.9	14.0
Mepe	15	65.2	8	34.8	23.0
Sogakope	18	78.3	5	21.7	23.0
Total	***41***	***68.3***	***19***	***31.7***	***60.0***

Source: Fieldwork, 2018

Almost all the interviewees and discussants knew about possible services that would be rendered or are currently being rendered at adolescent-and-youth-friendly health facilities. The various services cited comprised counseling, contraception, abortion, ante and post-natal, HIV testing, library games, treatment of sexually transmitted infections/sexually transmitted diseases (STIs/STDs) and referrals to other health facilities. Of these range of services, more of the adolescent discussants indicated that contraceptives, especially condoms, were available and affordable in the health facilities, while abortion services were reportedly viewed as least

available, expensive, restricted and stigmatized. Nonetheless, some respondents indicated that those needing abortion services either patronized the services of health professionals in health facilities or resort to dangerous means such *as grinding and drinking of bottles* (SISTAs' Club-member, 13 years old, Upper East region). It must also be noted that feedback from some of the key stakeholders indicated that the facilities do not generally offer abortion services. The facilities that offer the services, according to the respondents, are usually referral cases of attempted unsafe abortions by adolescents. These narratives are very insightful:

> *They give the condoms for just 50 Ghana pesewas which, I think, is very affordable. It is just the abortion services that are a bit expensive because our referral clinic is a private facility.* **[PPAG Program Manager, Northern Region]**
>
> *The facilities provide counseling services-they provide information on sexual and reproductive health; they do community visits to mobilize the youth and educate them on sexual and reproductive health issues; they provide contraception services such as condoms, pills, and injectables; but refer abortion services to the regional hospital where they have the required things to perform it safely.* **[26 years old, PPAG Facilitator, Gambibgo, Upper East Region]**
>
> *Adolescents in this and other neighboring communities have access to services such as abortion, family planning, and counseling.* **[32 years old, Public Health Nurse, Wa, Upper West]**
>
> *At AsokoreMampong, family planning and sexual and reproductive health counseling services are always accessible and affordable to the adolescents. In fact, it is almost free. They just take a small fee or token that they pay to access the services; I think it is GH¢1.00 or so which is very low. Condoms are given to them for free. What I do not know is whether they provide abortion services…* **[57 years old, Gender Officer, Ashanti Region]**
>
> *I have referred many of them. I referred them for counseling, comprehensive abortion care, and family planning services.* **[51 years old, Public Health Officer, Tamale Northern Region]**

Accessibility of Adolescent-and-youth-friendly Health Services

Availability and affordability of youth-friendly sexual and reproductive health services do not generally lead to utilization of the services by the intended users. The greater proportion (96%) of the SISTAs' Club members indicated that they have never accessed any adolescent-and-youth-friendly health services available in their communities. All (100%) the SISTAs' Club members surveyed in the Northern, Upper East, and Upper West regions indicated that they have never accessed sexual and reproductive health services. It was only threr (3) out of 27 members in the Amessakyire community and seven (7) out of 76 members in the Volta region who responded that they have ever accessed adolescent-and-youth-friendly health services (Table 11). This might mean that either none of them surveyed patronized the outreach/temporary SRH

services implemented by the Program or no outreach services were conducted in the communities involved.

Table 11: Utlization of ASRH services

Region/Community	Utilization of any ASRH Services available in Community				
	Yes		No		Total
	Frequency	%	Frequency	%	Frequency
All regions/Communities	**11**	**4.5**	**231**	**95.5**	**242**
Central region					
Amessakyire	3	11.1	24	88.9	27
Total	**3**	**11.1**	**24**	**88.9**	**27**
Ashanti region					
Apromase	0	0.0	12	100.0	12
Asawase	1	4.8	20	95.2	21
Total	**1**	**3.0**	**32**	**97.0**	**33**
Upper East region					
Gambibgo	0	0.0	20	100.0	20
Yarigabisi	0	0.0	24	100.0	24
Total	**0**	**0.0**	**44**	**100**	**44**
Northern region					
Gurugu	0	0.0	20	100.0	20
Sagnarigu	0	0.0	8	100.0	8
Total	**0**	**0.0**	**28**	**100**	**28**
Upper West region					
Kabanye	0	0.0	21	100.0	21
Suuriyiri	0	0.0	13	100.0	13
Total	**0**	**0.0**	**34**	**100.0**	**34**
Volta region					
Adidome	2	8.7	21	91.3	23
Mepe	3	12.0	22	88.0	25
Sogakope	2	7.1	26	92.9	28
Total	**7**	**9.2**	**69**	**90.8**	**76**

Source: Fieldwork, 2018

Challenges with Access to Adolescent-and-youth-friendly Health Services

The non-utilization might result from some challenges that the adolescents encounter in their attempt or quest to access the services. This evaluation explored the challenges that adolescents have been encountering accessing these services (see Table 12). More than half (57%) of the SISTAs' Club Initiative members responded no when asked whether they had challenges accessing any adolescent-and-youth-friendly health services available in their communities. At the community level, 71 percent of the SISTAs' Club members at Kabanye indicated that adolescents in that community have challenges accessing adolescent-and-youth-friendly health services.

It was further ascertained from the responses of the SISTAs' Club Initiative members who participated in this study that the major challenges they face in accessing these services were the negative attitude of gatekeepers (27%) and the attitude of other adolescents (23%) towards these services.

Table 12: Challenges with Access to Adolescent-and-youth-friendly Health Services

Challenge	Frequency	Percentage
Not always available	14	11.3
Not affordable	9	7.3
Not reachable	19	15.3
Attitude to service providers	20	16.1
Attitude towards other adolescents	29	23.4
Attitude of gatekeepers	33	26.6
Total	**124**	**100**

Source: Fieldwork, 2018

Multiple Responses-One respondent could mention more than one challenge

During the key informant interviews and FGDs, the most cited barrier for adolescents in accessing sexual and reproductive health services was the *feeling of shyness.* Other minor challenges indicated by the respondents were transportation cost and the high cost of abortion services as well as stigmatization by some gatekeepers, peers and service providers. The respondents explained that adolescents feel shy to approach service providers (Nurses or other health workers), meet familiar faces at the health facilities or attraction of peer's attention. Transportation, both cost and distance, was mentioned by a few respondents whose communities did not have the facilities and required them traveling to other communities to access the services. Only a few respondents bemoaned the relatively high cost of accessing abortion care services. The responses below are some examples of how the interviewees or discussants explained their challenges:

> *You mean utilization of family planning services? You can't even go and tell them that you want to do family planning. The Nurses will look at you someway and some will even shout at you. Madam, you just imagine even if you are sick and you go to the hospital, look at how they shout at you and now you are going for family planning as a young girl of my age, then count yourself dead that day. They will insult you rough.* **[18 years old, non-SISTAS' Club Focus group discussant, Gurugu, Northern Region]**

> *How to get to the facility is also sometimes a problem. Some of them are still students and they do not have money for transportation. Also, how to ask for permission from school they would have to hide and come out, and that is bad, sometimes they have to use sickness as an excuse. Religious leaders are sometimes very rigid and restrictive when it comes to such things about adolescents, if you really want to give a talk about comprehensive abortion sometimes, it becomes very difficult for them to accept.* **[51 years old, Public Health Officer, Tamale Northern Region]**

> *The adolescents always have that challenge of feeling shy in accessing sexual and reproductive health services. Since the facility doesn't have enough rooms to secure their privacy…so they might be feeling shy that someone, other than the nurse, is eavesdropping their conversation.* **[27 years old, PPAG Facilitator, Kabanye, Upper West Region]**

It must, however, be noted that the challenges identified by the respondents run contrary to the rationale for the establishment of adolescent-youth-friendly corners. The site of the facilities and trained staff (desk officers and health) are all expected to be youth-friendly to their clients. Empowering adolescents with comprehensive information on their sexuality and support services available to enable them to achieve optimum reproductive health is one of the common recommendations made by the respondents. It was in this context that the implementation of the Integrated Adolescent Sexual and Reproductive Health Program (SISTAs' Cub Initiative) for selected girls in six regions of Ghana resonated very well with the beneficiary Club members, non-members, parents, facilitators and other national key stakeholders in the education, health and security sectors who were surveyed. The respondents were unanimous in their responses that the adolescents should be educated and resourced to overcome the above challenges. They suggested the establishment of more adolescent-youth-friendly health facilities in the communities, but this should be strongly supported with comprehensive education and awareness creation for adolescents, parents, service providers, law enforcement officers and other community gatekeepers on the relevance of making sexual and reproductive health services and products easily available, affordable, accessible and utilized by adolescents as echoed by this adolescent group discussant:

> *Healthcare providers should change their behavior. They should stop telling parents about girls who access these services from the facilities. There should also be privacy when you visit these facilities…They shouldn't bring their friends there to be chatting with them at the facility for long hours.* **[15 years old, non-SISTAs' Club Focus group discussant, Gurugu, Northern Region]**

Conclusion

International and national developmental efforts hinge on the positive contribution of the population. Incorporating population issues into Ghanaian developmental policies and programs have been on-going at the national, regional and district levels. Unavailability, accessibility, affordability, and utilization of adolescent-and-youth friendly health services have the great potential of undermining effective growth and development of Ghana. The youthful nature of Ghana's population presents more adolescents reaching puberty and marrying later. This situation leads to adolescents being vulnerable to various sexual and reproductive health

problems or challenges, including STIs, teenage pregnancies, child marriages and unsafe abortion (World Health Organisation, 2009). The provision of adolescent-friendly health services was intended to make it easier for adolescents to have equitable, accessible, acceptable, appropriate and effective sexual and reproductive health services.

The GHS and its collaborators such as the PPAG instituted these health facilities in various parts of the country to meet the sexual and reproductive health services need of adolescents. Findings from this evaluation affirmed the existence of adolescent-and-youth-friendly health services in some communities surveyed. These services were being provided in health facilities such as hospitals, clinics and occasional or temporal structures mounted by health professionals for outreach services. Although, the respondents admitted the key attributes of adolescent-friendly health services and the various services they provide, their utilization was being hampered by challenges principally comprising negative attitude of gatekeepers (health personnel, parents, and opinion leaders) and attitude of other adolescents. It is, therefore, imperative that all gatekeepers, especially parents and health care providers, will change their negative attitude or stance and support adolescents to have unfettered access to quality sexual and reproductive health services. The capacity of adolescents should also be continuously built to enable them access quality reproductive health services through continuous education and life-enhancing interventions such as the implementation of the SISTAs' Club Initiative.

CHAPTER FIVE

CHILD MARRIAGE, TEENAGE PREGNANCY, RAPE AND VULNERABILITIES

Introduction

This chapter presents the findings on child marriage, teenage pregnancy, rape, and vulnerabilities. It touches on sexual activeness of SISTAs' Club members as well as the incidence, causes and mitigation measures of child marriage, teenage pregnancy, and rape.

Sexual Activeness of SISTAs' Club Members

Table 13 presents the results from the study on the SISTAs' Club Initiative members' perception of adolescent's sexual activeness in the various communities. A greater percentage (93%) of the respondents in all the communities indicated that adolescents in their communities were sexually active. In terms of communities, all (100%) the respondents in Apromase (Ashanti region), Adidome (Volta region), Yarigabisi (Upper East region) and Sagnarigu (Northern region) communities indicated that adolescents in their communities are sexually active.

Table 13: Perception ofAdolescent's Sexual Activeness

Region/Community	**Yes**		**No**		**Total (n)**
	Frequency	Percentage	Frequency	Percentage	
Total	218	90.1	24	9.9	242
Central					
Amessakyire	24	88.9	3	11.1	27
Total	***24***	***88.9***	***3***	***11.1***	***27***
Ashanti region					
Apromase	12	100	0	0	12
Asawase	19	90.5	2	9.5	21
Total	***31***	***93.94***	***2***	***6.06***	***33***
Upper East region					
Gambibgo	13	65	17	35	20
Yarigabisi	24	100	0	0	24
Total	***37***	***84.9***	***7***	***15.9***	***44***
Northern region					
Gurugu	18	90	2	10	20
Sagnarigu	8	100	0	0	8
Total	***26***	***92.9***	***2***	***7.1***	***28***
Upper West region					
Kabanye	19	90.5	2	9.5	21
Suuriyiri	10	76.9	3	23.1	13
Total	***29***	***85.3***	***5***	***14.7***	***34***
Volta region					
Adidome	23	100	2	0	23
Mepe	22	88	0	12	25
Sogakope	26	92.9	3	7.1	28
Total	***71***	***93.4***	***5***	***6.6***	***76***

Source: Fieldwork, 2018

It was found from the study that close to 80 percent (75%) of Club members who were surveyed indicated that female adolescents were becoming increasingly sexually active than males. All (100%) of the respondents in Suuriyiri community in Upper West region indicated that females are increasingly sexually active compared to males. Ninety-five, ninety-two and eighty percent of SISTAs' Club Initiative members respondents in Kabanye (Upper West region), Mepe (Volta region) and Asawase (Ashanti region) communities, respectively were of the view that female adolescents are increasingly sexually active. However, about 58 percent of adolescents in Apromase (Ashanti region) indicated that males are increasingly sexually active compared to females (see Table 13).

Table 14: Adolescent's Sexual Activeness

Region/ Community		**Male (%)**		**Female (%)**	**Total(n)**
Total	**59**	**25.2**	**175**	**74.8**	**234**
Central region	Frequency	Percentage	Frequency	Percentage	
Amessakyire	7	25.9	20	74.1	27
Total	*7*	*25.9*	*20*	*74.1*	*27*
Ashanti region					
Apromase	7	58.3	5	41.4	12
Asawase	4	19.1	17	80.9	21
Total	*11*	*33.3*	*22*	*66.7*	*33*
Northern region					
Sagnarigu	4	50.0	10	50	8
Gurugu	9	47.4	4	52.6	19
Total	*13*	*48.2*	*14*	*51.8*	*27*
Upper West region					
Kabanye	1	4.8	20	95.2	21
Suuriyiri	0	0.0	13	100	13
Total	*1*	*2.9*	*33*	*97.1*	*34*
Upper East region					
Gambibgo	4	30.7	9	69.3	13
Yarigabisi	8	33.3	16	66.7	24
Total	*12*	*32.4*	*25*	*67.6*	*37*
Volta region					
Adidome	6	26.1	17	73.9	23
Mepe	2	8.0	23	92	25
Sogakope	7	25.0	21	75.0	28
Total	*15*	*19.4*	*61*	*80.3*	*76*

Source: Fieldwork, 2018

Child Marriage

Incidence of child marriage

As shown in Table 15, 44 percent of the SISTAs' Club Initiative members' respondents indicated that there is somewhat an incidence of adolescent marriages in their communities. With this, 71 percent of respondents, at Yargabisi in the Upper East region responded that there was an increasing rate of incidence of adolescent marriage in their community, while 86 percent of the respondents from Sagnarigu said there is no incidence of adolescent marriage in the community.

Table 15: Perception of the Incidence of Adolescent Marriage

Region/Community		**no incidence**		**somewhat an incidence**		**increasing rate of incidence**	**Total**
		(%)		(%)		(%)	(n)
Total	98	40.5	107	44.2	37	15.3	242.0
Central region							
Amessakyire	15	55.6	9	33.3	3	11.1	27.0
Total	**15**	**55.6**	**9**	**33.3**	**3**	**11.1**	**27.0**
Ashanti region							
Apromase	5	41.7	5	41.7	2	16.7	12.0
Asawase	7	33.3	13	61.9	1	4.8	21.0
Total	**12**	**36.4**	**18**	**54.5**	**3**	**9.1**	**33**
Upper East region							
Gambibgo	4	20.0	8	40.0	8	40.0	20.0
Yarigabisi	0	0.0	7	29.2	17	70.8	24.0
Total	**4**	**9.1**	**15**	**34.1**	**25**	**56.8**	**44**
Northern region							
Gurugu	17	85.0	2	10.0	1	5.0	20.0
Sagnarigu	7	87.5	1	12.5	0	0.0	8.0
Total	**24**	**85.7**	**3**	**10.7**	**1**	**3.5**	**28**
Upper West region							
Kabanye	3	14.3	17	81.0	1	4.8	21.0
Suuriyiri	6	46.2	7	53.9	0	0.0	13.0
Total	**9**	**26.5**	**24**	**70.6**	**1**	**2.9**	**34**
Volta region							
Adidome	11	47.8	10	43.5	2	8.7	23.0
Mepe	14	56.0	11	44.0	0	0.0	25.0
Sogakope	9	32.1	17	60.7	2	7.1	28.0
Total	**34**	**44.7**	**38**	**50**	**4**	**5.3**	**28.0**

Source: Fieldwork, 2018

A 50 years old mother who was interviewed in the Sagnarigu community in the Northern region of Ghana gave a vivid account of how she was given out for early marriage by her grandmother. According to her:

> *I was living with my parents and a laborer at Akosombo in the Eastern region of Ghana, but my father died so after the funeral rites, my grandmother kidnapped and gave me up for marriage to the laborer...He sent me all the way to Damongo. I had no option; I only had to succumb to what the family wanted because I was afraid to disgrace the family…No, I never loved him but I could not tell my grandmother or even my own mother that I do not love the man. If it was now, I would have resisted fiercely but at that time I was only forced because I had no power to stop it. It was purely by force' marriage. I am happy that now it has changed a bit. It will only happen if the child goes out and bring the man home or get pregnant for the man...Nowadays the forced ones are not common.*

A key informant in the Ashanti region recounted an incidence of child marriage that her outfit observed. According to her:

> *Child marriage is an issue in the Asokore-Mampong Municipality. The girls who are given into marriage are from 13 years upwards. We even rescued a girl who was fourteen years and being forced into marriage… We immediately reported the case to DOVVSU and arrested the parents and rescued the girl.* **[57 years old, Department of Gender, Ashanti Region]**

As concluded by the mother, the incidence of child marriages from the responses of interviewees and discussants pointed to a general reduction in the rate of this marriage in conformity with internal reduction trends. What was deduced from their responses were that perpetrators of child marriages use *force*o on pregnant teenage girls to marry or cohabitate with the men responsible for the pregnancy. A SHEP Coordinator in the Northern region asserted that incidences of child marriage were common in some communities, but has significantly reduced in recent times. The downward trend, according to her, might be the positive impact of the various advocacy and awareness creation activities being embarked upon in the communities which have empowered some of the girls and enlightened parents to desist from this negative practice.

The concerns the adolescents raised about the incidence of child marriage in their communities are presented in Table 16. More than one quarter (35%) of the SISTAS' Club Initiative members surveyed said adolescent marriage is somewhat a concern in their communities, while nine percent said it is a very worrying concern in the communities. At the community level, majority (88%) of adolescents in Sagnarigu community in the Northern region expressed their concern that child marriages is a concern in their community, but closer to three-quarters (60%) of the members in Mepe (Volta region) indicated that it is not a concern at all in that community.

Table 16: Views about the Concern of Incidence of Adolescent Marriage

Region/Community	It is not a concern at all		It is somewhat a concern		It is a concern		It is a worrying concern		Total
	F	(%)	F	(%)	F	(%)	F	(%)	(N)
Total	72	29.8	85	35.1	63	26.0	22	9.1	242.0
Central region									
Amessakyire	13	48.2	9	33.3	4	14.8	1	3.7	27.0
Total	***13***	***48.2***	***9***	***33.3***	***4***	***14.8***	***1***	***3.7***	***27.0***
Ashanti region									
Apromase	5	41.7	3	25.0	3	25.0	1	8.3	12.0
Asawase	8	38.1	10	47.6	2	9.5	1	4.8	21.0
Total	***13***	***39.4***	***13***	***39.4***	***5***	***15.2***	***2***	***6.1***	***33***
Upper East region									
Gambibgo	0	0.0	3	15.0	6	30.0	11	55.0	20.0
Yarigabisi	0	0.0	6	25.0	15	62.5	3	12.5	24.0
Total	***0***	***0.0***	***9***	***20.5***	***21***	***47.7***	***14***	***31.8***	***44***
Northern region									
Gurugu	3	15	8	40	7	40.0	2	35.0	20.0
Sagnarigu	0.0	0.0	1	12.5	7	87.5	0	0.0	8.0
Total	***3***	***10.7***	***9***	***32.1***	***14***	***50***	***2***	***7.1***	***28***
Upper West reion									
Kabanye	5	23.8	12	57.1	4	19.1	0	0.0	21.0
Suuriyiri	3	23.1	5	38.5	4	30.8	1	7.7	13.0
Total	***8***	***23.5***	***17***	***50***	***8***	***23.5***	***1***	***7.7***	***34***
Volta region									
Adidome	11	47.8	6	26.1	6	26.1	0	0.0	23.0
Mepe	15	60.0	9	36.0	1	4.0	0	0.0	25.0
Sogakope	9	32.1	13	46.4	4	14.3	2	7.1	28.0
Total	***35***	***46.1***	***28***	***36.8***	***11***	***14.5***	***2***	***2.6***	***76.0***

Source: Fieldwork, 2018

Causes of child marriage

The key informants and focus group discussants attributed the causes of child marriages in the communities to some factors which revolve around the individual, parental or the society. At the individual level, peer influence on girls, disrespect to parental authority and experimentation with sexual intercourse (which could lead to teenage pregnancy) were enumerated as possible factors for early child marriages in the communities. For instance, a 12 years old SISTAS' Club member from Apromase Community in the Ashanti region indicated that *some girls disrespect*

their parents and are not open to any advice so parents shirk their childcare responsibilities which force the girls to depend on men for livelihood, becoming pregnant in the process and being forced to marry as a child. Some parents and focus group discussants, on the contrary, indicated that the uncontrolled behavior of some teenage girls sometimes gives the parents limited options than to give the girls up for early marriage; a decision which other respondents also vehemently opposed. A 42 years old mother asserted that some parents, on realizing that the daughter has initiated sexual intercourse pushes them to give her out for marriage to avert any disgrace associated with teenage pregnancy or giving birth before marriage. Peer influence was cited as encouraging girls to initiate early sexual intercourse, becoming pregnant in the process and being made to 'marry' the man responsible for the pregnancy.

Poverty or financial constraints faced by parents constituted the second major factor that facilitates early marriage in the communities. This was explained by the respondents as emanating from parents' inability to provide some basic needs for their children which sometimes make children, particularly girls, to engage in other livelihood activities, including indulgence in sexual intercourse or dependence on men for money. Some respondents also opined that such parents do so as a means of shirking their responsibilities towards their children. The end result, according to the respondents, is early sexual intercourse, teenage pregnancy, and child marriage. Furthermore, parental poverty served as enticing entry points for some men to win the support of a parent or a girl for early marriage. A 15 years old female non-SISTAs' Club member at Sagnarigu community in the Northern region observed that if parents cannot even provide their daughters with basic sanitary pads due to poverty, child marriage becomes one of the easy options for both the parent and the girl if, particularly there is a man who shows interest in supporting the parents and girl financially.

In separate focus group discussions with non-SISTAs' Club members, a 14-year old boy in Asawasi (Ashanti region), a 16-year old girl at Amessakyire (Central region), 15-year old Club member at Gurungu (Northern region) and 17-year old girl at Kabanye (Upper West region) communities, respectively described some parents as being *greedy* in forcing their teenage daughters to marry rich people just because the parents are not resource endowed. These sentiments were vividly recounted by a non-SISTAs' Club discussant:

> *Some parents threaten their daughters that if they do not agree to marry the rich man, they will not take care of them again. Some of the girls become scared and agree to…sometimes, the mother will tell her daughter that if she marries the rich man they will become rich as well…so the girl being naive will accept to marry the rich man. Child marriage is common with us Muslims because of our religion but I don't think it is right. A small girl who does not know anything is made to marry…even our mothers sometimes cannot stand marital problems, how much more a small girl who does not know anything?* **[15 years old, Female Non-SISTAs' Club Member, Amessakyire, Central Region]**

Lastly, societal or cultural practices were cited by a few respondents and discussants as accounting for child marriages. These were particularly cited as being the case in the Northern region of Ghana. A PPAG facilitator in the Sagnarigu district of the Northern region also shared an experience of child marriage in the community that she once observed. According to the 19 years old facilitator, in 2014, a man in the community gave up the daughter to a possible

kingmaker for early marriage to facilitate his successful chieftaincy ambition. Some of the participants opined that some cultures practice betrothal of girls to older men for varied reasons, including financial security, promotion of chastity and prestige. The narratives by a Gender Activist in the Ashanti region, a Public Health Officer in the Northern region and a Facilitator in the Volta region aptly describe this practice:

> *I will say it is part of their culture. Because they are Muslims, they…they don't want their girls to become promiscuous so at an early stage they give them out for marriage. Poverty is another factor so they give the girls out so that they can enjoy from the bride price. Some of the girls are willing to get married early because of the things they receive from the men during the ceremony so it entices them to also get married…They kind of see marriage as a prestige.* **[57 years old, Department of Gender, Ashanti Region]**

> *Apart from economic, here with our culture, we normally give out our children to their aunties to stay with and they are powerful in terms of decisions concerning the child's life. When the girl is still growing the family may say that the girl's umbilical cord was cut by a man in a particular household, so the girl will be betrothed to that family. So, while they know that you are just growing up, they can just decide to give you out to a man in that family for marriage, not only the biological parents can take such a decision, but the aunty or somebody who has authority by culture to do that, and when they speak nobody can challenge them.* **[51 years old, Public Health Officer, Tamale Northern Region]**

> *You see, the Moslem children do not have a say in that decision. The mothers will start teaching them what they should do when they get married at a very early stage. Sometimes the girl will cry and cry but still, the parents will push her into it.* **[14 years old, Facilitator, Sogakope, Volta Region]**

Control of child marriages

Continuous education of the girls, parents, and society were the predominant mitigating measure proposed by all the respondents to curb child marriages in Ghana. They encouraged the girls to pursue formal education to the highest levels which has prospects for enhancing their social and economic status, enforce their independence, empower them to be assertive in their decision making and provides them with a variety of decision-making tools and options. The respondents entreated parents to endeavor to provide the girls with basic livelihood and educational support needs to avert incidences of school dropout, economic disempowerment, teenage pregnancy, and forced marriage. They also advocated increased education of girls on sexual and reproductive health issues such as consequences of teenage pregnancies and child marriages. Initiatives such as the SISTAs' Club were recommended to girls and their parents as a unique avenue which educates and equips its members with life development skills. An 18 years old non-Club member discussant admonished parents not to *be too greedy for money* because *money doesn't solve all their problems* and that *they have to be patient to allow their daughters to become adults to make our own informed decisions.* This was further elaborated by a 65 years old Father in the Upper West region: According to him:

> *Education is the best thing. Telling parents that child marriage is not good is the best thing. If you talk to them and they understand, they will also tell their*

> *children to complete school before marriage… If you send a girl to school at an early age, by the time the girl becomes a woman, she will be in the secondary school… early education is very good.* **[65 years old, Father, Suuriyiri, Upper West Region]**

Institutions such as district assemblies and chieftaincy were also entreated to play their respective roles in ending child marriages. The Assembles were requested by the respondents to enforce by-laws on child marriages, while the chiefs and community opinion leaders were to be educated on the negative consequences of child marriages and how to eliminate or minimize them.

The law enforcement agencies in Ghana were also implored to act swiftly on reported child marriages by prosecuting the perpetrators, enforcing laws that guarantee children's welfare as well as enhancing their public education programs on this issue.

Teenage Pregnancy

Incidence of teenage pregnancy

Teenage pregnancy is one of the developmental challenges in countries, including Ghana. Birth at an early age may lead to some negative health outcomes for both the child and the teen mother (GSS *et al*., 2015). Teenage pregnancy in most societies is associated with shame, disruption to academic pursuit or withdrawal and limited chances of advancement for the mother and the child (Gyan, 2013). It could lead to a vicious cycle of poverty as well as lengthen the reproductive period and increased fertility (GSS *et al*., 2015). The 2014 Ghana Demographic and Health Survey report indicated that about one-fifth of Ghanaian women aged 25-49 (22%) had given birth before reaching age 18. Considering the fact that Ghana's population is largely considered as youthful (38%) of the total population (GSS *et al*., 2018) could lead to population momentum which has a high tendency of slowing, if not reversing, efforts aimed at national development. It then becomes imperative for policy formulators and implementers to devise multiple approaches to curb the incidence of teenage pregnancies in Ghana. The coming into force of some national policies such as the National Strategic Framework on Ending Child Marriage in Ghana (2017-2026) by the MoGCSP as well as the UNFPA-UNICEF Global Program to Accelerate Action to End Child Marriage could be considered as timely in addressing the challenges posed by teenage pregnancies in Ghana. For instance, the strategic framework seeks to work towards having a Ghana free of child marriage by 2030, while the Joint Global Program aims to ensure that all girls fully enjoy their childhood free from the risk of marriage (MoGCSP, 2016; UNFPA-UNICEF, 2016).

All the respondents contacted during the evaluation of the SISTAs' Club Initiative project affirmed the existence of teenage pregnancies in their communities. For instance, it was only 10 percent of the SISTAs' Club Initiative members surveyed who indicated no incidence of teenage pregnancies in their communities with a little above half (51%) positing that they perceived a high incidence of teenage pregnancies in their communities (Table 17). Across communities, all the respondents from Sagnarigu (Northern region) and majority (91%) from Apromase (Ashanti region) communities affirmed the existence of teenage pregnancies. It is also pertinent to note that significant proportions of respondents from Amessakyire community in the Central region (74%), Mepe community in the Volta region (72%) and Gurugu community in the Northern

region (70%) also viewed the rates of teenage pregnancies in the respective communities as being on the increase.

Table 17: Incidence of Teenage Pregnancies

Community	Perception of incidence of teenage pregnancies			
	No incidence	**Somewhat incidence**	**Increased incidence**	**Total**
Adidome	0(0.0%)	11 (47.8%)	12 (52.2%)	23 (100%)
Amessakyire	3 (11.1%)	4 (14.8%)	20 (74.1%)	27 (100%)
Apromase	0 (0.0%)	1 (8.3%)	11 (91.7%)	12 (100%)
Asawase	1 (4.8%)	15 (71.4%)	5 (23.8%)	21 (100%)
Gambibgo	5 (25.0%)	10 (50.0%	5 (25.0%)	20 (100%)
Gurugu	3 (15.0%)	3 (15.5%)	14 (70.0%)	20 (100%)
Kabanye	3 (14.3%)	13 (61.9%)	5 (23.8%)	21 (100%)
Mepe	0 (0.0%)	7 (28.0%)	18 (72.0%)	25 (100%)
Sagnarigu	0 (0.0%)	0 (0.0%)	8 (100%)	8 (100%)
Sogakope	2 (7.1%)	7 (25.0%)	19 (67.9%)	28 (100%)
Suuriyiri	5 (38.5%)	7 (53.8%)	1 (7.7%)	13 (100%)
Yarigabisi	3 (12.5%)	16 (66.7%)	5 (20.8%)	24 (100%)
Total	**25 (10.3%)**	**94 (38.8%)**	**123 (50.8%)**	**242 (100%)**

Source: Fieldwork, 2018

Furthermore, the generality of the SISTAs' Club Initiative members (85%) perceived the rate of teenage pregnancies in their communities as a concern with some 25 percent describing it as a worrying concern (Table 18).

Table 18: Views about the Concern of Incidence of Teenage Pregnancies

Response	Frequency	Percent
It is not a concern at all	36	14.9
It is somewhat a concern	50	20.7
It is a concern	96	39.7
It is a worrying concern	60	24.8
Total	**242**	**100.0**

Source: Fieldwork, 2018

The issue of teenage pregnancies was echoed by almost all the other respondents interviewed and discussants in the communities. Parents, SISTAs' Club Initiative members, and non-SISTAs' Club Initiative members, as well as other opinion leaders, affirmed the prevalence of teenage pregnancies in their respective communities. For instance, during an interview with a 56-year old mother at Adidome community in the Volta region, she asserted that teenage pregnancy is an issue in the community to the extent *that some of the pupils, about 6 out of 45 girls in JHS may get pregnant before they complete the Basic School.* This assertion was also made by a 17 years old Club member focus group discussant and a stakeholder:

> *I think teenage pregnancy is occurring most, it is becoming too much in the community. Right now, you would like me to take you to the town and you will see that most of the teenagers who dropped out of school as a result of teenage*

pregnancy are more than those of us who are in the school. **[17 years old female Club member, Mepe, Volta Region]**

It is a big challenge. First, it was early marriage and once the child gets married the child gets pregnant for the person and it becomes teenage pregnancy but they don't regard it as such because it is a culture thing here. I also think it is social and financial issues, as well as lack of education play a part in contributing to teenage pregnancies in this community. The apparent neglect of parents and not caring for their young girls is also a factor. **[DOVSU Officer, Upper East Region]**

Causes of teenage pregnancies

The respondents attributed four predominant causes or vulnerability pathways of the incidence of teenage pregnancies in the communities surveyed. These were parental neglect, financial constraints, peer influence and limited knowledge of sexual and reproductive health issues. Some parents were cited for neglecting their core duties of providing basic upkeep needs for their daughters. These needs comprised adequate food, accommodation, sanitary pads and enabling environment that engenders healthy communication between parents and their children. Relatedly, some respondents were of the view that some parents were active agents in promoting teenage pregnancies by influencing or urging their teen daughters to engage in sexual intercourse in exchange for some livelihood support from men or in conformity with their perceived societal standards for girls. These issues were succinctly echoed in an interview with a Public Health Officer in the Northern region of Ghana:

The causes of teenage pregnancy are many…Let us talk about the home. I remember during one meeting we were talking about parents- how they do take care of their adolescents at home? What do they tell them about being an adolescent? What they do tell them about getting pregnant? Per our culture, it is difficult for a woman to even sit her daughter down and talk to her about sex. Always they normally wait until she goes out there and get pregnant and come back, then that they begin to talk to her, by then it would have been too late… I also realized that peer influence is another factor.

Peer influence was cited as another principal factor in promoting teenage pregnancies in various communities. These come about as a result of experimentation, a feeling of a sense of belonging to the group and, as stated earlier, and limited parental control of their children. Some girls who were deemed to be virgins were reported to be swayed by their peers to indulge in sexual activity and experiment with unprotected sexual intercourse. Commenting further on the role of peer influence in promoting teenage pregnancies, a father from Gurungu in the Northern region opined that:

Some children are such that they always do not listen to advice and due to the experimental nature of the adolescents, they will just go and try sexual intercourse and you will see that they get pregnant. They just look at what their colleagues are doing and they will go and try it. So, it is just disobedience on the part of the children.

Another 15 years old non-Club member in the Northern region summed up the peer influence factor as follows:

Teenage pregnancy is somehow common here in this community and it is caused by curiosity and peer pressure. When their friends are having sexual intercourse, they also want to know how it feels like so they also go for boyfriends. Sometimes too, their friend's maybe telling them about their bad behavior like having boyfriends so they are influenced to have a sexual partner. Girls who have bad friends are those who are likely to get pregnant.

Mitigation measures against teenage pregnancy

The interviewees and discussants were general in their suggestions for mitigating the incidences of teenage pregnancies in the various communities. Largely, they advocated for increased and intensified educational programs to create awareness among the general population on the causes and various effects of teenage pregnancies as well as measures that could be adopted to minimize its occurrence. The education could center on some sexual and reproductive health topics such as contraception and utilization of adolescent-and-youth friendly health services located in the various communities. The interviewees and discussants also entreated parents to encourage their daughters to pursue formal education. Provision of focused interventions such as the SISTAs' Club Initiative was also advocated as an intervention measure.

Rape

Incidence of rape in the communities

The results from the study on the perception of the incidence of rape among the respondents are presented in Table 19. More than half (51%) of the SISTAs' Club Initiative members surveyed said there is an increasing rate of incidence of rape in their communities. Specifically, 63 percent of adolescents in Yargabisiin the Upper East region were of the view that there is an increasing rate of incidence of rape in the community. Nonetheless, in some of the communities, the greater proportion of the respondents said there is no incidence of rape in their communities. For example, 80 percent of respondents in Gurugu (Northern region) said there is no incidence of rape in the community, while 72 percent, 55 percent and 54 percent of adolescents in Mepe (Volta region), Gambibgo (Upper East) and Suuriyiri (Upper West) communities, respectively indicated there is no incidence of rape in their communities.

Incidences of rape were rarely reported by all the qualitative respondents. In almost all the communities, the respondents seldom affirmed widespread rape cases with some even being definitive in their responses that rapes do not exist in their communities. What was also clear from the data was that, if even they existed, they are normally not reported due to varied reasons such as stigma, denigration of family reputation and fear of prosecution. These views are encapsulated in these two quotes below:

I think in this community, there are some kind of dignitries that the people hold on to, so they do not want to face the chief with a rape offense. I do not know why one may even think of that!!! Because everyone is holding the family in high esteem and do not want to a bad name for the family, that is the main reason; they do not want to drag their family name into the mud. **[26 years old, Facilitator Gambibgo Upper East Region]**

In fact, there is an incidence of rape, but it is not common. One thing is that people don't really report due to stigma. In some instances, people approached

me personally but when I said the suspects should be arrested, they went back.
[41 years old, DOVSU Officer, Domeabra, Ashanti Region]

Table 19: Perception of the Incidence of Rape

Region/ Community		It is not a concern at all		It is somewh at a concern		It is a concern		It is a worryi ng concern	Total
Total	108	44.6	56	23.1	45	18.6	33	13.6	242.0
Central region									
Amessakyire	17	(62.9)	5	18.5	3	11.2	2	7.4	27.0
Total	***17***	***62.9)***	***5***	***18.5***	***3***	***11.2***	***2***	***7.4***	***27.0***
Ashanti region									
Apromase	3	25.0	3	25.0	4	33.3	2	16.7	12.0
Asawase	4	19.1	10	47.6	5	23.8	2	9.5	21.0
Total	***7***	***21.2***	***13***	***39.4***	***9***	***27.3***	***4***	***12.1***	***33.0***
Upper East region									
Gambibgo	3	15.0	2	10.0	4	20.0	11	55.0	20.0
Yarigabisi	4	16.6	6	25.0	11	45.8	3	12.5	24.0
Total	***7***	***15.9***	***8***	***18.2***	***15***	***34.1***	***14***	***31.8***	***44***
Northern region									
Gurugu	11	55.0	1	5	0	0	8	40.0	20.0
Sagnarigu	7	87.5	0	0.0	0	0.0	1	12.5	8.0
Total	***18***	***64.9***	***1***	***3.6***	***0***	***0***	***9***	***32.1***	***28***
Upper West region									
Kabanye	6	28.6	11	52.4	3	14.3	1	4.8	21.0
Suuriyiri	3	23.1	3	23.1	7	53.9	0	0.0	13.0
Total	***9***	***26.5***	***14***	***41.2***	***10***	***29.4***	***1***	***2.9***	***34***
Volta region									
Adidome	13	56.5	5	21.7	5	21.7	0	0.0	23.0
Mepe	19	76.0	5	20.0	0	0.0	1	4.0	25.0
Sogakope	18	64.3	6	21.4	2	7.1	2	7.1	28.0
Total	***50***	***65.9***	***16***	***21.1***	***7***	***9.2***	***3***	***3.9***	***76***

Source: Fieldwork, 2018

The SISTAs' Club Initiative members also shared their perspectives on the incidence of rape in their communities. When asked to express their concerns on the menace, nearly half (45%) of the survey respondents were of the view that rape is not a concern at all in their communities, while

14 percent indicated that rape was a worrying concern in the communities. In the various communities, 88 percent of the respondent in Sagnarigu community in the Northern region indicated that rape was not a concern at all, while 55 percent of those in Gambibgo community in the Upper East region said rape is a worrying concern in the community (see Table 20).

Table 20: Views about the Concern of Rape

Region/ Community	**It is not a concern at all**		**It is somewhat a concern**		**It is a concern**		**It's a worrying concern**		**Total**
	F	%	F	%	F	%	F	%	
Total	**108**	**44.6**	**56**	**23.1**	**45**	**18.6**	**33**	**13.6**	**242**
Central									
Amessakyire	17	62.9	5	18.5	3	11.2	2	7.4	27.0
Total	***17***	***62.9***	***5***	***18.5***	***3***	***11.2***	***2***	***7.4***	***27.0***
Ashanti region									
Apromase	3	25.0	3	25.0	4	33.3	2	16.7	12.0
Asawase	4	19.1	10	47.6	5	23.8	2	9.5	21.0
Total	***7***	***21.2***	***13***	***39.4***	***9***	***27.3***	***4***	***12.1***	***33.0***
Upper East region									
Gambibgo	3	15.0	2	10.0	4	20.0	11	55.0	20.0
Yarigabisi	4	16.6	6	25.0	11	45.8	3	12.5	24.0
Total	***7***	***15.9***	***8***	***18.2***	***15***	***34.1***	***14***	***31.8***	***44***
Northern region									
Gurugu	11	55.0	1	5	0	0	8	40.0	20.0
Sagnarigu	7	87.5	0	0.0	0	0.0	1	12.5	8.0
Total	***18***	***64.9***	***1***	***3.6***	***0***	***0***	***9***	***32.1***	***28***
Upper West region									
Kabanye	6	28.6	11	52.4	3	14.3	1	4.8	21.0
Suuriyiri	3	23.1	3	23.1	7	53.9	0	0.0	13.0
Total	***9***	***26.5***	***14***	***41.2***	***10***	***29.4***	***1***	***2.9***	***34***
Volta region									
Adidome	13	56.5	5	21.7	5	21.7	0	0.0	23.0
Mepe	19	76.0	5	20.0	0	0.0	1	4.0	25.0
Sogakope	18	64.3	6	21.4	2	7.1	2	7.1	28.0
Total	***50***	***65.9***	***16***	***21.1***	***7***	***9.2***	***3***	***3.9***	***76***

Source: Fieldwork, 2018

Causes of rape

It was clear from the responses of the interviewees and focus group discussants that they were knowledgeable of the possible causes of rape in the communities. Largely, these causes could be classified as victim induced, perpetrator behavior and parental/societal factors. In relation to the victim induced causes of rape, the respondents enumerated factors such as walking alone at obscure places and odd hours (in the night), wearing provocative dresses (miniskirts, short tops), patronising unprotected public spaces such as night Clubs, continuous hanging out with the opposite sex (*ahohyihye),* indulgence in drug or substance abuse or alcohol consumption as the key pre-disposing factors of being rapped. The issue of parental control was cited by some respondents as resulting from parent's apparent endorsement of their children indecent dressing and reluctance to educate their children on the causes, effects and preventive measures of rape. These three quotes are very illustrative:

> *Some girls are raped in this community and this is caused by some of the provocative dresses they wear. For instance, when you wear a short dress and boys who smoke Marijuana see you, they can abduct and rape you. It has happened to an adolescent girl in this community before. Her mother sent her on an errand but she went to pass at the spot of the smokers. It was around 7:00 pm. So, they attacked her, carried her away and raped her. Now she is pregnant.* **[Focus Group Discussant, SISTAs' Club Initiative member, Asawasi, Ashanti Region]**
>
> *What I can say about rape is that some of the boys are heartless because when they are in the mood for sex…they rape the girls. It happens here a lot. Some of the girls are also stubborn. Even when their parents advise them not to enter the rooms of men, they still do it and they get raped. The boys also intentionally send the girls on errands and when they return from the errand and enters the boy's room, he may lock the door and rape the girl.* **[14 years, non-Club Member, Asawasi, Ashanti Region]**
>
> *Rape is caused by poor parental control. If parents do not control or advise their children not to wear indecent dresses, avoid hanging out at dangerous places in the night or should not walk alone, rape will occur*. **[15 years old, Female non-Club Member Focus Group Discussant, Gurugu, Northern Region]**

Mitigation measures against rape

The mitigating measure proffered by the various interviewees and discussants cut across all the communities and regions that were involved in this evaluation. They centered on girls being knowledgeable in rape pre-disposing factors, adopting preventive measures, being responsible in their behavior, parental assertiveness in leading the education and robustness of Ghanaian law enforcement agencies to arrest and prosecute perpetrators of rape. Although the constitution and other Ghanaian laws guarantee individual fundamental rights which include their rights to dressing, the respondents entreated girls to dress 'decently' to avoid attracting sexual attention of men, and to stand up to peer influence that could lead to indulgence in vices like substance/alcohol abuse. The suggestion below is very typical:

I think to address the issue of rape there should be education for the girls on rape and not the girls per se but the society as a whole and let the men also know that there are punitive measures...If the culprits are prosecuted it will be better but some family members even discourage the girls from reporting thinking it will bring them shame. **[41 years old, DOVSU Officer, Domeabra, Ashanti region]**

Abortion

Table 21 shows the results from the SISTAs' Club Initiative members' perception of the incidence of abortion among adolescents in their communities. Approximately 41 percent of the adolescents said there is an increasing rate of incidence of abortion in their communities, while 19 percent said there is no incidence of abortion in their communities. All (100%) the respondents in Sagnarigu in the Northern region indicated that there is an increasing rate of incidence of abortion, while 43 percent of respondents in Kabanye (Upper West region) and Asawase (Ashanti region) communities perceived that there is no incidence of abortion in their communities.

Table 21: Perception of the Incidence of Abortion

Region/ Community	**There is no incidence**		**There is somewhat an incidence**		**There is an increasing rate of incidence**		**Total**
	F	(%)	F	(%)	F	(%)	F
Total	47	19.4	96	39.7	99	40.9	242
Central region							
Amessakyire	8	29.6	9	33.3	10	37.0	27
Total	**8**	**29.6**	**9**	**33.3**	**10**	**37.0**	**27**
Ashanti region							
Apromase	3	25.0	4	33.3	5	41.7	12
Asawase	9	42.9	6	28.6	6	28.6	21
Total	**12**	**36.4**	**10**	**30.3**	**11**	**33.3**	**33**
Upper East region							
Gambibgo	2	10	7	35	11	55.0	20
Yarigabisi	0	0	12	50	12	50	24
Total	**2**	**4.5**	**19**	**43.2**	**23**	**52.3**	**44**
Northern region							
Gurugu	2	10.0	5	25.0	13	65.0	20
Sagnarigu	0	0.0	0	0.0	8	100.0	8
Total	**2**	**7.1**	**5**	**17.6**	**21**	**75**	**28**
Upper West region							
Kabanye	9	42.9	12	57.1	0	0.0	21
Suuriyiri	5	38.5	8	61.5	0	0.0	13

Total	**14**	**41.2**	**20**	**58.8**	**0**	**0**	**34**
Volta region							
Adidome	1	4.4	11	47.8	11	47.8	23
Mepe	4	16.0	12	48.0	9	36.0	25
Sogakope	4	14.3	10	35.7	14	50.0	28
Total	**9**	**11.8**	**33**	**43.4**	**34**	**44.7**	**76**

Source: Fieldwork, 2018

Furthermore, 32 percent of the SISTAs' Club Initiative members indicated that abortion is somewhat a concern in the communities, while 21 percent said abortion was not a concern at all in the communities (Table 22).

Table 22: Views about the Concern of Abortion

Region/ Community	**It is not a concern at all**		**It is somewhat a concern**		**It is a concern**		**It is a worrying concern**		**Total**
	F	%	F	%	F	%	F	%	N
Total	50	20.7	73	30.2	67	27.7	52	21.5	
Central region									
Amessakyire	10	37.0	10	37.0	2	7.4	5	18.5	27.0
Total	***10***	***37.0***	***10***	***37.0***	***2***	***7.4***	***5***	***18.5***	***27.0***
Ashanti region									
Apromase	3	25.0	3	25.0	3	25.0	3	25.0	12.0
Asawase	8	38.1	4	19.1	6	28.6	3	14.3	21.0
Total	***11***	***33.3***	***7***	***21.2***	***9***	***27.3***	***6***	***18.2***	***33.0***
Upper East region									
Gambibgo	2	10.0	4	20.0	2	10.0	12	60.0	20.0
Yarigabisi	1	4.2	12	50.0	8	33.3	3	12.5	24.0
Total	***3***	***6.8***	***16***	***36.4***	***10***	***22.7***	***15***	***34.1***	***44***
Northern region									
Gurugu	3	15.0	3	15.0	4	20.0	10	50.0	20.0
Sagnarigu	0	0.0	0	0.0	7	87.5	1	12.5	8.0
Total	***3***	***10.7***	***3***	***10.7***	***11***	***39.3***	***11***	***39.3***	***28***
Upper West region									
Kabanye	10	47.6	7	33.3	3	14.3	1	4.8	21.0
Suuriyiri	4	30.8	4	30.8	4	30.8	1	7.7	13.0
Total	***14***	***41.2***	***11***	***32.3***	***7***	***20.6***	***2***	***5.9***	***34***
Volta region									

Mepe	1	20.0	5	28.0	13	44.0	3	8.0	25.0
Adidome	5	4.4	7	21.7	11	56.5	14	17.4	23.0
Sogakope	3	10.7	14	50.0	4	14.3	4	25.0	28.0
Total	***9***	***11.8***	***26***	***34.2***	***28***	***36.8***	***7***	***17.1***	***76***

Source: Fieldwork, 2018

Conclusion

Adolescents are generally vulnerable to negative sexual and reproductive health outcomes such as teenage pregnancies, child marriages, rape, and abortion. Respondents contacted for this assessment posited that adolescents were very vulnerable to these problems due to negative peer influence, parental neglect, and poverty. Adolescents' admittance of the possibility of being negatively influenced by their peers to indulge in unprotected sexual intercourse is a conduit for becoming pregnant at an early age or being forced to marry the prospective husband. Poverty had the power to constrain parent's ability to provide for their children, which could necessitate adolescents seeking alternative livelihoods, including indulgence in early marriages with attendant consequences such as teenage pregnancy, rape, and unsupervised abortions. The few parents accused of shirking their responsibilities to *rich* prospective child husbands should not be encouraged to fester. This will require concerted efforts from all stakeholders to empower adolescents and their parents as well as educate society to frown on teenage pregnancies, child marriages, and rape. Legislations in the country should also be strengthened and enforced to deter perpetrators of sexual and gender-based offenses such as rape. The formulators and implementers of the SISTAs' Club Initiative could consider scaling up the initiative to empower more adolescents to make informed decisions on matters that relate to their sexual and reproductive health.

CHAPTER SIX

ESTABLISHMENT AND FUNCTIONING OF SISTAs' CLUBS

Introduction

This chapter focuses on the establishment and functioning of the SISTAs' Clubs in all the sampled communities. Specifically, it describes and assesses the designs adopted to establish the Clubs, the key characteristics of the Clubs, selection of members, expectations of girls, periodicity of meetings, various components and methods in engaging the girls as well as leadership and governance structures.

Establishment and Functioning of SISTAs' Clubs

The design used to establish Clubs

Two main participatory designs were adopted to establish SISTAs' Clubs at the selected communities. These are the vertical participatory design and the horizontal participatory design. With the vertical participatory design, a local board was constituted and the board members identified communities where the incidence of teenage pregnancy was high. Subsequently, schools were purposively selected and Clubs were formed in the selected schools. Teachers and pupil-facilitators were then trained to manage the Clubs. This design was adopted in the Volta region. The governing body was made up of nine (9) members, comprising one (1) representative from PPAG, GHS, GES, Department of Gender, Traditional Council, District Assembly (UNFPA, 2015a). There was no adolescent girl on the board.

> *We have a Management Board which oversee the SISTAs' activities so within a quarter of the year we meet. The Board is made up of representatives of the GHS, GES, District Assembly, Gender Department, and Traditional Authorities. So, during the quarter whatever we have done we update the Board about the challenges and if there is anything that we need to do, we incorporate the input from the Board for us to have a successful program…the board is chaired by a member of the District Assembly.* **[Program Officer]**

Conversely, with regard to the horizontal participatory design, local community durbars were first organized at selected sites (based on needs and vulnerability assessment) to explain the SISTAs' Initiative project. Subsequently, community leaders identified and selected facilitators to be trained. Later, the facilitators formed the Clubs with a minimum composition of 30 members. This design was adopted in the other five regions. In the Ashanti region, for instance, a need/vulnerability assessment which was conducted during the implementation of a previous project served as a basis to select the communities for the implementation of SISTAs' initiative. These explanations were provided:

> *It was formed after training of the Life Planning Skills facilitators who were selected by the community leaders...the chiefs, the assembly people, the youth volunteers, the 'magagia's) (women leaders)...So that was how we brought the people, trained them and asked them to go back to their various communities to form groups through their peers and facilitators.* **[Program Officer]**

We trained Life Planning Skills facilitators…they were selected from those communities and after their training, we had three implementation meetings with stakeholders from this community. After their training, they were supposed to form the Clubs in their various communities; they did their selection with the help of the opinion leaders that were part of the pre-implementation stage. So they worked with the facilitators and selected the SISTAs' for the training. The opinion leaders included some teachers from the community, Imams, Chiefs, Assemblymen, and parents. They helped with the selection in the community. **[Program Officer]**

Ownership of an intervention/project is as critical as its implementation design. The design actually provides the basis for the governance structure, and by extension, ownership. Arnstein's model of citizen participation explains that where there is citizen participation, control, and power, ownership is guaranteed (Arnstein, 1969; Mubita, Libati & Mulonda, 2017). Citizen control in the context of SISTAs' initiative implementation could mean mandated and committed participation, resource mobilization and control of the project by all the stakeholders, particularly the communities and the district assembly with the partner organization, including PPAG.

The results show that most of the respondents had the understanding that the Initiative was owned by the community. In addition to the Program Officers, most of the respondents from the partner organizations in all the regions had this understanding.

I think the initiative should be owned by all of us, we all must see it as 'my thing'. I shouldn't say it belongs to PPAG so I am going to wait for them to start something before I come in. All of us should take initiatives. If I see that something that I think can be done to enhance the initiative, I should be able to tell PPAG...because PPAG did not see the initiative as theirs but rather as for everyone. So they involved teachers in the schools, so even if they are not there, the teachers can take care of it. **[Stakeholder, Volta Region]**

The Clubs are being owned by the Club members...But at the community level, some of the communities decided to give the Clubs a local name...Some of the communities have levied themselves that anytime they go for a meeting or an engagement they will pay a token for their own welfare. So, they owned it and feel that it is for them because they were given the chance to draw their own activities and action plan. **[Female Stakeholder, Northern region]**

It is the schools which own it. We [PPAG] only come in to add to their activities. Because during those activities, once a while, the teachers meet with them to find out what help they can offer to Club members. But once a while, we walk in to give a talk or film show. So, I must say that even though the initiative is from us it belongs to the schools or the communities where the Clubs have been formed. **[Program Officer]**

The initiative is basically meant for the community. We empowered their leaders so that they can empower girls in the community. It is something that they should own so whatever they are doing they are doing to help the community. Since it is

a community-based program, it is the community that owns the Club. **[Program Officer]**

However, some of the respondents were either ignorant about the governance and ownership structure of the initiative/SISTAs' Club or thought that the Initiative was owned by the PPAG. Those who were ignorant could not describe the ownership structure, while the others were of the opinion that the PPAG owned the Initiative, even though in their view, the girls or community must own it. However, the PPAG, as an organization, was of the view that the Initiative is community-owned. These were illustrations of the varied views:

> *I am not sure about their [SISTAs'] governance structure. I don't think it is owned by a particular institution because I see PPAG taking part, Ghana Health Service and the Department of Gender so I can't tell the ownership. The Assembly Member is also part of the project. I think they are accountable to their funding agency but I am not really sure.* **[Female Stakeholder, Ashanti Region]**

> *I usually get in contact or collaborate with PPAG...I don't know about the SISTAS' Club. I met him because we and PPAG were having a durbar about teenage pregnancy, early marriage, and comprehensive abortion care...Well, I don't know anything about the Club*. **[Female Stakeholder, Upper West Region]**

> *The SISTAs' initiative is owned by the association, PPAG, but in actual fact, it should be owned by the girls themselves because it is their own Club so they should own it. But for us as PPAG, we are just supervising them and making sure that they get the right information*. **[Program Officer]**

> *I don't know of the governance structure of the SISTAs' Initiative. I think that the SISTAs' Initiative is owned by the Planned Parenthood Association of Ghana. The community cannot claim ownership of the initiative.* **[Male Stakeholder, Ashanti Region]**

The exact membership per Club at the time of the study was not certain due to irregular attendance of some of the members (as a result of migration, household related activities, and educational progression). Documents available were not up-to-date to show average attendance. That notwithstanding, a total of 20 or more memberships was recorded at all the sampled communities during the survey except at Apromase (12) and Sagnarigu (8) (see Appendix 4). However, during the simulation exercise at Apromase, 22 members participated.

Club characterization

The SISTAs' Clubs in all the study sites can be put under two categories: composition and context. With regard to the composition of the Clubs, there were mainly two types. These were in-school Clubs and mixed (both in-school and out-of-school) Clubs. The context was either school-based or community-based. It was realized that all the school-based Clubs had only in-school Club members, while the community-based Clubs had both in-school and out-of-school membership. However, all the Club members that were interviewed attended formal school. Out

of the 12 communities sampled (including the replacements), eight were mixed and community-based, while four were in-school and school-based (Table 23).

Table 23: SISTAs' Club Characteristics

Region	Municipality/District	Sampled Communities	Composition/Context
Ashanti	AsokoreManpong	Asawasi	Mixed/Community-based
	EjisuJuaben	Apromase	Mixed/Community-based
Central	Cape Coast Metro	Amessakyire	Mixed/Community-based
Upper East	Bolgatanga Municipal	Ganbibigo	Mixed/Community-based
		Yarigabisi	Mixed/Community-based
Northern	Sagnarigu Municipal	Sagnarigu,	Mixed/Community-based
		Gurugu	Mixed/Community-based
Upper West	Wa Municipal	Suriyri	Mixed/Community-based
		Kabanye	In-school/School-based
Volta	Central Tongu	Adidome	In-school/School-based
	North Tongu	Mepe	In-school/School-based
	South Tongu	Sogakope	In-school/School-based
Total		**12**	

Source: Fieldwork, 2018

Selection of Club members

The selection criteria for the girls into the Clubs were both demographic and socio-economic. Demographically, the age range of 10-19 years was the fundamental criterion. Socio-economically, those who are considered poor, vulnerable, and potentially sexually active or had the interest to join were also selected. One of the Program Officers had this to say:

> *We came out with some selection criteria. One, you need to be vulnerable in the community, i.e., not from a rich home. You see, those from the rich home, the parents are overprotective, even attending a meeting, they won't allow them to go but we needed people who were just walking about from poor homes - they needed our services more. You need to be between ages 10-19.*

Table 24 shows that majority of the members in Ashanti (69.7%) and Central (59.3%) regions indicated that existing members introduced them to SISTAs' Club. On the other hand, the majority of the respondents in Northern (96.4%), Upper East (54.5%) and Upper West (58.8%) regions were introduced to the Club by the facilitators. Almost half of the members in the Volta region were introduced to the Club by teachers, while 38 percent of the girls became members of the Club through existing members. What was not clear is whether the existing members' referrals and teachers' announcements were based on the selection criteria apart from age. These were how some of the girls became members:

> *When I was promoted to JHS1, the teachers announced the SISTAs' and told us that those who are interested can join. So, I showed interest and I was selected with other two girls to take part in a training which was organized at the PPAG Centre*. **[Facilitator, Volta Region]**

I joined the SISTAs' Club when they came to our school and after school worship, told us that all the ladies should wait so when we waited they informed us about the Club and told us that anybody can join the Club, thus, it is meant for females and adolescents so if you are a female you can join the Club so they gave us forms to fill. **[Member, 13 years, JHS 2, Upper East Region]**

Table 24: How Girls Became Members of SISTAs' Club

Region	Community	Who do you stay with?						Total % (N)
		Through a member % (N)	Through my parent/ guardian % (N)	Through the facilitator % (N)	Through my teacher % (N)	Personally % (N)	Other % (N)	
Ashanti	Apromase	66.7 (8)	0.0 (0)	33.3 (4)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (12)
	Asawase	71.4 (15)	0.0 (0)	28.6 (8)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (21)
	Total	***69.7 (23)***	***0.0 (0)***	***30.3 (10)***	***0.0 (0)***	***0.0 (0)***	***0.0 (0)***	***100.0 (33)***
Central Northern	Amissaekyir	59.3 (16)	3.7 (1)	22.2 (6)	3.7 (1)	0.0 (0)	11.1 (3)	100.0 (27)
	Gurugu	0.0 (0)	0.0 (0)	100.0 (20)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (20)
	Sagnarigu	12.5 (1)	0.0 (0)	87.5 (7)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (8)
	Total	***3.6 (1)***	***0.0 (0)***	***96.4 (27)***	***0.0 (0)***	***0.0 (0)***	***0.0 (0)***	***100.0 (28)***
Upper East	Gambibigo	100.0 (20)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (20)
	Yarigabisi	0.0 (0)	0.0 (0)	100.0 (24)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (24)
	Total	***45.5 (20)***	***0.0 (0)***	***54.5 (24)***	***0.0 (0)***	***0.0 (0)***	***0.0 (0)***	***100.0 (44)***
Upper West	Kabanye	33.3 (7)	0.0 (0)	61.9 (13)	0.0 (0)	4.8 (1)	0.0 (0)	100.0 (21)
	Suuriyiri	46.2 (6)	0.0 (0)	53.8 (7)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (13)
	Total	***38.2 (13)***	***0.0 (0)***	***58.8 (20)***	***0.0 (0)***	***2.9 (1)***	***0.0 (0)***	***100.0 (34)***
Volta	Adidome	26.1 (6)	0.0 (0)	8.7 (2)	60.9 (14)	4.3 (1)	0.0 (0)	100.0 (23)
	Mepe	48.0 (12)	0.0 (0)	36.0 (9)	16.0 (4)	0.0 (0)	0.0 (0)	100.0 (25)
	Sogakope	3.6 (1)	0.0 (0)	21.4 (6)	67.9 (19)	7.1 (2)	0.0 (0)	100.0 (28)
	Total	***25. 0 (19)***	***0.0 (0)***	***22.4 (17)***	***48.7 (37)***	***3.9 (3)***	***0.0 (0)***	***100.0 (76)***

Source: Fieldwork, 2018

It was found that one of the possible indicators of vulnerability was staying with non-biological or single parents who are also poor. Thus, a girl's vulnerability could increase to some extent because she stayed with a poor single biological parent/guardian. The results reveal three main factors that cause or increase the vulnerability of girls. These are parental neglect/poor parental control, peer influence, and ignorance contextual/community-based perceptions about sexuality. For instance, the community perception that an older adolescent should get pregnant to show her cultural and sexual pride is still held, especially in rural communities. These factors are consistent with findings from other studies (UNFPA, 2015b, 2018). Some of the respondents expressed their knowledge of the vulnerability of girls:

Another reason for increasing teenage pregnancy is that parents do not have time to talk to the children; they do not have time to educate their children about teenage pregnancy. So even at night, they do not care whether the child is sleeping or not, they only say to the child that...I am going to sleep so when you

are about to sleep make sure you lock the door. They will not even shout on the children for them to go to bed so that they [parents] themselves can lock the door. But they will allow them [children] to be roaming about in town, that is what most of the parents do. **[FGD: Member, 17 years, stays with grandmother, Volta Region]**

Peer group and bad friends: As your peers force you to do something, without your will, sometimes you might need the money and you will go and do such acts [sexual intercourse for money]. **[FGD: Female non-member, 17 years, stays with both parents, Northern Region]**

Poverty too is a major cause of this early marriage in this community. You remember when we were talking about the early pregnancy we said poverty. They are very related. For example, if the lady cannot get basic things such as sanitary pad then a man is ready to be doing that for her she will go in for that man. Some too it is their parent's poverty status. Because they cannot take care of you they prefer to give you out early for marriage and get some freedom. [**FGD: Female non-member, 15 years, stays with both parents, Northern Region]**

The upbringing of adolescents is the fundamental issue. For example, here, when you're 15, 16 and you do not have your first-born, it's like you have been cursed and parents will force you that "kɔwo" (you need to give birth). They don't consider the fact that the person is schooling, learning a vocation or whatever. The parents don't look at that. It's all about having your first-born and most of them would be in school. When they get pregnant and are not able to get back to the classroom, they drop out of school. **[Program Officer]**

*The first I will say is ignorance. The girls do not know about family planning and at times they want to experiment because they are sexually active so they fall prey to such circumstances. I will also say broken homes and neglect by parents is another cause. Most of the parents in these communities are single parents. Parental care is not all that strong so the girls are left on their own do whatever they want. I will say that broken homes and poverty are the major causes of teenage pregnancy. Some of them because their parents are not financially sound, they want to go in for financial assistance from boys and that leads to sex and teenage pregnancy. These causes make them vulnerable to teenage pregnancy.***[Male Stakeholder, Ashanti Region]**

Expectations of Club members

From the findings, almost all (96%) the respondents indicated that they have achieved their expectations of joining the Club. In fact, all the respondents in Central, Northern and Upper East regions said that they have achieved their expectations (Table 25). A few, however, indicated that they expected to learn about how to make soap and beads, how to wear the condom correctly and also take up family planning services to prevent pregnancy. These, according to the respondents, were not met.

During the FGDs, on the other hand, all the girls indicated that they have achieved their expectations. This was across all age groups, educational level and regions. In summary, these were the expectations that were met: ability to educate peers on ASRH issues, how to prevent pregnancy, how to prevent STIs, including HIV, how to have safer sex, being assertive, ability to speak to peers and the public, as well as the acquisition of some basic life development skills such as sewing, hairdressing, and face make-up. One of the respondents had this to say:

> *I wanted to know about how to prevent teenage pregnancy and now I know that, if I use condoms I will not get pregnant and, if I abstain from sex also I will not get pregnant.* **[FGD: Member, 13 years, JHS 2, Upper East Region]**

Table 25: Achievement of Expectations

REGION/ COMMUNITY		Have you expectations been met?	
		Yes	No
TOTAL		96.3 (233)	3.7 (9)
Ashanti	Apromase	30.3 (10)	6.1 (2)
	Asawase	63.6 (21)	0.0 (0)
	Total	***93.9 (31)***	***6.1 (2)***
Central	Emisaekyir	100 (27)	0.0 (0)
	Total	***100 (27)***	***0.0 (0)***
Northern	Gururgu	71.4 (20)	0.0 (0)
	Sagnarigu	28.6 (8)	0.0 (0)
	Total	***100 (28)***	***0.0 (0)***
Upper East	Gambibigo	45.5 (20)	0.0 (0)
	Yargabisi	54.5 (24)	0.0 (0)
	Total	***100 (44)***	***0.0 (0)***
Upper West	Kabanye	65.6 (21)	0.0 (0)
	Suuriryiri	34.4 (11)	5.9 (2)
	Total	***94.1 (32)***	***5.9 (2)***
Volta	Adidome	30.3 (23)	0.0 (0)
	Mepe	32.9 (25)	0.0 (0)
	Sogakope	30.3 (23)	0.0 (0)
	Total	***93.4 (71)***	***6.6 (5)***

Source: Fieldwork, 2018

Periodicity of meetings

The Club met once a week for their regular activities. The in-school Clubs met every Friday, while the community-based Clubs met every Friday or Sunday depending on the religious inclination of the community. The periodicity of meetings depended on the availability of the facilitators and, to an extent, change of venue. For instance, at Apromase (Ashanti region) the

change of venue for meetings affected not only the regularity of organized meetings, but also attendance of members.

The in-school or school-based Club meetings seemed regular and effective compared with the community-based Club meetings. Perhaps, this is because the former has a regulated space. Again, apart from the facilitators, there were two or three teachers who supervised the activities of the Clubs. The following expressions were made by the following respondents:

> *Three teachers [two females and one male] accompanied them to the office where they went and had the training... Because from time to time, when they meet, even my teachers do meet them and there we factor all those things [activities] into it*. **[Male Parent, Volta Region]**

The results show that more than 60 percent of the respondents participated in all Club activities. Specifically, about 46 percent and 54 percent of respondents aged 10-14 and 15-19, respectively participated in all Club activities. Furthermore, among those who participated in all Club activities, about 82 percent were in JHS and more than 16 percent were in primary school, while 66 percent and 34 percent were Christians and Muslims, respectively (Table 26).

Table 26: Participation of Club Activities

Variable	Response		Total
Age	**Yes**	**No**	
10-14	57.3 (67)	42.7 (50)	100.0 (117)
15-9	63.2 (79)	36.8 (46)	100.0 (125)
Total	***60.3 (146)***	***39.7 (96)***	***100.0 (242)***
Level of education			
Primary	55.8 (24)	44.2 (19)	100.0 (43)
JHS	61.3 (119)	38.7 (75)	100.0 (194)
SHS	60.0 (3)	40.0 (2)	100.0 (5)
Total	***60.3 (146)***	***39.7 (96)***	***100.0 (242)***
Religion			
Christian	58.5 (96)	41.5 (68)	100.0 (164)
Muslim	64.1 (50)	35.9 (28)	100.0 (78)
Total	***60.3 (146)***	***39.7 (96)***	***100.0 (242)***
Region			
Ashanti	42.4 (14)	57.6 (19)	100.0 (33)
Central	74.1 (20)	25.9 (7)	100.0 (27)
Northern	89.3 (25)	10.7 (3)	100.0 (28)
Upper East	100.0 (44)	0.0 (0)	100.0 (44)
Upper West	52.9 (18)	47.1 (16)	100.0 (34)
Volta	32.9 (25)	64.3 (51)	100.0 (76)
Total	***60.3***	***39.7***	***100.0 (242)***

Source: Fieldwork, 2018

Components of initiative and methods of Club/community engagement

The study recorded a number of components of the SISTAs' initiative. Basically, there were four main components: comprehensive sexuality education (specifically, personal hygiene, teenage pregnancy, STIs, early marriage, assertiveness, advocacy, gender-related issues, etc.), livelihood empowerment and skills development (including fabric designing, bead and soap making, cooking skills, hair styling and facial make-up), mentorship, and parent-child communication/interaction (child training and guidance, responsibilities of parents and children, etc.). The results show that all the adolescent girls have been reached with information on how to prevent teenage pregnancy, STIs (including HIV) and early marriage. Most (68.2%) of them knew about how to prevent teenage pregnancy (with abstinence: 73%; use of condom: 48%) and STIs (with abstinence: 65.8%; use of condom: 54%). Others reported that they first learned about the issue of early marriage (30.6%) and HIV (27.3%) at Club meetings. Others had these to say:

> *I have learned about teenage pregnancy. Initially, I knew about teenage pregnancy but now I have learned about how I will prevent it. I knew about abstinence but now I have learned about contraceptives like condom use.***[FGD: Member, 14 years, JHS 2, Upper East Region]**

A sizeable number also had comprehensive knowledge (GSS, GHS & ICF International, 2015) about HIV. For instance, 77 percent of the respondents indicated that being faithful to just one uninfected sexual partner who has no other sexual partner reduces the chance of getting HIV. Again, 69 percent said that consistent use of condom during sexual intercourse reduces the chance of getting infected with HIV. However, only 19 percent indicated that they can use the condom correctly. Girls aged 15-19 (24%), who were in JHS (21.1%) and were Christians (24.4%) were more likely to know how to use the condom correctly, likewise, those in the Volta region and lived at Mepe. It was observed during the simulation sessions and also the FGDs that emphasis was placed on abstinence during discussions on teenage pregnancy and STIs (see also Sen & Govendr, 2015; USAID, 2018).

The study also identified knowledge about misconceptions or incorrect beliefs about HIV transmission in order to assess the level of knowledge among the girls. Common misconceptions about HIV include the following: a healthy-looking person cannot have HIV, HIV can be transmitted by mosquito bites, HIV can be transmitted by supernatural means, and a person can be infected by sharing food with a person who has HIV. The results show that 61 percent knew that a healthy-looking person can have HIV. Again, 74 percent knew that HIV cannot be transmitted by supernatural means, while more than 74 percent knew that mosquito bites cannot spread HIV. Similarly, 78 percent of the respondents knew that a person cannot get infected by sharing food with an HIV infected person. Knowledge, however, increased among older adolescents (15-19 years), respondents in JHS and Muslims (Table 27). Comprehensive knowledge was high among the respondents compared with the national results among females aged 15-19 (25.2%) and all women (22.7%) (GSS, GHS & ICF International, 2015).

Table 27: Knowledge about HIV: Misconceptions

Variable	**Can a person get HIV by sharing food with a person who has HIV?**		**Can a person get HIV because of witchcraft or other supernatural means?**		**A healthy-looking person can have HIV?**		**HIV can be transmitted by mosquito bites?**	
Age	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
10-14	34.4 (40)	65.5 (76)	34.5 (40)	65.5 (76	56.9 (66)	43.1 (50)	34.2 (40)	65.8 (77)
15-19	11.2 (14)	88.8 (111)	18.4 (23)	81.6 (102)	64.0 (80)	36.0 (45)	13.6 (17)	86.4 (108)
Total	***22.4 (54)***	***77.6 (187)***	***26.1 (63)***	***73.9 (178)***	***60.6 (146)***	***39.4 (95)***	***23.6 (57)***	***76.4 (185)***
Level of Education								
Primary	30.9 (13)	69.0 (29)	47.6 (20)	52.4 (22)	45.2 (19)	54.8 (23)	39.5 (17)	60.5 (26)
JHS	21.1 (41)	78.9 (153	21.6 (42)	78.4 (152)	63.9 (124)	35.0 (70)	20.1 (39)	79.9 (155)
SHS	0.0 (0)	100.0 (5)	20.0 (1)	80.0 (4)	60.0 (3)	40.0 (2)	20.0 (1)	80.0 (4)
Total	***22.4 (54)***	***77.6 (187)***	***26.1 (63)***	***73.9 (178)***	***60.6 (146)***	***39.4 (95)***	***23.6 (57)***	***76.4 (185)***
Religion								
Christian	18.4 (30)	81.6 (133)	23.9 (39)	76.1 (124)	62.0 (101)	38.0 (62)	18.3 (30)	81.7 (134)
Muslim	30.8 (24)	69.2 (54)	30.8 (24)	69.2 (54)	57.7 (45)	42.3 (33)	34.6 (27)	65.4 (51)
Total	***22.4 (54)***	***77.6 (187)***	***26.1 (63)***	***73.9 (178)***	***60.6 (146)***	***39.4 (95)***	***23.6 (57)***	***76.4 (185)***
Region								
Ashanti	9.1 (3)	90.9 (30)	24.3 (8)	75.8 (25)	33.3 (11)	66.7 (22)	25.9 (12)	63.6 (21)
*Central	42.3 (11)	57.7 (15)	46.7 (12)	53.8 (14)	53.8 (14)	46.2 (12)	33.3 (9)	66.7 (18)
Northern	67.9 (19)	32.1 (9)	0.0 (0)	100.0 (28)	85.7 (24)	14.3 (4)	35.7 (10)	64.3 (18)
Upper East	9.1 (4)	90.9 (40)	20.5 (9)	79.5 (25)	72.7 (32)	27.3 (12)	15.9 (7)	84.1 (37
Upper West	26.4 (9)	73.5 (25)	50.0 (17)	50.0 (17)	58.8 (20)	41.2 (14)	32.3 (11)	67.6 (23)
Volta	11.8 (9)	88.2 (67)	22.4 (18)	77.6 (59)	59.2 (45)	40.8 (31)	10.5 (8)	89.5 (68)
Total	***22.4 (55)***	***77.6 (187)***	***26.1 (64)***	***73.9 (178)***	***63.5 (153)***	***36.5 (88)***	***20.7 (50)***	***79.3 (192)***

Source: Fieldwork, 2018

**1 Missing value*

Various methods were used to reach the girls, particularly with the components of the SISTAs' Club Initiative. These include interactive information sharing, talks, group and hands-on activities, theatrical session, community durbar, community-radio session, mentorship session, and parent-child interaction. For instance, almost all the girls indicated that they enjoyed the mentorship sessions. They further explained that the mentors motivated them to think positively and aspire to achieve their future career. Others were motivated to be assertive, confident and to avoid teenage pregnancy to enable them realize their future dreams. Additionally, the parent-child session is an interactive space for girls to share their challenges and vulnerabilities to their parents, while the parents also shared their challenges and intentions for their children. The space was also used as an educational platform to create awareness and deepen understanding about the responsibilities and needs of parents and girls. Some of the respondents had these to say on mentorship and parent-child interactive sessions:

> *Recently, at the gender office, we realized that teenage pregnancy is increasing in the district so we decided to have some engagement with students, teachers, and parents together. We asked them to talk freely so that we can find a way to address it.* **[Female Stakeholder, Volta Region]**

> *At one of the parent-child sessions that we had, some of the chiefs were part of some of these parent-child communication activities. So, at the meeting, some of them said that when they go back, they will even work to make a by-law and come out with a time that no 'Okada man' [commercial motor rider] should carry a girl.* **[Program Officer]**

Leadership and governance of Clubs

The leadership structure of the Clubs was generally similar comprising the Facilitator, President, Vice President, Secretary, and Vice Secretary. The in-school Clubs had the facilitators (who are also pupils) as leaders of the Clubs assisted by the Vice President and the others. They are, however, guided by at least two teachers. The governance structure could be classified at two levels: the school or community-based Club level and the stakeholder level. The latter had oversight jurisdiction over the former.

Conclusion

In conclusion, two main participatory designs were adopted to establish SISTAs' Clubs at the selected communities - vertical participatory and horizontal participatory designs. Most of the respondents had the understanding that the Initiative was owned by the community. The SISTAs' Clubs in all the study sites can be put under two categories (composition and context). With regard to the composition of the Clubs, there were mainly two types. These were in-school Clubs and mixed (both in-school and out-of-school) Clubs. The contexts were either school-based or community-based. It was realized that all the school-based Clubs had only in-school Club members, while the community-based Clubs had both in-school and out-of-school membership. It was found that one of the possible indicators of vulnerability was staying with non-biological or single parents who are also poor. Three main factors were found to be responsible for increasing the vulnerability of girls - parental neglect/poor parental control, peer influence, ignorance on contextual/community-based perceptions about sexuality. There were four main components of the SISTAs' Club Initiative: comprehensive sexuality education (specifically,

personal hygiene, teenage pregnancy, STIs, early marriage, assertiveness, advocacy, etc.), livelihood empowerment and skills development (including fabric designing, bead and soap making, cooking skills, hair styling and facial make-up), mentorship, and parent-child communication/interaction. The results show that all the adolescent girls have been reached with information on how to prevent teenage pregnancy, STIs (including HIV) and early marriage. The various activities that have been implemented by the Clubs have generally contributed to Club members improved knowledge in issues such as public speaking, prevention of teenage pregnancy and early marriage, personal hygiene as well as access to quality information on ASRH.

CHAPTER SEVEN

PARTNERSHIP STRUCTURES AND MECHANISMS

Introduction

This chapter outlines the main models and structures that underpinned the implementation of the SISTAs' Clun Initiative in general and Clubs in particular. It assesses the structures within the context of relevance, effectiveness, and impact.

Partnership and Collaborative Mechanisms

Four key partner categories were directly involved in the SISTAs' Club Initiative. These are development partners, implementer, stakeholder, and beneficiary categories. All these categories of partners were expected to work together to ensure and enhance the effective implementation and sustainability of the initiative. The expectation was for the mechanism to work and ensure the ownership and sustainability of the initiative locally.

The development partner category was made up of the UNFPA. This organization provided tangible inputs, including funding, technical inputs, and social behavior change communication materials as well as information and, education communication materials.

The PPAG is the implementer. It had the mandate to roll out the components of the Initiative in selected regions, districts, and communities, train facilitators and girls as well as conduct monitoring and evaluation. The PPAG also had the task to provide space for the girls to access youth-friendly services, including adolescent sexual and reproductive health services at the implementing site. The PPAG had a direct collaborative mechanism with both the development partner and the stakeholder categories.

The third category of partner is the stakeholder organization comprising of the district assembly, traditional/local community authority, GHS, GES, DOVSU, Department of Gender and the National Youth Authority. Each of these partners had a mandate and roles to play collaboratively. For instance, the district assembly was to host the Initiative and create the enabling environment for the collaborative mechanism to be effected. Also, traditional leadership was committed to facilitate community entry processes and protocols. The role of the GHS in this collaborative mechanism was to provide health education and services, especially at places where the PPAG did not have facilities to provide such services to the beneficiary category. The expected role of the GES includes facilitating the implementation of the Initiative in the schools. The DOVSU and the Gender Desk were to provide information and education to the adolescents in particular and adults in general about rights and responsibilities of children and parents, as well as certain acts (such as early marriage) that are unlawful, based on national laws such as the Domestic Violence Act.

The last partner in the collaborative mechanism is the beneficiaries. The direct beneficiaries are the adolescent girls and facilitators, while the indirect beneficiary was composed of other adolescents (male and female), and parents. While the facilitators had the mandate to train the girls at the Club level, the girls and the parents were to be responsive to the education and information received to reduce teenage pregnancy and early child marriage.

Assessment of collaborative mechanism

The composition of the partner and the collaborative mechanism was made up of appropriate organizations which have the capacity, skill, and know-how, experience and funding ability to execute the mandate given. In fact, the mechanism also depicted generally, the governance structure of the Initiative. As such, as a model, the mechanism entailed the necessary features for effective delivery of mandates (see Esia-Donkoh & Marfo, 2015). The mechanism also allowed for participation which to a large extent, promoted the implementation of the Initiative. This exemplifies the strength of the mechanism. However, what the collaborative mechanism lacked was a memorandum of understanding (MoU) to expressly spell out each partner's roles, tasks, commitments and responsibilities to the Initiative. This would have provided evidence of direction, timeliness, activity schedule and the conduit to hold each partner unto its mandate and specific commitment tasks. This was shared:

> *This year we have not met at all [as a Board]...it is overdue now because if we want to have the meeting, we normally give incentives but because there are no funds for that now we have failed [as a Board] to meet...But on one and one anytime I am less busy I do visit the partners and tell them about the activities on-going.* **[Program Officer]**

The inputs committed to the Initiative were also assessed. Basically, funds and learning materials and a number of facilitators comprised the inputs. Generally, the respondents expressed that the inputs were adequate and reliable. Apart from the funds that were received and the number of facilitators that were trained (including supply of BCC and IEC materials) on life planning skills manual, charts and posters), other logistics that were provided by the Project include T-shirts, exercise books and sanitary pads. With respect to the funds, the results show that it was adequate and based on the budget submitted to the development partner. However, the concern that was raised touched on delays that characterized the release of funds quarterly. To address it, PPAG positioned itself to mitigate it with interim/partial funds. That notwithstanding, some of the respondents perceived that supplies such as sanitary pads and T-shirt were insufficient. Again, certain activities such as community radio program (which were not budgeted for because the community was expected to provide the space for free) became a cost to the Club or the Facilitator/Program Officer. This, consequently, affected regularly community-based program, especially at Apromase (Ashanti region).

According to the step to behavior change communication, advocacy is the last step to behavior change (USAID, 2018). The expectation was that the information and knowledge received, gained and approved could also be practized and shared. Seventy-five percent of the respondents indicated that they shared the information and knowledge gained. The results also show that irrespective of their background, the majority of the respondents were likely to share information and knowledge they gained but with the peers of the same sex. Over 92 percent of the girls shared what they learnt with the peers of the same sex. Thus, less than 10 percent shared their knowledge with adolescent boys and parents. Other non-member respondents as well as parents, narrated how they got some of the information and knowledge that the members acquired at Club meetings:

One of the girls told me that they normally teach them how to prevent teenage pregnancy...I do receive such information at least six times in a month. **[FGD: Male non-member, 18 years, JHS 3, Upper East Region]**

What I know about it is that when the girls go for their meetings, they give them advice on how to prevent themselves from teenage pregnancy and things like that. In addition, I was also told that they encouraged them to abstain from sex or use condoms anytime they want to have sex if they feel like they cannot abstain. **[FGD: Male non-member, 17 years, JHS 3, Volta Region]**

Some of the members told me that at the Club they advise young girls about male friends, child marriage, and teenage pregnancy. Secondly, they help you not to be a bad girl. Thirdly they teach you what to do during menstruation and sometimes they give them sanitary pads. Lastly, they help young girls who are not more than 18 years to do good things like respect elders. [**FGD: Female non-member, 14 years, JHS 1, Ashanti Region]**

Yes, what I know about SISTAS' is that they always teach the girls how to prevent themselves from getting teenage pregnancy and HIV. **[FGD: Male Non-member, 16 years, JHS 2, Northern Region]**

*She tells me almost the same things you are asking me about now. Specifically, she tells me about teenage pregnancy, early marriage, and bad behavior among young people.***[Male Parent, 40 years, Northern Region]**

My friend told me but she didn't give me a lot of details. She only said they have some group and they have been teaching them on teenage pregnancy and those things. I don't know the organizations involved in the Club. **[FGD: Female non-member, 17 years, JHS 3, Central Region]**

My daughter did not tell me anything but the last time I asked her myself and she told me that she has learnt about how to prevent teenage pregnancy and why giving birth anyhow is not good. She said they have been advised to avoid teenage pregnancy and early marriage so that they would not destroy their lives and education. **[Female Parent, 42 years, Ashanti Region]**

It was observed in all the implementation sites that a few others, both non-member and parent respondents, did not know about the activities of the SISTAs' initiative. Some, particularly the non-member boys, wondered why the Club was strictly female-based and that they (boys) were not allowed to get near the Club meeting venue. It was also observed that some of the parents were not aware of the existence of the Club, hence, were un-sure or doubted their female wards' attendance at Club meetings. To address this, some of the girls suggested that the facilitators must provide information about SISTAs' to all the parents of Club members. This could also mean that not all the parents of the girls in the Club participated in the Parent-Child Communication component of the SISTAs' Club. Below are some of the views of the respondents:

But she doesn't tell me about what they discuss and I don't follow her to the meeting so I don't know. I don't know when they started going for the meeting and I cannot tell the exact date but it has been long. **[Female Parent, 65 years, Northern Region]**

Yes, I have heard about SISTAS'. It is a Club made up of only girls. My sister is a member of SISTAS' but I don't know what they do or how it came about since she doesn't tell me what they learn at their meetings. **[FGD: Male non-member, 12 years, Primary 6, Ashanti Region]**

I have heard about the SISTAs' Club, but I don't know exactly what they do and the reasons for the formation of the Club. **[FGD: Female non-member, 14 years, JHS 2, Volta Region]**

They [facilitators] should let our parent also come together so that they can inform them that there is a Club called SISTA's Club so that whenever we are going for meetings they will not think any bad about us. My mother once said I was going to my boyfriend's house even though I was going to Club meeting. **[FGD: Member, 13 years, JHS 2, Upper East Region]**

Relevance, Effectiveness, and Impact

The study adapted the Development Assistance Committee criteria to assess the relevance, effectiveness, impact, and sustainability. For the purposes of this study, relevance is conceptualized under three key issues: focus (purpose and objective), context and benefits. Focus as an indicator of relevance, relates to how significant the initiative is to human development. Evidence shows that comprehensive and timely provision of (adolescent) sexual and reproductive health and rights information are at the heart of good health and human rights because it prepares the adolescent to achieve positive and fulfilling healthy sexual and social life now and in the future (Sen & Govender, 2015; UNFPA, 2015). As a result, investments in adolescent (sexual) health and wellbeing bring a triple dividend of benefits now, into future adult life, and for the next generation of children (Cense & Ruard, 2018). Thus, from a theoretical perspective, the SISTAs' initiative is relevant.

Secondly, the context within which the initiative was situated is also appropriate. Empirical evidence available shows that over 14 percent of adolescents aged 15-19 were pregnant or have begun childbearing. The incidence of teenage pregnancy and childbearing were high in rural communities and highest in the Volta region (GSS *et al.*, 2015). The results from the current study confirmed that in all the sampled communities, teenage pregnancy was a concern leading to school drop-out. Thus, contextually, the initiative is relevant.

Thirdly, the results show that the SISTAs' initiative is relevant because of its associated benefits to both members of the Club and non-members (both girls and boys). Intended benefits included knowledge about how to prevent teenage pregnancy and STIs, including HIV, how to negotiate for safer sex and prevent early marriage. Some of the respondents even confirmed that the knowledge gained has improved parent-child communication, and has also broadened their

understanding beyond the classroom. The benefits also 'spilled' unto the non-member male population across the various implementation sites as well.

> *First, I didn't know how to protect myself out of danger but now I can avoid danger by not walking at a quiet place at night. I also didn't know when you follow bad friends they can influence you to have sex which can make you pregnant but now I know. I also know that when a man forces you and rapes you, you can get pregnant*. **[FGD: Member, 13 years, JHS 1, Upper West Region]**
>
> *The only difference that I have seen is that when she first started her menses, she used to hide it from me. She felt shy to let me know about her menses, so how to carry herself in her menses was becoming a problem but since she joined the Club, she now talks to me about her menses and she also manages her menses well.* **[Female Parent, 53 years, Volta Region]**
>
> *I was also getting it [information] from school, our teachers used to teach us, but we were learning it for exams sake. But at SISTAs' I am trying to practise it... At SISTAs' we do demonstrations on how to use a condom, but with the teachers they will just tell you that use a condom to prevent teenage pregnancy. But SISTAs' will teach you how to use it.* **[FGD: Member, 16 years, JHS 3, Volta Region]**
>
> *Because of the advice they normally give to them and they [members of the Club] share with us, when I want to do something bad, like sex, and I remember what they tell me, I will stop.***[FGD: Male non-member, 13 years, Upper East Region]**
>
> *The benefit I derived from the SISTAS' was when they came and performed a play that highlighted teenage pregnancy and the associated challenges. It made me learn a lesson and encouraged me to be careful with my sexual life.* **[FGD: Male Non-member, 17 years, JHS 3, Volta Region]**

The respondents also recounted other benefits they did not anticipate to gain from the Club, but which they have acquired as social assets now. Some of them mentioned that through the SISTAs' activities they have learnt how to cook, dress, use the sanitary pads, make soap, style the hair, etc. These were how some of them put it:

> *SISTAS' has helped me to know how to wear the sanitary pad even though I have not started menstruating.* **[FGD: Member, 12 years, Primary 6, Ashanti Region]**
>
> *I am twelve years and I stay with my grandmother. At first, I did not know how to cook but thanks to SISTAS', I have learnt how to cook.* **[FGD: Member, 12 years, JHS 1, Ashanti Region]**
>
> *There was this girl in the school. Now she has completed and she does bead making and also makes liquid soap at home. It was her who mentioned the name*

SISTAs' to my hearing and that she learnt the bead and soap making at SISTAs'. **[FGD: Male non-member, 19 years, JHS 3, Volta Region]**

So we did that and the children went there during holidays and they trained them on how to do liquid soap...a lot of us testified that the liquid soap is one of the best on the market. **[Male Parent, 59 years, Volta Region]**

The study also conceptualized effectiveness in relation to input, process, and output of the initiative. Generally, the resources (funds, BCC and IEC materials, etc.), number of facilitators, number of Club members, etc. were, to a large extent, perceived to be adequate to implement the Initiative. Moreover, the governance structure and the partner-collaborative mechanism were consistent with recent participatory models for community-based project implementation (Muhammad, 2016; Onyango & Worthen, 2010). The limitation, however, was the absence of MoU for stakeholders, succession plan for facilitators, follow-up plan for Club members, and sustainability plan for the Initiative (see later discussion under gaps).

The intention of the Initiative was also to cause a behavior change among the beneficiaries. Impact of the Initiative was assessed at two levels: individual level and community level.The results show that the initiative has achieved an appreciable level of impact. For example, 86 percent of the girls said that they have had a change in behavior. Moreover, more than 72 percent indicated that they have seen a change in the behavior of other Club members. It was observed that some of the girls have had a change in behavior in relation to sexual relations with male partners. The following individual behavior change stories were shared:

If it was not for SISTAs'; I am sure I would be pregnant by now because I used to be promiscuous, but now I have changed. **[FGD: Member, 15 years, JHS 2, Ashanti Region]**

In my case, when my sister came back from the training, what I noticed was that she had changed. She used to be daring and do sleep outside the home sometimes. But when she came back [from the SISTAs' training] she changed completely. As a result, she was able to pass her exams and was admitted to secondary school. When I realized she had changed, I asked her and she told me that they were educated on the dangers of early sexual activity and how teenage pregnancy can negatively affect an adolescent. **[FGD: Malenon-member, 17 years, JHS 3, Volta Region]**

Yes, I have noticed some positive changes in some adolescents. There is this girl who used to always be in the company of boys. But, since the facilitator spoke with her, she has now changed. She was having a number of boys [boyfriends] but she has now stopped. She has no boyfriend now. **[FGD: Male non-member, 14 years, JHS 1, Volta Region]**

At first, I was the shy type, even when I am talking to you, I cannot look at your face; I will be looking elsewhere and will be talking to you but now I can see that I have improved on that...I can walk anywhere at any time and educate anybody

that I think needs information to access health services. **[Facilitator, Volta Region]**

I have seen some changes in the behavior of some of the members- the way they talk in the community and their boldness; I can say they have really acquired some knowledge. These girls are sure of themselves, they are clear and they know what they are doing. Others who are not part of the Club are not like that. So, I think it is bringing some impact. **[Male Parent, 60 years, Volta Region]**

The extent to which the girls have been empowered was also assessed (Table 28). Majority of the respondents indicated that they have been empowered to say NO to sex (88.4%), say NO to unprotected sex (88.0%) and early marriage (91.3%), and could negotiate for safer sex (72.7%). For instance, girls who said they have been empowered to say NO to sex increased slightly among those aged 15-19 and among respondents in primary school and Volta region. Some of the girls also demonstrated how they have been empowered to prevent early marriage. One of them had this to say:

Now I know that when someone wants to marry me or push me to marry I can report the person and I know where to report the person to. I will report the person to the police if he/she tries to do that to me. **[FGD: Member, 17 years, JHS 2, Upper East Region]**

Across all the regions and in all the Clubs, the girls demonstrated confidence in expressing their knowledge in ASRH issues. This was more evedent during the simulation sessions where the girls were able to facilitate sessions devoid of fear and shyness but characterized predominantly with mastery of key ASRH termilologies and accurate illustrations. Most of the respondents attributed it to the Club's activities. It was also observed from the respondents that the activities of the Club and the girls have contributed to a general awareness of how to prevent teenage pregnancy and other related issues. Thus, the community has somehow been impacted too. Some of the parents and stakeholders across the regions shared their views as follows:

It has impacted on them a lot. It all goes down to what I said earlier: confidence, self-esteem knowing their rights and responsibilities. At the community level, last time during an outreach, they were saying that some of the out-of-school girls have started schooling and some have gone to learn vocational skills all because with the help of this initiative. **[Female Stakeholder, Northern Region]**

The issues that they discuss during meetings are helping them a lot, that is why we have not been hearing cases of teenage pregnancies in those schools where the Clubs are formed...I have not been hearing the incidence of teenage pregnancies in those schools where they have these Clubs. So, I think the program has been very helpful. [**Female Stakeholder, Upper East Region]**

Teenage pregnancy used to be a common phenomenon here but now it has reduced, I think the Club has contributed. This is because of late I haven't been seeing many young girls becoming pregnant again as I used to see them. **[Female Parent, 75 years, Upper East Region]**

Formally, about six of our girls in JHS get pregnant before writing the BECE but now we don't experience this issue of teenage pregnancy again...In fact, how some of the girls behaved previously had changed. They used to follow boys for money and other material things but I think now these girls I knew who used to do that seem content with what they have. **[Female Stakeholder, Volta Region]**

Table 28: Empowerment of Respondents

Variable	**Do you think you have been empowered to say NO to sex?**		**Do you think you have been empowered to say NO to unprotected sex?**		**Do you think you have been empowered to say NO to early marriage?**		**Do you think you have been empowered to say NO to negotiate for safer sex?**	
Age	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
10-14	88.0 (103)	12.0 (14)	88.0 (102)	12.1 (14)	87.8 (101)	12.2 (14)	70.9 (83)	29.1 (34)
15-19	88.8 (111)	11.2 (14)	88.8 (111)	11.2 (14)	94.4 (118)	5.6 (7)	74.4 (93)	25.6 (32)
Total	***88.4 (214)***	***11.5 (28)***	***88.4 (214)***	***11.6 (28)***	***91.3 (219)***	***8.7 (21)***	***72.7 (176)***	***27.3 (66)***
Level of Education								
Primary	90.7 (39)	9.3 (4)	86.0 (37)	13.9 (6)	81.0 (34)	19.0 (8)	60.5 (26)	39.5 (17)
JHS	87.6 (170)	12.4 (24)	88.6 (171)	11.4 (22)	93.3 (180)	6.7 (13)	74.7 (145)	25.3 (49)
SHS	100.0 (5)	0.0 (0)	100.0 (5)	0.0 (0)	100.0 (5)	0.0 (0)	100.0 (5)	0.0 (0)
Total	***88.4 (214)***	***11.5 (28)***	***88.4 (214)***	***11.5 (28)***	***91.3 (219)***	***8.7 (21)***	***72.7 (176)***	***27.3 (66)***
Religion								
Christian	92,7 (152)	7.3 (12)	93.9 (153)	6.1 (10)	92.6 (150)	7.4 (12)	76.8 (126)	23.2 (38)
Muslim	79.5 (62)	20.5 (16)	76.9 (60)	23.1 (18)	88.5 (69)	11.5 (9)	64.1 (50)	35.9 (28)
Total	***88.4 (214)***	***11.5 (28)***	***88.4 (214)***	***11.5 (28)***	***91.3 (219)***	***8.7 (21)***	***72.7 (176)***	***27.3 (66)***
Region								
Ashanti	87.9 (29)	12.1 (4)	87.9 (29)	12.1 (4)	78.8 (26)	21.2 (7)	63.6 921)	36.4 (12)
Central	88.9 (24)	11.1 (3)	92.4 (23)	7.6 (2)	88.0 (22)	12.0 (3)	59.3 (16)	40.7 (11)
Northern	53.6 (15)	46.4 (13)	53.6 (15)	46.4 (13)	85.7 (24)	14.3 (4)	67.9 (19)	32.1 (9)
Upper East	88.6 (39)	11.4 (5)	90.9 (40)	9.1 (4)	93.2 (41)	6.8 (3)	72.7 (32)	27.3 (12)
Upper West	94.1 (32)	5.8 (2)	88.2 (30)	11.8 (4)	91.2 (31)	8.8 (3)	79.4 (27)	20.6 (7)
Volta	98.7 (75)	1.3 91)	98.7 (75)	1.5 (1)	98.7 (75)	1.3 (1)	80.3 (61)	19.7 (15)
Total	***88.4 (214)***	***11.5 (28)***	***88.4 (214)***	***11.5 (28)***	***91.3 (219)***	***8.7 (21)***	***72.7 (176)***	***27.3 (66)***

Source: Fieldwork, 2018

Across all the regions and in all the Clubs, the girls demonstrated confidence in expressing their knowledge in ASRH issues. This was more evedent during the simulation sessions where the girls were able to facilitate sessions devoid of fear and shyness but characterized predominantly with mastery of key ASRH termilologies and accurate illustrations. Most of the respondents attributed it to the Club's activities. It was also observed from the respondents that the activities of the Club and the girls have contributed to a general awareness of how to prevent teenage pregnancy and other related issues. Thus, the community has somehow been impacted too. Some of the parents and stakeholders across the regions shared their views as follows:

> *It has impacted on them a lot. It all goes down to what I said earlier: confidence, self-esteem knowing their rights and responsibilities. At the community level, last time during an outreach, they were saying that some of the out-of-school girls have started schooling and some have gone to learn vocational skills all because with the help of this initiative.* **[Female Stakeholder, Northern Region]**
>
> *The issues that they discuss during meetings are helping them a lot, that is why we have not been hearing cases of teenage pregnancies in those schools where the Clubs are formed...I have not been hearing the incidence of teenage pregnancies in those schools where they have these Clubs. So, I think the program has been very helpful.* [**Female Stakeholder, Upper East Region]**
>
> *Teenage pregnancy used to be a common phenomenon here but now it has reduced, I think the Club has contributed. This is because of late I haven't been seeing many young girls becoming pregnant again as I used to see them.* **[Female Parent, 75 years, Upper East Region]**
>
> *Formally, about six of our girls in JHS get pregnant before writing the BECE but now we don't experience this issue of teenage pregnancy again...In fact, how some of the girls behaved previously had changed. They used to follow boys for money and other material things but I think now these girls I knew who used to do that seem content with what they have.* **[Female Stakeholder, Volta Region]**

Conclusion

Four key partner categories were directly involved in the SISTAs' Club Initiative – development partner, implementer, stakeholder and the beneficiary categories. The composition of the partner and collaborative mechanism was made up of appropriate organisations which have the capacity, skill and know-how, experience and funding ability to execute the mandate given. The mechanism also allowed for participation which, to a large extent, promoted the implementation of the Initiative. However, the collaborative mechanism lacked an MoU to expressly spell out each partner's roles, tasks, commitments and responsibilities to the Initiative. This would have provided evidence of direction, timeliness, activity schedule and the conduit to hold each partner unto its mandate and specific commitments tasks. Some of the respondents complained about delays that characterized the release of funds quarterly, while others perceived that supplies such as sanitary pads and T-shirt were insufficient. Again, certain activities such as community radio program (which were not budgeted for because the community was expected to provide the space for free) became a cost to the Clubs or the Facilitator/Program Officers. This, therefore, affected regularly community-based program, especially at Apromase (Ashanti region).

CHAPTER EIGHT

GAPS, CHALLENGES AND LESSONS LEARNT

Introduction

This chapter of the report is devoted to the gaps and challenges associated with the structures and implementation of the SISTAs' initiative. The chapter also presents lessons learnt from these challenges and how they are inter-related.

Gaps and Challenges

The study identified four main gaps in the implementation of the Initiative. The first is the lack of MoU to specify the governance structure and identify the roles, responsibilities, resource mobilisation and ownership of the Initiative. The second is the non-existence of succession or replacement plan and strategies to address facilitator turnover. Thirdly, there were no follow-up plans or strategies to monitor the progress of girls who moved out of the Club as a result of educational progression, job demands or pregnancy to collect change stories and/or status progression. Lastly, there was no sustainability plan for the Initiative should the main funding regime close.

There were three main challenges as well. One of the challenges was associated with the input. The results show that there were instances where information and education communication materials became inadequate because some of the facilitators who are no longer available did not return these materials. Re-training and getting additional materials came with unbudgeted cost implications. One of the program officers and other facilitators shared their concerns:

> *Unfortunately, some of them [facilitators] go away with the materials...most of them have gone to the secondary school...when we did a follow-up in the secondary schools they said they continue to share whatever they have learnt at where they are. So, some have taken it out.*
>
> *No, we do not have them [BCC materials] ...I think they should provide us with some instructional materials that show some educative picture which could be used in teaching.*
>
> *The only one that we need is the vagina model and additional flipchart to show to the people when teaching them.*

The second challenge was associated with misconception of community members (especially gatekeepers). It was explained by the respondents that some of the opinion leaders and parents as well as sections of the community members were of the view that educating adolescents about contraceptives and demonstrating how to use them were not only immoral but will encourage the adolescents to engage in pre-marital sex. As a result, they spoke and opposed the concept of SISTAs' Initiative. For instance, at in-school Clubs, the adolescent-facilitators were not permitted to do a condom demonstration. These concerns were shared:

> *Some of them [parents] have some misconceptions about the Club. They say that the teachers are teaching the girls to use contraceptives and be having sex casually. Some also say that these people [facilitators] are spoiling the children.*

So not all parents accept the movement of their wards to where they have the meetings. Sometimes they accuse them that they only go there to talk about condoms...they say when the girls go there, they tell them to have sex with contraceptives; that is a misconception! **[Male Parent, 59 years, Volta Region]**

After the three-day training, when I came back to educate my peers for the first time, I educated them about how to use the female and the male condom. But when we went for a meeting on the next week Sunday, one of my managers said our Headmaster said what we are now doing we are spoiling our friends...indirectly what they were saying was that we are to stop. **[Facilitator, Volta Region]**

The third challenge was pregnancies that occurred among some of the members of the Club. This created a slur on the Club. This image-challenge affected the Club to some extent in the sense that some of the community members and other adolescents used it as a reference of ridicule. Clubs at Apromase, Kabanye and Sogakope recorded pregnancies among members. Some of the facilitators provided these reports:

One of our members got pregnant. They [non-members of SISTAs'] began saying that the girl went through a lot of teachings; she was taught about the dangers of teenage pregnancy but upon all that she has been taught she became pregnant. It was her friends who are not members of the Club who were mocking her that she always pretends to be a good girl, but she has finally gotten herself pregnant. **[Facilitator, Volta Region]**

We have recorded some pregnancies among SISTAs' Club members. I have seen three of them who were members and got pregnant...they were all less than 20 years. In fact, one was 15 and another 16 and 18. This created a scar on SISTAs'. Somebody has made reference to that saying that all our girls in SISTAs' are pregnant. It really demoralized me; I feel so bad about it. **[Facilitator, Ashanti Region]**

Lastly, observations at the Clubs did not have up-to-date and reliable records on membership, written minutes of meetings and attendance records in all the communities. The expectation by the program officers that the Club members would ensure regular capture of records was not met.

Lessons Learnt

Lessons learnt have been categorized into two. These are lessons learnt at the individual (girl-child/adolescent) level and lessons learnt at the community/stakeholder level. At the individual level, three main issues arise – needs, interest and impact. Needs of the adolescents encompassed both material/physical needs and sexual and reproductive health needs. Meeting these needs of the adolescent could go a long way to prepare them to achieve positive and fulfilling healthy sexual and socio-economic life now and in the future. While the partner organisations with PPAG (local) and UNFPA provide the latter, parents/guardians must be responsible to provide the material needs of their girl-children.

Secondly, the study reveals the issue of interest. All the identified groups of stakeholders including members and non-members of SISTAs' Club have diverse but unified interests. The collaborative mechanism that was modelled harnessed these interests to target and achieve a common objective: reduce teenage pregnancy and early marriage. The lesson is that the stronger the interest, the higher the probability of achieving the objective.

The study identified that because the needs of adolescents could not be met by their parents/guardians, they became less empowered to say no to sex/unprotected sex with its associated outcomes. The SISTAs' Club, therefore, became an appropriate platform for the girls to develop their self-worth and self-esteem. That notwithstanding, the role of parents in meeting the basic needs of their girl-children would be critical to sustain the self-esteem of the girls.

Similarly, three lessons were drawn from the results. The lessons touch on partnership, participation and ownership. Partnership, as defined by some authors means an equal commitment of persons to achieve mutual interests (Carnwell & Carson, 2008; Carpentier, 2011). Although the Initiative seemed to revolve around a partnership model, it was not clear about the structure. Perhaps, this explains the reason the concepts of partnership and collaboration (or collaborative mechanism) were used interchangeably although the two are not the same. Collaboration is the process where organizations work together to achieve a common mission. While members of partnerships share the same vested interests with appropriate governance structures, collaboration is based on the willingness to work together on an agreed purpose (Carnwell & Carson, 2008). The lesson in this context is that there was no partnership structure but collaboration among the partner-organizations.

The second issue is participation. Arnstein (1969) explains that the highest level of participation is citizen control (see also Kumari, 2015; Mubita *et al*., 2017). From the results, it was realized that although the intention was for the community (made up of the stakeholders) to have control over the Initiative, the PPAG seemed to have the control. Perhaps, this arose because the partnership/collaborative structures were not well defined for each partner-organization to control its defined space and responsibility with or without the PPAG. That notwithstanding, the school Club structures outlined a localized structure under the jurisdiction of the school authority.

The last lesson learnt relates to ownership. Ownership is conceptualized as a right indefinite in point of the user and unlimited in point of duration over a determinate object (intervention) (Kumari, 2015; Radtke, Holstenkamp, Barnes & Renn, 2018). A well-defined partnership/collaborative structure and the level of participation would also prescribe the structure of ownership. Thus, where both preceding structures are not clearly defined, ownership of an intervention would be vague. In the context of the SISTAs' Club Initiative, the preceding structures were loosely structured, hence, the reason some of the stakeholders did not see the community as the owner of the Initiative.

Conclusions

The SISTAs' Club Initiative was purposed to introduce knowledge and equip adolescent girls especially, to be empowered to make informed choices about their sexuality and enjoy the best of sexual and social lives now and in the future. To a large extent, this purpose has been achieved.

Behavior change is, however, a process and therefore consistent information transmission and access to youth-friendly and gender-sensitive adolescent sexual and reproductive health services are critical to avoid relapse. Re-structuring the collaborative mechanism would strengthen the Initiative and ensure its community-ownership structure and sustainability.

CHAPTER NINE

SUSTAINABILITY AND REPLICABILITY

Introduction

The concluding chapter covers issues relating to the strengthening and replication of the SISTAs' Club Initiative. Responses solicited from the respondents focused on whether the SISTAs' Club Initiative should be sustained, how the Club would be sustained, roles that can be performed to ensure its sustenance and whether the Initiative should be replicated in other areas.

Sustainability

Sustainability has been explained differently based on the subject being discussed and the background of those discussing the concept (United Nations, 2015). Generally, sustainability means a life-long activity or a going-concern process. Thus, the sustainability of SISTAs' Club Initiative means that the Initiative has to be a life-long activity without a definite life-span. From the perspective of the Initiative, since the community was expected to own it, then it would be timeless. This study focuses on sustainability from two dimensions: the project dimension and the advocacy dimension. The project dimension entails the sustainability of the Initiative in general but the Clubs in particular.

From the survey results, close to universal of the respondents in all the regions and communities, and among all age-groups indicated that the SISTAs' Club Initiative must be sustained. The results were similar to the qualitative findings where all the participants, including parents and stakeholders, also echoed the need to sustain the activities of the SISTAs' Club Initiative. They were of the view that the SISTAs' Club activities should be sustained because of the positive effects on the girls. These were how some of the participants expressed their views:

> *Yes, it should be sustained because we don't need to begin something and leave it like that, we are still giving birth to children so the youth will continue to exist. Therefore, the program should continue to exist until we see that the information has gone very down to the grassroots. So it is not something that should be stopped, the youth will continue to exist.* **[Female Stakeholder, Upper West region]**
>
> *Yes, per the benefits we are getting we think it should be sustained. Things like pregnancies, child marriages and also empowering the girls to say no to some of these things [teenage pregnancy, early marriage, rape] have really helped.* **[Female Parent, 31 years, Upper East Region]**
>
> *Yes. Because it [SISTAs' Club] is an organization that helps us to know how to take care of ourselves as girls. Some of us, in our homes, our parents don't tell us about how to live our lives as girls [how to relate with boys, issues like menstruation, how to avoid teenage pregnancy]. So it [SISTAs' Club] will help us to know how to live our lives as girls.* **[FGD: Member, 15 years, JHS 3, Upper East Region]**

> *Yes. Because, personally, it has transformed me and I can see that my colleagues have also been transformed...I have seen a change in their lives. There has also been a reduction in teenage pregnancy.* **[Facilitator, Volta Region]**

The second dimension of the sustainability of SISTAs' is the issue of advocacy. Beyond the project, and in the private spaces of Club members, the expectation was that they should share the knowledge and skills they have acquired with their peers and even parents. More than 75 percent of the Club members indicated that they have shared what they learnt at Club meetings. This cohort could serve as the basis for sustainability in terms of continuity of advocacy involving the spread of information about adolescent sexual and reproductive health issues. The results further showed that almost 65 percent of the respondents have developed interpersonal skills such as advocacy and communicative skills. A male parent (65 years) in the Upper West region used this analogy to establish the need for the continuity of the initiative through advocacy. This was how he conceptualized it:

> *When you plant a tree, without roots it doesn't grow...When you plant a tree [SISTAs' Club] and it grows, some of the roots [Club members and beneficiaries] may pass through different places with the information and when the wind [of opposition or challenge] blows, it [transmission of information] cannot be broken.* **[Male parent, 65 years, Upper West Region]**

How to Sustain the Initiative

Respondents and participants were asked about how the Initiative could be sustained. Three key suggestions were raised by the survey respondents. The first is to ensure that there is a sustained membership in all Clubs. The second is that members of the Club should endeavor to adhere to and practice what they have been taught, and lastly, adults, especially parents, must fully be integrated to support their wards to achieve a fulfilling sexual and social life now and in the future. The qualitative participants also focused on three main issues: strengthening the advocacy process, conceptualizing a holistic approach towards monitoring, and encouraging and motivating girls to participate in Club's activities. The following statements were made to buttress the suggestions raised:

> *Funding cannot continue to be there forever as I said earlier. During the SISTAs' training sessions, we made them understand that they [trained volunteers] may not be in the community forever so whiles they are also training the girls, they should look for the active ones so that periodically they will let them lead discussions so that if they are not there, the other members will be there.* **[Program Officer]**

> *I think there should be constant monitoring of the project so that we would know the progress of the Initiative at each point in time. I think all the stakeholders [PPAG, DOVSU, GES, and Department of Children] should monitor the Initiative. The community too has to see the project as their own so that it would be sustained. I suggest that we also involve the boys because if we concentrate on the girls all the time, the boys will be at a disadvantage. So we need to encourage the boys to join so that they will understand the issues of the girls and all help in*

solving the issues because they feel they are being neglected. **[Female stakeholder, Ashanti Region]**

The GES and the Police are already on board but I think we should involve them more. Teachers can add it up in their subjects like citizenship education as well. The education should be for the parents since they uphold the traditions, parents should be targeted. **[Male Stakeholder, Ashanti Region]**

At the moment, the Club is not so strong so I will be happy, if PPAG comes around more often to encourage and entice the other students to join. **[Facilitator, Volta Region]**

Roles that Individuals Can Play to Sustain the Initiative

The study also sought to assess the roles individual stakeholders could play to facilitate the sustainability of the Initiative. It is evident that, the study participants are keenly interested in the sustenance of the SISTAs' Initiative. Generally, most of the stakeholders indicated that they would continue to play their specific roles to enhance the sustainability of the Initiative. However, the call was also made for stakeholders to encourage the girls to access services from their facilities or departments. These were some of the recorded views:

Personally, I can contribute to the sustenance by providing education services for young people in this community. Other people like the pastors, headmasters and Assemblyman can all come on board to promote the Club by endorsing it and advocating for it to be supported by all. The school headmasters, for instance, can invite us to their schools so that we can educate people and recruit members. The Assemblyman can also announce it for people to hear about it. **[Female Facilitator, Central Region]**

The various stakeholders in the schools have school outreach programs. The SHEP coordinator could help the various Clubs in the various schools to go on outreach. GHS will always be there in terms of SRH service provision. DOVSU and other stakeholders are there too. Once the young people know that there is a place where they can report or complain in case of rape and abuses, they will keep going to them. **[Program Officer]**

Replication

Replication was understood in the context of the study as increasing the number of Clubs and component activities at implementing sites and at different communities in the region. In all cases, the rationale is to upscale the intervention to increase the reach and coverage. From the survey results, all (99.6%) of the respondents indicated that the Initiative should be up-scaled. However, there were diverse views among the IDI and FGD participants. Actually, most of the Program Officers were of the view that the current reach and coverage of the Initiative should rather be strengthened with the funds available for a while until such a time that the Initiative could be seen as successful in all its component forms. The others were of the opinion that the Initiative must be replicated owing to its benefits. These were some of the divergent views:

I think we should improve on what we are doing now and if we are successful, we scale it up. For now, I am thinking that they should rather concentrate on a small area, make an impact and have success stories; good stories to tell before up-scaling. **[Program officer]**

All require some funding to extend to other communities or increase the number of Clubs. For instance, there are communities that are quite far away, so we would need financial and logistics assistance to fuel our car to go there...it requires training which also needs to be funded. **[Program Officer]**

It is also important if we extend the Club to other communities like Brofoyeduru. Ayedan and London Bridge because the incidence of teenage pregnancy is high there too. I usually go there and I see children aged 12 being pregnant. **[Facilitator, Central Region]**

I think it should be extended to them [to other communities] because there are also girls and boys there who engage in early sex without knowing how to protect themselves from teenage pregnancy. **[FGD: Member, 18 years, JHS, Northern Region]**

CHAPTER TEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the summary of the results of the study, the conclusions drawn based on the findings and recommendations.

Summary of the Study

The main objective of the study was to assess the overall effectiveness and benefits of the SISTAs' Club Initiative and identify appropriate approaches to assure a robust programming model. Specifically, the study was undertaken to:

1. Profile the background characteristics of the SISTAs' Club Initiative members;
2. Assess Club members' health-seeking behaviors relative to sexual and reproductive health, contraceptive use/family planning, coping strategies against rape, adolescent pregnancy and abortion;
3. Analyse the gender dynamics, social relations and factors that influence the vulnerabilities of the girls to disempowerment, rights abuses, unwanted pregnancies, child and forced marriages and other harmful practices;
4. Ascertain the processes employed in the establishment and functioning of the SISTAs' Clubs;
5. Assess available partnerships, collaborative or coordination mechanisms adopted by the various strategic agencies/structures to strengthen referrals to adolescent-and youth-friendly health services;
6. Examine the effectiveness, impact and benefits of the SISTAs' Club Initiative; and
7. Recommend measures that could be employed to strengthen and replicate the SISTAs' Initiative.

In order to carry out a comprehensive assessment, four main activities were undertaken; desk review activity, pre-field activity, fieldwork, and data analysis. Employing a constructive evaluation technique as a methodological framework, the study drew evidence from both quantitative and qualitative data concurrently. This allowed for confirmation, validation and corroboration of the responses. The quantitative data were analysed using SPSS version 23 and the results are presented in tables using descriptive statistics, simple frequency and cross-tabulations. The qualitative data, on the other hand, was analysed using thematic analysis (framework analysis), and appropriate quotes from the transcripts were used to support the themes that emerged.

Summary of the Findings

The respondents/participants were between the ages of 10-19 years with a slight majority (51.7%) of them within the age group 10-14 years (younger adolescents). All the respondents have had a formal education with 80 per cent currently in JHS. None of the respondents was married at the time of the study.

With regard to the availability of adolescent-and-youth friendly health facilities, there was a mixed result. Whereas the respondents (adolescents) in some regions indicated the availability of such facilities, the opposite was evident in other regions. Similar divergent views were expressed among the key informants and focus group discussants. However, almost all the participants

knew about possible services that would be offered or currently being offered at such facilities. It was, however, observed that availability of services does not necessarily translate into service utilisation among the adolescents. Key challenges in access to sexual and reproductive health services are the negative attitude of gatekeepers (health personnel, parents and community members) and other adolescents towards such services.

Generally, the adolescents expressed vulnerability to undesirable sexual and reproductive health outcomes, including teenage pregnancy, child marriage, rape, abortion, amid some variations. The vulnerability of the adolescents was as a result of negative peer influence, parental neglect, and poverty, with some parents accused of shirking their responsibilities to "wealthy" prospective child husbands.

The SISTAs' Clubs have been established in all study sites. The Clubs can be categorized into two, based on composition and context. With regard to composition, there were mainly two types – in-school Clubs and mixed (both in-school and out-of-school) Clubs. The context was either school-based or community-based. The criteria for the selection of the girls were both demographic (age range 10-19) and socio-economic (considered poor, vulnerable, and potentially sexually active). The overwhelming majority of the respondents (96%) indicated that their expectations for joining the Club have been met. In most study sites, the Clubs usually meet once a week, with the majority of the respondents participating in all Club activities. The initiative was made up of four main components – comprehensive sexuality education, livelihood empowerment and skills development, mentorship, and parent-child communication/interaction.

Four main partner categories were directly involved in the SISTAS' initiative – development partner, implementer, stakeholder, and the beneficiaries. The initiative adopted a collaborative mechanism which was expected to ensure greater participation. However, it was found that the collaborative mechanism, in this case, lacked MoU to clearly spell out roles, tasks, commitments, and responsibilities of all partners. With regard to the inputs/materials for the initiative, the respondents generally indicated they were adequate, appropriate and reliable. Generally, it was evident that the SISTAS' initiative is relevant, effective and has a positive impact.

To a large extent, the purpose of the SISTAS' initiative which is to introduce knowledge, equip, and empower adolescent girls to control their sexuality has been achieved. However, some gaps and challenges have been identified. Firstly, there was no MoU to specify the governance structure and identify roles, responsibilities, resource mobilisation, and ownership of the initiative. Secondly, the absence of succession or replacement plan and strategies to address facilitator turnover is a threat to the sustainability of the initiative. In addition, there were no follow-up plans and strategies to monitor the progress of girls who moved out of the Club for educational or vocational progression, job demands, and pregnancy. There were no plans for the sustainability of the initiative beyond the current funding regime.

As regards the sustainability of the initiative, the respondents/participants almost unanimously asserted that the SISTAS' initiative ought to be sustained. Two main reasons were given as the basis for such overwhelming assertion. First is due to the benefits and the positive impacts of the initiative. Secondly, the need to reach and establish the information in the hearts and minds of adolescents will require continuous effort. Sustained membership, adherence and practice of

what has been learnt and the involvement and support of parents were highlighted as ways to sustain the initiative. Whereas the all the adolescents in the survey wished for the initiative to be replicated in other communities, the key informants expressed reservations about replicability now, due to the need to strengthen the current coverage of the initiative.

Conclusions

Adolescent-and-youth friendly health facilities are available in most of the study sites, but some of them lack prominence as a result of limited activities. Availability of such facilities does not necessarily result in utilisation of services.

There is a general feeling of vulnerability to negative sexual and reproductive health outcomes among adolescents due to poverty and parental neglect among other factors.

The SISTAs' Clubs have been established in all the study sites with some variations in terms of composition and context.

There are various partner categories directly involved in the SISTAS' initiative with a collaborative mechanism adopted to enhance participation.

The purpose of the SISTAs' Initiative has been achieved to a large extent. However, some gaps and challenges exist that need to be addressed.

The SISTAs' Initiative has to be sustained due to its positive impact and the benefits that adolescents derived from the initiative. The initiative needs to be replicated in other communities, but efforts need to be directed at strengthening the existing Clubs before establishing new ones in other communities.

Recommendations

The general view of the respondents agrees to the sustainability and replication of all the component parts of the SISTAs' Club initiative. However, there are underpinning factors that must prevail to ensure the sustainability and replication:

1. The partnership and ownership structures must be conceptualized, developed and well defined. These should be guided by a holistic MoU which will specify responsibilities, roles and commitments of each stakeholder as well as sources of resources, including human, material, capital, financial and possibly spiritual resources. The vertical participatory approach of governance structure is recommended and it could include adolescents.
2. Plans of activities could be defined taking into account succession plans and follow-up plans.
3. The model of implementation should also be integrative to include parents as well. This will enhance the ownership as well as participation of all key stakeholders in the governance of the SISTAs' especially in planning, implementation, monitoring and evaluation.
4. Awareness and sensitisation of SISTAs' activities could be intensified to increase understanding and knowledge particularly among parents and other gatekeepers. In

addition, knowledge about SISTAs' and the purpose of its implementation could be deepened during Parent-Child Communication sessions.

5. The facilitators of SISTAs' Clubs could organize specific programs with parents of SISTAs' Club members. This interaction, by extension, could reinforce the Parent-Child Communication activity in general, and remove misconceptions and ignorance about SISTAs' Club in particular.
6. There could also be an engagement with Health personnel who provide adolescent sexual and reproductive health and rights services to adolescents to broaden their understanding particular on rights of adolescents to sexual and reproductive health services. Periodic appraisal and exit interviews could be conducted by the facilitators to assess the performance of the health personnel who are part of the SISTAs' project.
7. For the Initiative to be replicated, communities must be in the position to support all the activities SISTAs' Club with the needed resources. However, emphasis needs to be placed on in-school replication since that could be integrated into the school activities. Again, given the current free SHS intervention, replication could also focus on girls in the secondary schools where are no SISTAs' Clubs.
8. Lastly, there should be the development and implementation of boys-only programs and mixed programs. This will provide basic understanding about the purpose of objective of the SISTAs' Club and its activities to the boys also. This could enhance their knowledge and the need to appreciate sexual and reproductive health and rights of girls especially.

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APPENDICES

Appendix 1: Evaluation Instruments

Questionnaire for members of SISTAs

UNIVERSITY OF CAPE COAST
DIRECTORATE OF RESEARCH INNOVATION AND CONSULTANCY
ASSESSMENT OF SISTAS CLUB INITIATIVE IN GHANA
QUESTIONNAIRE FOR MEMBERS OF SISTAS

Section A: Background Issues

No	Questions	Coding Category	Skip
1	Name of area	Region: …… Community: ……	
2	Age (in completed years)	[ ][ ]	
3	Marital status	Single/Never Married ……...…… 1 Co-habitation ……...…… 2 Married …….. 3 Separated/Divorced …….. 4 Widowed ……... 5	
4	What is your religion?	Christian ……. 1 Moslem ……..……. 2 Traditional …….…. 3 No religion ……. 4 Others (Specify…… 5	
5	Type of education/training	Formal …….……. 1 Informal/Apprenticeship ……..…….…..... 2 None ……..……... 3	→ **Q7**
6	Level of formal education attended	Primary …… 1 JSS/JHS/Middle …….……... 2 SHS/SSS ……..…… 3 Others (specify) ……..……. 4	
7	Length of stay in community	Years…… Month…….	
8	Occupation	Unemployed …….……..…. 1 Formal sector …….…….... 2 Informal sector …….…….. 3 Other (specify) ……..…….. 4	
9	Who do you stay with?	Biological mother ……..…… 1 Biological father ……..…….. 2 Both biological parents ……..…...… 3 Male guardian ……..…..…….. 4 Female guardian ……..…... 5 Both guardians ……..…. 6 Other relative (specify) ……..……. 7	
10	When did you join SISTAS?	[ ][ ] [ ][ ] [ ][ ]	
11	How many members are in yours SISTAS?	[ ][ ]	

12	How did you get to know of SISTAS?	Through a member ...……..…….. 1 Through a non-member ..... 2 Through my parent/guardian ..... 3 Through the Coordinator ..... 4 Through my teacher ..... 5 Personally visited/poster, etc. ..... 6 Other (specify) 7	
13	Why did you join the SISTAS Club?		
14	What is your role in SISTAS Club?	Member……..…….. 1 Trained Peer Educator……..…… 2 Other (specify) …….…… 3	
15	Have you been trained as a peer educator?	Yes …….. 1 No …….…… 2	
16	What was your **main** expectation for joining the SISTAS Club?		
17	How many times have you attended SISTAS Club meetings since you joined?	[ ][ ]	
18	How many times did you participate in outreach activities? (i.e. outside the usual meeting venue)	[ ][ ]	
19	How many mentors have you ever listened to since you joined the Club?	[ ][ ]	
20	Are you sexually active?	Yes ……. 1 No …….…… 2	
21	Have you ever been sexually active before?	Yes ……. 1 No …….…… 2	
22	Have you ever had sex before?	Yes ……. 1 No …….…… 2	→ **Q26**
23	If **Yes** to **Que 22**, the last time you had sex did you use condom?	Yes ……. 1 No …….…… 2	
24	Have you ever had sex since you joined SISTAS?	Yes ……. 1 No …….…… 2	→ **Q26**
25	If **Yes** to **Que 24**. did you use condom the last time you had sex?	Yes ……. 1 No …….…… 2	
26	Has any attempt ever been made to get you into marriage?	Yes ……. 1 No …….…… 2	→ **Q29**
27	If **Yes** to **Que 26**, who made the attempt?	Biological mother …….…… 1 Biological father …….. 2 Both biological parents …….…… 3 Male guardian …….. 4 Female guardian ……... 5 Both guardians …….. 6 Other (specify) …….……... 7	
28	Was the attempt to get you into marriage made before joining SISTAS?	Yes ……. 1 No …….…… 2	

Section B: Community-based Information

No	Questions	Coding Category	Skip
29	Do you think adolescents in your community are sexually active?	Yes ……. 1 No …….…… 2	→ **Q31**
30	Which of these do you think are increasingly sexually active?	Male adolescents …… 1 Female Adolescents …….. 2	
31	Do we have adolescents in your community who have been given into marriage?	Yes ……. 1 No …….…… 2	
32	What is the perception about the rate of incidence of teenage pregnancy in this community?	There is no incidence ……... 1 There is somewhat an incidence ….…….. 2 There is an increasing rate of incidence …….. 3	
33	What is the view of this community on teenage pregnancy?	It is not a concern at all ..... 1 It is somewhat a concern ..... 2 It is a concern ..... 3 It is a worrying concern 4	
34	What is the perception about the incidence of rape in your community?	There is no incidence ……... 1 There is somewhat an incidence ….…….. 2 There is an increasing rate of incidenc…….. 3	
35	What is the view about the concern of rape in your community?	It is not a concern at all ..... 1 It is a somewhat a concern ..... 2 It is a concern ..... 3 It is a worrying concern 4	
36	What is the perception about the incidence of adolescent marriage in your community?	There is no incidence ……...…….... 1 There is somewhat an incidence ……..….. 2 There is an increasing rate of incidence…….. 3	
37	What is the view about the concern of incidence of adolescent marriage in your community?	It is not a concern at all ..... 1 It is a somewhat a concern ..... 2 It is a concern ..... 3 It is a worrying concern 4	
38	What is the perception about the incidence of abortion by adolescents in your community?	There is no incidence ……..….…..... 1 There is somewhat an incidence ……..…….. 2 There is an increasing rate of incidence …….. 3	
39	What is the view about the concern of abortion by adolescents in your community?	It is not a concern at all ..... 1 It is a somewhat a concern ..... 2 It is a concern ..... 3 It is a worrying concern 4	
40	Do you have any adolescent-and-youth-friendly health services available in your community?	Yes ……..…… 1 No …….…… 2	→ **Q50**
41	Do adolescents freely and conveniently access any of these adolescent-and-youth-friendly health services available in your community?	Yes ……. 1 No …….…… 2	
42	Do adolescents have any challenges accessing any of these adolescent-and-youth-friendly health services available in your community?	Yes ……..……. 1 No ……..…….…… 2	→ **Q44**
43	If **Yes** to **Que 42**, what are the challenges adolescents face in accessing adolescent-and-youth-friendly health	Not always available ……...……... 1 Not affordable …… 2 Not reachable (distance) …….…… 3	

	services available in your community? (TICK AS MANY AS APPLY)	Attitude of service providers …….…… 4 Attitude of other adolescents ……..…… 5 Attitude of gatekeepers …….…… 6 Other (specify) …….…….... 7	
44	Have you ever accessed any of the adolescent-and-youth-friendly health services available in your community?	Yes ……. 1 No …….…… 2	→ **Q46**
45	If **Yes** to **Que 44**, what services did you go to access? (TICK AS MANY AS APPLY)	Contraceptive services …….…… 1 Family planning services ……..…… 2 Abortion services …….…… 3 STI treatment/services …….…… 4 Counselling services …… 5 Other (specify) …….….. 6	
46	Have you ever referred someone to the adolescent-and-youth-friendly health services available in your community?	Yes ……. 1 No …….…… 2	→ **Q50**
47	If **Yes** to **Que 46,** how many persons have you ever referred since you joined SISTAS Club?	[ ][ ]	
48	Do you think the community supports the SISTAS Club Initiative?	Yes ……. 1 No …….…… 2	
49	Do your parents/guardians support the SISTAS Initiative?	Yes ……. 1 No …….…… 2	

Session C: Knowledge and Skills

No	Questions	Coding Category	Skip
50	What are the key lessons that you have acquired since you joined SISTAS Club? (TICK AS MANY AS APPLY) **DO NOT PROMPT**	To avoid unintended pregnancy….…….…… 1 To be empowered to say no to early sex …… 2 To be empowered to say no to unsafe sex …..... 3 To be empowered to know my rights ……..... 4 To be empowered to avoid early marriage ...….. 5 To prevent STI/HIV …… 6 Other (specify)…….…… 7	
51	Did you know any of these lessons before joining the SISTAS?	Yes ……. 1 No …… 2	→ **Q53**
52	If **Yes** to **Que 51**, which are these lessons? (TICK ALL THAT APPLY)	To avoid unintended pregnancy…….…… 1 To be empowered to say no to early sex …… 2 To be empowered to say no to unsafe sex ..…... 3 To be empowered to know my rights ……..... 4 To be empowered to avoid early marriage ..…... 5 Other (specify)…….…… 6	
53	How can adolescents prevent unintended pregnancy? (TICK AS MANY AS APPLY) **DO NOT PROMPT**	Abstinence ……. 1 Use of condoms …….…… 2 Use of other modern contraceptives ……3 Withdrawal …… 4 Calendar method …… 5 Other (specify) ……..…... 6	
54	How can an adolescent prevent contracting STI/HIV?	Abstinence ……. 1 Use of condoms …….…… 2 Use of other contraceptives ……..…… 3	

	(TICK AS MANY AS APPLY) **DO NOT PROMPT**	Withdrawal …… 4 Calendar method ……..… 5 Other (specify) ……... 6	
55	Can people reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners?	Yes …… 1 No …….…… 2	
56	Can a person get HIV from mosquito bites?	Yes …… 1 No …….. 2	
57	Can people reduce their chance of getting HIV by using a condom every time they have sex?	Yes …… 1 No …….. 2	
58	Can people get HIV by sharing food with a person who has AIDS?	Yes …… 1 No …….. 2	
59	Can people get HIV because of witchcraft or other supernatural means?	Yes …… 1 No …….. 2	
60	Is it possible for a healthy-looking person to have HIV?	Yes …… 1 No …….. 2	
61	Being faithful to one uninfected sexual person can reduce the risk of HIV infection.	Yes …… 1 No …….. 2	
62	Which contraceptive prevents both unintended pregnancy and STI/HIV infections?		
63	Do you think you have adequately been empowered to say no to sex?	Yes …… 1 No …….. 2	
64	Do you think you have adequately been empowered to say no to unprotected sex?	Yes …… 1 No …….. 2	
65	Do you think you have adequately been empowered to say no to early marriage?	Yes …… 1 No …….. 2	
66	How can you prevent yourself from early marriage?		
67	If you decide to have sex, can you negotiate for safer sex?	Yes …… 1 No …….. 2	→ **Q69**
68	If **Yes** to **Que 67**, how will you negotiate for safer sex?		
69	Have you developed any interpersonal skills since you joined SISTAS?	Yes …… 1 No ……..… 2	→ **Q71**
70	If **Yes** to **Que 69**, what is/are the skill(s)?	1. 2.	
71	Do you know how to use the condom correctly?	Yes …… 1 No …….. 2	

Section D: Behaviour Change

No	Question	Coding Category	Skip
72	Have your expectation for joining SISTAS Club been met?	Yes …….…… 1 No …….…….. 2	→ **Q74**
73	If **No** to **Que 72**, which expectation was not met?		
74	Have you had any behaviour change	Yes …….…. 1	

	since you joined SISTAS Club?	No ……..……. 2	→ **Q76**
75	If **Yes** to **Que 74,** which behaviours of yours have changed since your joined SISTAS? (TICK AS MANY AS APPLY) **DON'T PROMPT**	I can now talk to my parents/guardians on ….. 1 issues that relate to my reproductive health I now know how to engage in protected sex…. 2 I now avoid visiting certain places at night …. 3 I now avoid bad company of friends ……... 4 Other (specify) ……..…..……. 5	
76	What are the intended benefits you have received from SISTAS?	1. 2.	
77	What are the unintended benefits you have received from SISTAS?	1. 2.	
78	Have you ever shared what you learnt at SISTAS meetings with someone before?	Yes ……..…. 1 No …….……. 2	→ **Q80**
79	If **Yes** to **Que 78**, who do you **most often** share such knowledge with? (TICK ONLY **ONE**)	Peers (girls) …… 1 Peers (boys) ……... 2 Parents/guardians/relatives …… 3 Others (specify) …….. 4	
80	Have you observed any change in behaviour of any of your friends since she joined SISTAS?	Yes …….…… 1 No …….…..…… 2	→ **Q82**
81	If **Yes** to **Que 80, w**hich behaviour of your friend has changed since she joined SISTAS Club? **TICK AS MANY THAT APPLY**	She can now talk to her parents/guardians on issues that relate to her reproductive health ..... 1 She now knows how to engage in protected sex.2 She now avoids visiting certain places at night.. 3 She now avoids certain bad company of friends.4 Other (specify) …….…….……. 5	

Section E: Sustainability of SISTAS Initiative

No	Question	Coding Category	Skip
82	Did you participate in all the activities of SISTAS?	Yes ……..…….…… 1 No ……..……...……. 2	
83	Did you enjoy **every** activity you participated in?	Yes …….…….…… 1 No ……...…….……. 2	→ **Q85**
84	If yes to **Que 83**, which of the activities did you **most** enjoy?		
85	Did you like **all** the mentors who came to talk to you at SISTAS?	Yes …….…….…… 1 No ……...…….……. 2	
86	What did you **most** like about the mentorship meetings?		
87	Did you like the meeting days for the SISTAS?	Yes …….…….…… 1 No ….……..…….……. 2	
88	Did you like the duration you spent at each SISTAS meeting?	Yes …….…….…… 1 No ……...…….……. 2	
89	Did you like the venue for the SISTAS meetings?`	Yes …….…….…… 1 No ……...…….……. 2	
90	Do you think the SISTAS Initiative must be upscaled to include more	Yes …….…….…… 1 No ……..…….……. 2	→ **Q92**

	adolescents?		
91	If **Yes** to **Que 90**, why do you say so?		
92	Do you think SISTAS Initiative should be sustained in all communities?	Yes …….……. 1 No ……..…..……. 2	→ **Q96**
93	If **Yes** to **Que 92**, why do you say so?		
94	How can the SISTAS Initiative be sustained?		
95	How can we increase the number of adolescents in the SISTAS?		
96	If **No** to **Que 90**, why do you say so?		

Closing Courtesies

Are there other issues we have not touched on but you would wish to discuss with me?
I or any member of the UCC Team would call on you for further discussion on the same subject, if the need arises.

Thank you for your time.

IDI Guide for parents

UNIVERSITY OF CAPE COAST
DIRECTORATE OF RESEARCH INNOVATION AND CONSULTANCY
ASSESSMENT OF SISTAS CLUB INITIATIVE IN GHANA

IDI GUIDE FOR PARENTS

Background Issues

1. Please tell me about your background: age, educational background, religion, occupation, number of years stayed in this community.
2. How long have you stayed in this community? How long have you worked in this community?
3. What can you say about teenage pregnancy in your community? Is it a common phenomenon? (probe for views about causes, and category of vulnerable girls).
4. What do you think are the main causes of teenage pregnancy? How can it be addressed?
5. What can you say about child marriage in your community? Is it a common phenomenon? (probe for views about causes, and category of vulnerable girls)
6. What do you think are the factors that lead to child marriage? How can it be addressed?

About SISTAs

7. What do you know about the SISTAS Initiative? What was the purpose of the Initiative? (probe for issues about teenage pregnancy and early marriage of girls).
8. When did your child join SISTAS? How regular is your child to SISTAS meetings and programmes?
9. What has your daughter told you about regarding what she has learnt at SISTAS?
10. Do you think is it/was good that your daughter joined SISTAS? (probe for reasons)
11. What challenge do you have about SISTAS? (probe for topics they teach, duration and participation of the daughter)

Effectiveness and Impact

12. How has the SISTAS Initiative impacted on the behaviour of your daughter? (probe for evidence-based stories)
    a. What has been the impact of the intervention among other adolescents in this community? (probe for specific behavior change among adolescent)
    b. Do you think SISTAS Initiative has contributed to the reduction in teenage pregnancy in this community? Why do you say so (probe for reasons)
    c. Do you think the community in general has accepted the SISTAS Initiative? (probe for reasons)

Sustainability

13. Do you think the Initiative must be sustained in this community? Why should it be sustained? (probe for specific reasons). How should it be sustained? (probe for new approach to implementation)
14. Do you also think that the Initiative could be implemented in other new communities? Why do you say so?

15. What new ideas or innovations could you recommend if the Initiative is to be sustained in this community?

Closing Courtesies

Are there other issues we have not touched on but you would wish to discuss with me?

Thank you very much.

IDI and FGD for SISTAs Club Facilitators and members

UNIVERSITY OF CAPE COAST
DIRECTORATE OF RESEARCH INNOVATION AND CONSULTANCY
ASSESSMENT OF SISTAS CLUB INITIATIVE IN GHANA
IDI & FGD GUIDE FOR SISTAS CLUB FACILITATORS & MEMBERS

Background issues

1. Please tell me about your background: age, marital status, educational background, religion, community of residence, number of years stayed in this community, vocational skills acquired, etc.
2. Who do you stay with in this community? (probe for background of biological parents (and guardian). If not staying with your biological parents, how long have you stayed with your guardian?
3. What do you know about the SISTAS Initiative?
    a. What was the purpose of the Initiative? (probe for issues about teenage pregnancy and early marriage of girls)
    b. Why did you join the SISTAS Club? (probe for both personal, parental and institutional interests)
    c. How did you join the SISTAS Club? (probe for selection procedures)
    d. When did you join SISTAS Club? (probe for specific date)
    e. What were your expectations before joining SISTAS Club?
    f. What specific role do/did you play in SISTAS Club? (probe for executive role, trained person, etc)
4. What can you say about teenage pregnancy in your community?
    a. Is it a common phenomenon? (probe for views about causes, and category of vulnerable girls)
    b. What do you think are the major causes of teenage pregnancy?
    c. How can it be addressed? (probe for empowerment of girls, relevance of SISTAS Initiative)
5. What can you say about child marriage in your community?
    a. Is it a common phenomenon? (probe for views about causes, and category of vulnerable girls)
    b. What do you think are the factors that lead to child marriage?
    c. How can it be addressed? (probe for empowerment of girls, relevance of SISTAS Initiative)
6. What can you say about rape in your community?
    a. Is it common for an adolescent girl to be raped? (probe for views about causes, and category of vulnerable girls)
    b. What factors promote/inhibit the incidence of rape in this community? (probe for how to address its incidence)

c. How can it be addressed? (probe for empowerment of girls, relevance of SISTAS Initiative)

Access to Sexual and Reproductive Health Services

7. Do you have adolescent-and-youth-friendly health services available in this community or nearby?
8. What are the sexual and reproductive health services available to adolescents in your community? (probe for contraception, abortion, family planning, counseling services)
    a. Do adolescents in this community have access to these services? (probe for reasons)
        i. Which of these services are always accessible to adolescents (probe for availability, affordability and reachability)
        ii. What are the main challenges adolescents face in accessing any of these services (probe for specific challenges associated with access to specific services)
    b. Have you ever accessed any of these services before? (let her tell a rich story)
    c. Have you ever referred adolescents to access any of such services? (probe for stories)
    d. Do you think adolescents find it convenient to access any of these services? (probe for influence of gatekeepers)
    e. How can adolescents access sexual and reproductive health services conveniently?

Formation and Membership Issues

9. How was the SISTAS Club formed? How did you join the Club? (probe for personal interest, referral from peers, influence of parents, persuasions of program managers, other stakeholders, etc)
    a. How many girls are in the SISTAS Club? Do they all come from the community?
    b. What did you do to become a member of the SISTAS Club? (probe for filling of registration form, payment of membership dues, etc)
10. What benefits have you received from the SISTAS Club? (probe for training, learning materials, T-shirts, etc?
    a. Why were you trained? And how were you trained too?
    b. Were you given training materials? (probe for use of material for personal and peer advocacy/education)
    c. Do you still have all these materials? (probe for those missing, spoilt, etc)
    d. Have you informed your Club manager about the need for additional materials? (probe for reasons to the response given)
    e. What were your main expectations for becoming a member of the SISTAS Club? (refer to previous: Q3e)
    f. Have your expectations been met after joining the club? (request for a story)

11. How many times did you meet as club members in every month?
    a. How many outreaches did you participate in? Which of these was you best of outreach (probe for specific stories)
    b. How many mentors have you interacted with (who came to give talks to the club members?
       Which of these mentors do you admire so much? (probe for specific reasons and possible stories)
    c. Did any of the interactions with the mentors change your perceptions as a young girl? Who is this mentor and what did s/he say or do which have change you way of thinking or behavior? (probe for stories)

Benefits and Effects of SISTAS Club

12. What have you learnt since you joined the SISTAS Club? (probe for issues about how to prevent teenage pregnancy and early child marriage)
    a. Did you know these things before joining the SISTAS Club? If yes, what new things have you learnt which you didn't know before joining the SISTAS Club?
    b. What skills have you acquired or developed since you joined the SISTAS Club?
    c. Probe for knowledge on the following:
        i. ability to make informed decision; assertive skills;
        ii. how to: abstain from sex; have protective sex; prevent early child marriage; do peer advocacy; communicate with parents, etc)
13. How has the SISTAS Club changed you? (probe for stories)
    a. What aspects of your life have changed since you joined SISTAS Club? (probe for specific lifestyles and change; get change stories)
    b. How did you change from the lifestyles? (probe for specific practical steps, knowledge gained, support received, etc?
    c. Apart from the SISTAS Club, where have you ever visited for additional information or service? (probe for specific facilities, individuals, group, etc and reasons)
    d. Have you encouraged some of your peers to join the SISTAS Club? If yes, what was the outcome?
    e. Have you ever referred adolescents to access any of such services since you joined SISTAS Club? (probe for stories)
14. Do you think joining the SISTAS Club has empowered you to access sexual and reproductive health services? (Tell stories of change)
    a. Which sexual and reproductive health services have you ever accessed since you joined SISTAS Club (probe for contraception, abortion, family planning, HIV testing, etc)
    b. Did you face any challenges accessing the service(s) (probe for specific challenges and sources)

c. How can these challenges be addressed? (probe for who and how to address it; e.g. SISTAS Initiative)

Challenges and how they were Addressed

15. Mention some of the challenges the SISTAS Club faces? What do you think are the sources of these challenges mentioned?
    a. How can each of these challenges be addressed? (probe for specific actions and individuals to take or lead such actions?
    b. What challenges do/did you personally face since you decided to or joined SISTAS Club?
        i. What are/were the sources of these challenges? (probe for parental/family opposition, peer pressure, religious opposition, etc)
        ii. How have you addressed each of these challenges? (probe for specific practical steps and actions and stories)
        iii. How have others helped you to address any of these challenges? (probe for stories of action)
16. Has any member of the SISTAS Club got pregnant? If yes, what do you think was the reason she got pregnant? (probe for knowledge on protected sex, etc). Has she received any support from the Club or members of the Club? (probe for specific supports offered and from who)
    a. Has any member of the SISTAS Club been married after joining the Club? If yes, what do you think was the reason she got married? (probe for knowledge on early child marriage and rights of children) Has she received any support from the Club or any member from the Club? (probe for specific support offered and from who?)

Sustainability

17. Do you think that the SISTAS Club should be sustained? Why do you say so?
    a. How do you want the SISTAS Club to be sustained? What role can you play to sustain the SISTAS Club? (probe for specific roles)
    b. What roles do you think others can also play to sustain the SISTAS Club? (probe for specific actors and actions to take)
18. Do you think that the SISTAS Club should be formed in other communities?
    a. Which communities do you suggest and why?
    b. What role can you play to form the Club in other communities? (probe for specific roles)
    c. What roles do you think others can also play to sustain the SISTAS Club? (probe for specific actors and actions to take)

Closing Courtesies
Are there other issues we have not touched on but you would wish to discuss with me?
I may call on you for further discussion on the same subject, if the need arises.

Thank you for your time.

Appendix 2: Details of Research Assistants and Team Leaders

S/N	Name	Role	Region	Communities	Cell phone
1	Dr. Kobina Esia-Donkoh	Team Leader	Ashanti, Central & Volta	Emisaekyir, Asawasi, Apromase, Adidome, Mepe, Sogakope	0501402479
2	Isabella Anane-Fosuhene	Supervisor	Ashanti & Volta	Emisaekyir, Asawasi, Apromase, Adidome, Mepe, Sogakope	0242036037
3	Prince Justin Anku	Research Assistant	Central & Volta	Emisaekyir, Adidome, Mepe, Sogakope	0248419846
4	Jennifer Ewool	Research Assistant	Ashanti & Volta	Emisaekyir, Asawasi, Apromase, Adidome, Mepe, Sogakope	0543433922
5	Joshua Okyere	Research Assistant	Ashanti & Volta	Emisaekyir, Asawasi, Apromase, Adidome, Mepe, Sogakope	0249004634
6	Dr. Samuel AsieduOwusu	Team Leader	Northern, Upper East and Upper West	Sagnarigu, Gurugu, Ganbibigo, Yarigabisi, Suriyri, Kabanye	0244207814
7	Abdul-Aziz Seidu	Supervisor	Northern & Upper East	Sagnarigu, Gurugu, Ganbibigo, Yarigabisi	0244291198
8	Georgina AkolpokaAtambila	Research Assistant	Northern & Upper East	Sagnarigu, Gurugu, Ganbibigo, Yarigabisi	0240220986
9	Abigail Amoah	Research Assistant	Northern & Upper East	Sagnarigu, Gurugu, Ganbibigo, Yarigabisi	0241467393
10	CheiBukari	Research Assistant	Northern & Upper East	Sangnerigu, Gurugu, Ganbibigo, Yarigabisi	0542367212
11	Castro Ayebeng	Research Assistant	Northern & Upper East	Sagnarigu, Gurugu, Ganbibigo, Yarigabisi	0544395764
12	Bernard OwusuAfriyie	Supervisor	Upper West	Suriyri, Kabanye	0548227408
13	Alfred Blay	Research Assistant	Upper West	Suriyri, Kabanye	0247402653
14	Louis Kobina Dadzie	Research Assistant	Upper West	Suriyri, Kabanye	0247281309

Appendix 3: Training and Pre-testing Program Outline

DAY 1 (MONDAY, 10TH DECEMBER, 2018)

TIME	ACTIVITIES	RESPONSIBILITY
8:30am	Arrival of Participants/Introductions	
9:00am	Welcome Address and Introduction	Prof. Samuel Kobina Annim
9:30am	Overview of Project	Prof. Samuel K. Annim/ Dr. Samuel A. Owusu
Exposure and Translation to Survey Instrument		
10:00am	Questionnaire	Dr. Kobina Esiah-Donkoh
10:30am	SNACK BREAK	
10:45am	Questionnaire (continued)	Dr. Kobina Esiah-Donkoh
12:30pm	LUNCH BREAK	
1:30pm	In-Depth Interview Guides, Focus Group Discussion Guide and Simulation Checklist	Dr. Samuel A. Owusu
6:00pm	CLOSING	

DAY 2 (TUESDAY, 11TH DECEMBER, 2018)

TIME	ACTIVITIES	RESPONSIBILITY
8:30am	Arrival of Participants	
9:00am	Translation & Role-play Exercise	Resource Persons
1030am	Assessment Methodology	Resource Persons
11:30am	SNACK BREAK	
2:00pm	Pre-testing at Apewosika Community	Assessment Team
6:00pm	Debriefing	Prof. Samuel Kobina Annim
7:00pm	Preparation for Fieldwork	Dr. Kobina Esiah-Donkoh/Dr. Samuel A. Owusu
CLOSING		

Appendix 4: Data Collected from Each Project Site

Data Collected	Region													TOTAL
	Central		Ashanti		Volta			Northern		Upper East		Upper West		
	Apewosika (Pretest) *	*Emisaekyir*	*Apromase*	*Asawasi*	*Adidome*	*Mepe*	*Sogakope*	*Gurugu*	Sagnarigu	*Gambibigo*	*Yargabisi*	*Suuriyiri*	*Kabanye*	
IDI Facilitator	0	2	1	1	0	2	1	1	1	1	0	1	1	12
IDI Program Officer	0	1	1	na	na	na	1	1	na	1	na	0	-	5
IDI Parent	0	1	1	2	1	2	2	2	2	2	2	2	0	19
IDI Stakeholder	0	2	3	na	1	na	1	2	0	2	na	na	3	14
FGD Members	1	1	1	1	1	1	1	1	0	1	1	1	1	11
FGD Non-member Boys	1	1	0	1	1	1	1	1	1	1	1	1	1	11
FGD Non-member Girls	1	1	1	1	1	1	1	1	1	1	1	1	1	12
Survey	16	27	12	21	23	25	28	20	8	20	24	13	21	242
Simulation	-	1	1	-	-	1	-	1	-	1	-	-	1	6

**not included in Total*