

**DISSERTATION**

***AN ASSESSMENT OF THE VIRGINS PROJECT IN  
EJISU SUB DISTRICT***

***BY ABRAHAM NYAKO JNR.***

***THIS DISSERTATION IS SUBMITTED TO THE SCHOOL OF  
PUBLIC HEALTH, UNIVERSITY OF GHANA, LEGON  
IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE  
AWARD OF MASTER OF PUBLIC HEALTH DEGREE***

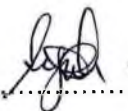
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**DECLARATION**

I declare that the study has been the result of my own research conducted under supervision and has not been presented for a degree in any other University or Institution.

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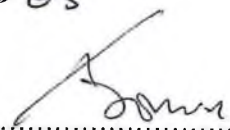
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## **DEDICATION**

This study is dedicated to my wife, Augusta Nyako and my son, Joel Mate Nyako.

## **ACKNOWLEDGEMENT**

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## **LIST OF ACRONYMS**

AIDS	-Acquired Immune Deficiency Syndrome
CDC	- Centre for Disease control
DHA	-District Health Administration
GDHS	- Ghana Demography Health survey
GHS	- Ghana Health Service
HIV	- Human Immunodeficiency Virus
ICASA	International Conference on AIDS and STIs in Africa
ICPD	International Conference on Population and Development
MOH	- Ministry Of Health
PID	Pelvic Inflammatory Disease
SRH	- Sexual and Reproductive Health
STIs	- Sexually Transmitted Infections
UNFPA	- United Nations Population Fund
UNICEF	- United Nations Children’s Fund
UNAIDS	– Joint United Nations Program on HIV/AIDS
WHO	- World Health Organization

## MAP OF GHANA SHOWING STUDY AREA



## **ABSTRACT**

The rising incidence of early sexual activity among young people has become an issue of great public health concern and is receiving attention worldwide. Many of the youth are at risk of unplanned pregnancy or sexually transmitted infection (STI) including HIV/AIDS and some may already be struggling with the consequences of these risks. Studies conducted in Ejisu-Juabeng district have revealed the existence of high level of sexual activity among the youth. To minimize risks associated with this behaviour and to secure a healthy future for the youth, the Ejisu-Juabeng Virgin Club project was established in 2001.

This study, which used both quantitative and qualitative methods of data collection, was undertaken to assess the extent to which the project has achieved its objectives since its inception three years ago. A number of indicators were measured to meet study objectives.

The key findings of the study include:

1. The project has adopted a holistic approach to addressing antecedent/determinants of behavior of the girls.
2. Girls between 10-19 years are mostly attracted to the club
3. Out of 151 of girls surveyed only 23% of girls have been with the club since its inception in 2001.
4. A number of factors appear to be hindering the potential of the project to achieve desired results, among which are:

- Negative perception of the project by some community members.
  - Lack of well-prepared, coherent training/teaching curriculum.
  - Inadequate Funding.
  - Lack of effective follow up of drop outs.
  - Low involvement of young girls on project management.
  - Over concentration of project activities at Ejisu.
5. Other factors which have kept the club operational include:
- Community Support by Queen Mothers, Village Health Committee members and other opinion leaders.
  - Commitment of Project Staff
  - Club Exit Package
6. The overall SRH knowledge, Attitudes, Perceptions and Skills of respondents is encouraging. However there a few misconceptions and myths that need to be addressed.

Based on the findings, the following is recommended:

- 1) Decentralization of activities to all 30 communities
- 2) Resource mobilization to support project activities needs to be intensified, especially marketing the project and proposal development.
- 3) Continuing education for project staff to update knowledge on SRH issues, with emphasis on STI/HIV/AIDS.
- 4) Promote increased participation of the virgins and parents in the planning and management of project activities.

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 THE WORLD SITUATION OF STI'S/HIV/AIDS, PREGNANCY AND THE YOUTH.**

One fifth of the world's population is made up of young people between the ages of 10 and 19 years. The rising incidence of early sex among this population has become an issue of great public health concern and is receiving attention worldwide. Studies show that 55% of the youth are sexually active and a greater percentage do not practice safe sex (UNAIDS, 2000).

Young people today marry at older ages than their parents and more start having sexual intercourse before marriage. Early initiation of sex is associated with risk factors such as STI'S/HIV/AIDS, teen pregnancy and its related complications. The Joint United Nations Program on AIDS (UNAIDS) and World Health Organization (WHO) AIDS Epidemic Update (2001) categorically states, "Youth worldwide are at acute risk of sexually transmitted infections including the HIV infection and unintended pregnancies.

In developing countries 20% 60% of pregnancies and births by young women are unintended, most coming sooner than planned. Fourteen (14) million children are estimated to be born to teen mothers – a representation of 10% of all births (Population Reports, 1995). The physical immaturity of many young girls increases their risk of

death or severe disabilities. Pregnancy related complications are among the major causes of death for girls 15 – 19 years worldwide (State of the World Population, 1998).

## **1.2 THE GHANAIAN SITUATION: THE YOUTH, PREGNANCY AND STI'S/HIV/AIDS.**

Adolescent Sexual and Reproductive Health is increasingly receiving attention in Ghana and this seems to be in the right direction. Nearly one half (45%) of the population is under age 15 years and young people between the ages of 15 – 24 constitute 20% of the total population. Anecdotal evidence suggests that pre – marital sex is widespread among young people in Ghana. (The Futures Group International, 2000).

In a study conducted by Nabilla and Fayorsey (1996) of adolescents in Accra and Kumasi, age at first sex was found to be as early as 10 years. The 1998 Ghana Demography and Health Survey (GDHS) puts the median age at first sex at 17.5 years for young people within ages 15 – 24 years. Thirty- eight percent (38%) of young females aged 15 – 19 years, and 19.3% of boys aged 15 – 19 years are sexually active and by age 20 years, over eighty percent (80%) of adolescents have experienced their first sex (GDHS, 1998). The consequence of early sexual initiation among the Ghanaian youth is indeed a problem since most sexual intercourse among teenagers is unprotected against accidental pregnancy and sexually transmitted infections.

According to the 1998 GDHS, approximately one third (32%) of females under age 20 years have started child bearing leading to higher risk of pregnancy induced hypertension, premature delivery, low birth weight and retarded foetal growth resulting in

a higher infant mortality rate. Moreover, HIV/AIDS among the youth is almost entirely a sexually transmitted infection. The 2002 cumulative reported AIDS cases for the 15 – 24 year group is 7,360 representing about 11.4% of the total cumulative cases for the country. The current HIV prevalence for the youth stands at 3.4 percent.

### **1.3 STI'S / HIV/AIDS AND PREGNANCY AMONG THE YOUTH IN THE STUDY AREA**

Ejisu–Juabeng is one of the eighteen administrative districts in the Ashanti region, with a population of 124113 (Projected Population, 2001). The district is divided into five (5) sub districts including Ejisu. The Ejisu sub district has a population of 43440 (Projected Population, 2001).

The findings of a study by Aboagye (2002) indicated the existence of a high level of sexual activity among the youth. The study revealed that the most sexually active age group is 15 – 19 years and that majority of the young people have had their first sexual encounter within the age range of 10 – 14 years. The risks associated with early sexual experience among the youth are obvious and should demand attention. The Ejisu Government Hospital in 2000 recorded a total number of 168 new HIV cases. (The National AIDS Control Program, 2000). In 2002, 21 percent of all reported pregnancy cases at the Ejisu Government Hospital were teenagers. The recorded high levels of abortion coupled with increasing incidence of teenage pregnancy presuppose that there could be a real threat of HIV/AIDS in the youth of the area (Aboagye 2002: 3).

## **1.4 RESPONSE STRATEGIES**

Adolescent pregnancy, abortion, early childbearing and STI/HIV/AIDS are indeed major issues of public health concern. This increasing public concern about the adverse consequences of adolescent sexuality has led to the organization and implementation of several programs, which attempt to address the needs of young people. Such programs are based on the premise that young people need accurate information about sexuality and sexual and reproductive health services to enable them make informed choices. These programs, which aim at ensuring that young people grow into responsible adults, vary widely in strategies and target two major categories of youth - the in school and out of school youth.

To date, such programs have used three key strategies – the direct strategy, the indirect strategy and in some cases, a combination of the direct and indirect strategies. The direct strategy involves outreach activities undertaken by trained peer educators. The indirect strategy utilizes facility-based services such as youth centres and clinics where trained personnel and peer educators provide information and services relevant to the sexual and reproductive health needs of young people. Such strategies have been used worldwide and have chalked much success in either delaying first sexual contact or preventing unwanted pregnancy and STI/HIV/AIDS through the provision of information, skill training, contraceptive and counselling services.

## 1.5. THE VIRGINS PROJECT

In response to the rising incidence of teen pregnancy, abortion and STI/HIV/AIDS among the youth of the Ejisu–Juabeng district, the Senior Medical Assistant of the Ejisu Government hospital together with Queen mothers and some Health personnel established the Virgins Club Project in 2001.

The Virgins club intervention is the first ever-formal community non-school based abstinence project in Ghana. The project was established with the main objective of promoting virginity among young girls as a means to control the incidence of teenage pregnancy, abortion and STI/HIV/AIDS. A virgin under the project is a person (female) who has not had sexual intercourse. Reference is made to categories of virgins – primary and secondary virgins. Primary virgins are people who have never had sexual intercourse and the term secondary virgin refers to the person who has ever had sex but has taken a decision not to indulge in sexual activity until marriage

The specific objectives of the Project include the following:

1. To educate and encourage young girls (up to 25 years) to abstain from sex until marriage.
2. To empower young girls with employable skills.
3. To provide the youth with accurate information on sexual and reproductive health

The virgins program covers 30 communities in the Ejisu sub district and undertakes activities such as the following:

1. Promotion of puberty rites
2. Employable skills training

3. Health Education and

4. Peer Education

Currently, the project provides support to one hundred and fifty one (151) virgins in the Ejisu sub district, and plans are underway to replicate the program in other sub districts.

## **1.6 JUSTIFICATION FOR THE STUDY**

Youth development programs are designed to help young people reduce their sexual and reproductive health risks. To be able to build very strong programs to meet the desired outcomes, it is important to have access to program data on what is working and what is not working. (Focus on Young Adults, June 2000). This information can only be generated through an effective evaluation system. Process and output/ impact evaluation are important for generating this type of information.

A large-scale process evaluation collects information that measures how well program activities are performed. It measures program quality and the extent to which programs or services are being used by the beneficiary populations. Process evaluation can also be used to assess program coverage. The outcome and/or impact evaluation deals with the extent to which program outcomes are achieved, and assesses the impact of a program on the target population. Process evaluation can be carried out periodically while an impact evaluation is carried out at the end of the project or after the program has worked for a considerable period of time (Focus on Young Adults, June 2000).

The Ejisu virgins program has never undergone any formal evaluation since its establishment in 2001. At the moment the program implementers and the Ejisu District Health Management Team do not have evidence-based information on whether or not the program is on track. It is important at this stage of implementation, ( i.e. 3 years after its establishment), for the program to undergo an evaluation that will seek to determine if the project is on course in terms of achieving its set objectives. The results of such an evaluation should be critical in the following ways:

- Provide the opportunity for Stakeholders and communities to understand what the program is doing, how well it is meeting its objectives and whether there are critical needs inhibiting progress.
- Provide the opportunity to educate potential funding agencies, local government officials and key community members who can help ensure social, financial and political support for the project.
- Help raise awareness of the program among the general public and help build positive perceptions about delaying sexual debut.
- Create public recognition and provide appreciation for stakeholders and volunteers who are working to make the program a success.

In the final analysis, the results of the study will contribute to the national understanding of what it takes to improve young peoples' sexual and reproductive health in relation to helping them to delay sexual debut. In a broad perspective, the study will help build a body of lessons learnt and best practices that can strengthen sexual and reproductive health (abstinence only) programs in Ghana.

## **1.7 STUDY OBJECTIVES**

### **1.7.1 GENERAL OBJECTIVE**

The general objective of the study is to assess the extent to which the Virgins Project in the Ejisu sub- district in the Ashanti Region of Ghana has met set objectives for which it had been established.

### **1.7.2 Specific Objectives**

The specific objectives are:

1. To determine the number of girls the project has been able to educate and encourage to abstain from sex between June 2001 and June 2004.
2. To determine the number of girls empowered with employable skills.
3. To determine the number of club members who have dropped out of all club activities between June 2001 and June 2004
4. To find out reasons for dropping out of the program
5. To determine the number/percentage of club members who are primary virgins
6. To determine number and percentage of club members who are secondary virgins.
7. To determine the number of health education activities undertaken for the benefit of the young people.
8. To determine the extent to which program activities have influenced HIV/AIDS related knowledge, attitudes and behaviours of the club members
9. To determine the factors, which have inhibited project implementation.
10. To determine factors, which have facilitated project implementation.
11. To make recommendations towards strengthening the project

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 DEFINITION OF TERMS / CONCEPTS

##### 2.1.1 Adolescence

Adolescence refers to the period of transition from childhood to adulthood. It's a time of rapid changes in the body, emotions, attitudes and values, intellect, relationships with parents and peers, and responsibility.

##### 2.1.2 Adolescents

In line with World Health Organization (WHO), the Ministry Of Health (MOH)/Ghana Health Service (GHS) defines adolescents as people between the ages of 10 to 19 years.

Other categories include:

- Pre- adolescents                      5 – 9 years
- Younger adolescents                10 – 14 years
- Older adolescents                    15 – 19 years
- Youth                                      15 – 24 years
- Young adults                            20 – 24 years

##### 2.1.3 Health

Health is a complete state of physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity (WHO).

#### **2.1.4 Reproductive Health**

Reproductive health is a state of complete physical, mental and social well – being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes. (ICPD, 1994 ).

#### **2.1.5 Sexual Health**

This concept is defined as the integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love. Every person has a right to receive sexual information and to consider sexual relationship for pleasure as well as for procreation (WHO Definition).

#### **2.1.6 Adolescent Sexual and Reproductive Health**

This refers to the physical and emotional well–being of adolescents including their ability to remain free from unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV/AIDS, and from all forms of sexual violence and coercion.

#### **2.1.7 Sexual Abstinence/Virginity**

The term “**abstinence**” denotes refraining from sexual intercourse. Most faith-based groups generally view abstinence as a commitment to refrain from sex until marriage. Others view abstinence as delaying sex until some future time, for example when entering into a committed relationship before marriage. A virgin is a person who has not had sexual intercourse. The term **abstinence** can also be used to refer to those who have

been sexually active at one time but now have decided to abstain. Such situations are referred to as “**secondary abstinence**” or “**secondary virginity**”. Complete sexual abstinence is the most effective means of protection against both pregnancy and STI/HIV/AIDS. (Abstinence and delayed sexual initiation, Youth Lens, September 2003).

## **2.2 WORLD POPULATION OF ADOLESCENTS**

According to Population Reports (October 1995), young people aged 10 to 19 years number more than one billion and comprise nearly one – fifth of the world population. By the year 2010, the number of young adults is expected to grow to more than 1.2 billion. Half of the world’s population is under age twenty-five (25) years. For developing countries the median age is 23 years whereas for developed countries it is thirty-five years (World Population Profile, 1994).

In Latin American for example, the median age is 20 years in Bolivia, 18.7 years in El Salvador and 18.1 years in Guatemala. In Africa median ages are even lower, 17.5 years and fifteen point one (15.1) years in Nigeria and Zambia respectively (Gibson, 1995).

## **2.3. SEXUAL ACTIVITY: A MAJOR SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE IN YOUNG PEOPLE**

The transition from child to adult comes with several challenges affecting the reproductive health of young people. Key of the challenges is early sexual activity. All over the world, studies have documented that most young people are sexually active and prone to sexual activity related hazards. Whereas among previous generations, sex was largely confined to marriage, today young people marry at a later age and thus are faced

with increasing temptation to engage in sexual practices before marriage. The risks related to sexual activity and childbearing are among the most serious health risks that young people face. These risks can jeopardize not only physical health of adolescents but also their long-term emotional, economic and social well-being (Population Report, 1995).

An analysis of WHO generated survey data among 15–19 years olds revealed that more than 25% of boys reported having sex before they were 15 years old in Brazil, Gabon, Haiti, Hungary, Kenya, Latvia, Malawi, Mozambique, and Nicaragua. The figure for girls was over fifteen percent (WHO, 2000). Sexual activity among unmarried youth is increasing in many regions. In Africa and Latin America, studies have reported increasing percentages of unmarried young adults who are sexually active. Casual sexual activity is also common among the youth and some of the attendant sexual and reproductive health risks include the following:

- Sexually Transmitted Infections including HIV/AIDS
  
- Early pregnancy and childbearing, with high risks of injury, illness and death for both mother and baby
  
- Unintended pregnancy, often leading to unsafe abortion and its complications. Furthermore young people who become parents too soon, especially girls, face the social and economic consequences of loss of education and lowered earnings.

### **2.3.1 Risks Associated with STI/HIV/AIDS**

Millions of young adults around the world become infected with STIs every year (Centre for Populations options and Population Ref Bureau, 1994). As a result the incidence of pelvic inflammatory disease, (PID), ectopic pregnancies and infertility have also increased. Among the major STIs are gonorrhoea, chlamydia, syphilis, herpes, genital warts and HIV. Sexual intercourse at a very young age has also been associated with an increased risk of cervical cancer (Population Reports 1993).

Untreated STI's can cause infertility in men and women as well as have other devastating consequences for young women and their children. In women, STI's especially gonorrhoea and Chlamydial infection can cause pelvic inflammatory disease (PID), leading to irreversible damage to the fallopian tubes and thus infertility. Even a simple episode of PID increases the risk of ectopic pregnancy, a condition that can kill from sudden and severe internal bleeding when the out-of-place pregnancy ruptures the fallopian tube. PID can also lead to chronic pelvic pain, pain during coitus, menstrual irregularities and repeat episodes of PID (Brabin et al 1993).

In pregnant women, STIs can affect the infant's health as well as that of the mother. STI's contribute to premature births and low birth rate (Cates, 1992). Syphilis and genital herpes infection can cause spontaneous abortion, stillbirth or perinatal birth (WHO Bulletin, 1990). Gonorrhoea and Chlamydial infection may spread to a baby's eyes during birth, damaging vision if not treated (Holmes et al., 1990).

HIV/AIDS poses special problem for young people. It is not only incurable but also fatal. Learning that one is HIV positive can have devastating personal consequences such as social ostracism. Anticipating an early death also leads to psychosocial problems. Over the past years, out of the sixty (60) million people who have been infected with HIV about half became infected between the ages of 15 – 24 years. Currently twelve (12) million young people are living with HIV/AIDS. Young women are several times more likely than young men to be infected with HIV. In nearly twenty (20) African countries, fifty-two (52) or more of women aged 15 – 24 years are infected. Young people often carry HIV for years without knowing they are infected. As a result the epidemic spreads beyond high – risk group to the broader population of young people, making it even harder to control (Population Reports, 2001).

As the AIDS epidemic spreads, younger and younger age groups are becoming exposed to the risk of infection. Young women are infected on average ten years earlier than men and consequently many are more likely to die with AIDS at younger ages than men.

### **2.3.2 Risks Associated With Early Pregnancy**

Teen pregnancy is one of the major health problems of adolescents worldwide. In developing countries, teen pregnancies frequently result from early marriages sometimes just after menarche, although there is a rising trend in the mean age of marriage. However in most countries, an increasing proportion of young people are becoming pregnant prior to marriage. Regardless of marital status, there are biomedical risks to the young adolescent and the baby, especially in the absence of adequate care. Girls who

have not reached full physical and physiological maturity are as much as three times more likely to die from eclampsia, obstructed labour, haemorrhage, or infection as women in prime, childbearing years. Those who survive early child birth run a higher risk of vesico–vaginal fistula or recto–vaginal fistula, which, if not repaired, may leave them physically and emotionally disabled for the rest of their lives. Complications of childbirth and unsafe abortion are among the main causes of death of women under twenty (20) years. Even under optimal conditions, young mothers especially those under age 17 years are more likely than women in their twenties (20's) to suffer pregnancy – related complications and to die in childbirth (Helen et al, 1995).

### **2.3.3 Risk of Unwanted Pregnancy and Abortion**

When faced with an unwanted pregnancy, many adolescents resort to unsafe abortion. Estimates of abortions among women under age twenty (20) years in developing countries range from 1 million to 4.4 million a year. Most of these abortions are unsafe, and for some unsafe abortion results in life – long disability, infertility or death. Where abortion is unsafe it may be one of the greatest health risks a sexually young woman can face (Population Reports, October 1995).

In Latin American Studies, fourteen percent (14%) to almost forty percent (40%) of women hospitalized for abortion complications during the 1980's were under age twenty (20) years. In the African context the percentages were even higher with women under age twenty (20) years accounting for as much as sixty-eight percent (68%) of abortion complications treated at selected hospitals (Populations Reports, 1995). Risks from such

operations include uterine infection, haemorrhage, uterine perforation and cervical and vaginal tears. In addition, young women are more particularly susceptible to complications from abortion because they often wait well into the second trimester of pregnancy before seeking an abortion. All of these complications can affect the future fertility of young women and carry the possibility of a fatal outcome. Young women often seek services from untrained abortion providers and attempt dangerous, late and often self-induced abortions. Also, many women delay seeking medical care if complications arise after abortion because of fear, shame, and lack of access or lack of money (Zamudio et al., 1995).

#### **2.4 DEALING WITH SEXUAL AND REPRODUCTIVE HEALTH CHALLENGES OF YOUNG PEOPLE**

The challenges of STI including HIV/AIDS, unintended pregnancy and abortion incidence do not only constitute significant health concern for adolescents but also constitute a major threat to fertility management in any country. This is so because the attitudes of young adults to reproduction, family size and development have profound implications for the size and characteristics of the future population of the country.

Adolescents need accurate and reliable information about their sexuality, the physical changes taking place within them and the changing human relationships, which take place during this developmental stage. To meet the challenges, specific programs are developed for young people. The programs seek to provide accurate information on sexuality and requisite skills to help the young person deal with the confronting issues. Studies world wide have documented that adolescents behave responsibly when they are

well informed. Thus interventions are designed which provide reliable information to guide young people to make the right choices in life.

#### **2.4.1 Response Interventions**

Programs addressing adolescent sexual and reproductive health needs vary widely and are labelled variously as health education, family life education, family life skills, and sexuality education. Some of the programs provide only biological information, while others put sexuality in a larger developmental context, which includes such issues as self-esteem, setting goals, and having respect for others. Irrespective of the type of intervention, it has been found that changing knowledge and attitudes associated with sexual behaviour is far easier than changing behaviours. Behaviour change as is known, is not a one-day process but a process that goes on for a considerable length of time before the desired outcome is achieved.

Intervention programs are either school based or out of school. The in – school programs target adolescents who are attending schools and interventions takes place within the environment of the school. The school as a socializing agent provides an avenue for learning new skills and for the acquisition of values, including those on sexual and reproductive health. Students at all levels of the school system constitute a captive audience who can be easily reached with information and services. (Ghana Adolescent Reproductive Health. Policy, 2000).

Out-of-school programs target adolescents who have never attended schools, those who dropped out of school for various reasons, young people involved in some form of

apprenticeship and the unemployed or 'home bound' (Ghana Adolescent Reproductive Health. Policy, 2000). This is a mixed group and they may be organized or not and the intervention takes place within their various environments. Out of school programs utilize innovative models in reaching out to young people and these models include:

Youth Centre: A facility based intervention program that aims at the following:

- Helps to prevent early pregnancy along with other risky behaviours while helping to enhance life skills.
- Assists pregnant and parenting teens to pursue educational and vocational objectives.

Peer promotion programs: These are programs that deliver activities through peers similar in age and background to the target audience. Peer education efforts have been successful in identifying and contacting difficult to reach populations such as out of school youth, street children and commercial sex workers (Pathfinder International, 1997)

Other outreach programs: Projects reaching youth in the community, in which adult professionals deliver the required services.

A lot of attention has been given to youth intervention programs within the past decade. However accompanying this attention has been considerable debate on what intervention is the most effective and appropriate.

#### **2.4.2 Preference For Abstinence Only Programs**

Impressions exist worldwide that all young people are sexually active (Community Life Project, 2002), and that condoms should be widely promoted among adolescents. As a result most interventions have emphasized safer sex strategies. However this assertion

raises questions. If a percentage of young people within a given geographical area is found to be sexually active, it does not mean that the entire young population is sexually active. Obviously the remaining proportion of the population is not sexually active and therefore may demand a different intervention strategy. At the International Conference on AIDS and STIs in Africa (ICASA) in Zambia (1999), the following remarks were made at the youth forum:

*'You tell us that because 20% of the youth are having sex, you provide us with safe sex education and a supply of condoms. Why not uphold the 80% who are not having sex and encourage the others to come back on board'* (The Irish Times, January 2004).

In Ghana, a joint study conducted by the Ghana Social Marketing Foundation (GSMF), Planned Parenthood Association of Ghana (PPAG), and Johns Hopkins University (JHU), show that 97 percent of those aged 12 – 14 years, 91 percent of those aged 15 – 19 years and 22 percent of those aged 20 – 24 years were not sexually active (GSMF et al, 2002). The Population Report, (October 1995) states that as attention focuses on sexual activity among young adults, it often goes unnoticed that in developing countries, the majority of young adults, especially young women, are not sexually active and that most sexual activity of young people takes place within marriage.

This interesting insight validates the promotion of virginity among the non – sexually active youth as a means of delaying sexual debut. This is more important as evidence suggests that young people who have never had sex are more likely to continue abstaining when provided with the necessary support structures than those who have ever

had sex. In Namibia, female virgins, participated in an abstinence only program – “My future is my choice”. There was a control group who did not participate in the program. The exposure group was found to have remained virgins twelve months after the program compared to virgins from the control group (Stanton et al., 1998). An American study found that students who had not had sex before enrolled in a sex education program were significantly less likely to have begun sexual activity 18 months later compared to a control group (Kirby et al 1991).

In both the Namibian and American studies the rate of contraceptive use among those already sexually active before the program began did not increase during the intervention, which underscores the need to start abstinence programs at a time when people have not yet had sexual intercourse. It goes without argument that a significant proportion of youth worldwide are abstaining; are eager to access help to abstain and would like to abstain. Virginity promotion activities therefore play an important role in sexual and reproductive health of young people. The bid to delay sexual intercourse among the youth is by far a sure way in delaying sexual intercourse. In the United States, a study assessed a program that encouraged teens to pledge to remain virgins until they marry. The study found that these young people are much less likely to have sex than adolescents who do not take the pledge (Bearmna et al., 2001).

The promotion of abstinence among young people as a means to reducing teen pregnancy is seen to be a more potent strategy than the promotion of condoms. In the most recent and extensive study done to date on the birth and pregnancy rates of single and married

teens 15 – 19 years in the United States, increased abstinence is the major cause of the declining birth and pregnancy rates among single teenage girls. Most striking among the findings is that among unmarried teenage girls aged 15 – 19 years, increased abstinence accounted for 67% of the decrease in pregnancy rate. Similarly, a 51% drop in the birth rate for single teenage girls aged 15 – 19 years is attributed to abstinence. (Adolescent and Family Health Study, April 2003). These findings are very significant since they challenge the widely accepted claims that decrease in birth and pregnancy rate is due primarily to increased use of condoms. Condom use is accredited with reduction of risk of infection while abstinence is noted for its 100% protection. Durex the manufacturers of condoms rightly states on its website that “for complete protection from HIV/STI the only totally effective measure is sexual abstinence or limiting sexual intercourse to mutually faithful uninfected partners. (www.durex.com).

A Harvard university study on the prevention of HIV/AIDS in Uganda credits abstinence education with “significant effectiveness in reducing AIDS in Uganda”. The study found that from the late 1980’s to 2001 the number of pregnant women infected with HIV dropped from 21.2% to 6.2%. By contrast in Botswana, where condoms are officially promoted as the solution, 38% of pregnant women were HIV positive in 2001 (Life Site Daily News, July 22<sup>nd</sup>, 2002). Clearly, abstinence programs constitute the key to dealing with the effects of teenage sexual activity. A 2001 survey by Centre for Disease Control (CDC) reported that the number of sexually active teenagers declined from 54% to 45% in the United States and that when surveyed about their sexual history, the majority of adolescents maintained that abstinence education programs play an important role in helping them to abstain from sex until at least after high school (CDC, 2001)

### **2.4.3 Abstinence Only Approaches – Success Stories**

Abstinence approaches have proved to be very effective in delaying the age of first sexual intercourse, reducing unplanned pregnancy and lowering rates of STI/HIV/AIDS. The largest volume of data on successful abstinence approaches come from the USA, where abstinence education has been both well funded and certainly as rigorously evaluated as any safer-sex program. Some of the scientifically evaluated success stories in the USA are included in this review of available literature

#### Abstinence (Virginity) Pledges Program

The most popular of the United States' virginity pledges programs is the 'True Love Waits' program. The program challenges teenagers and college students to delay sexual debut until marriage. Under the program, trained staff teaches young people how to abstain using a special curriculum and other teaching tools. Youth leaders carry the True Love Waits message to young people through churches, student organizations, health-care groups, and on campuses across the United States. A twenty-four (24)-hour counseling service is also provided to meet the concerns of the young people. In addition a website is operated to provide further information and support to the young person seeking to abstain from sex. Numerous national, city wide and regional rallies are held each year to promote the program (<http://www.lifeway.com/tlw/>).

A National Longitudinal Study on Adolescent Health in the USA (Resnick, 1997), reports that about 16% of all American teenagers took a public pledge to abstain from sex until marriage. One major study found that under-18 year old boys and girls who signed the pledge delayed intercourse on average one-quarter (1/4) longer (2 years) than those who

had not signed the pledge (Bearman et al 2001). The statistical link between making the pledge and delaying sexual activity held even after controlling for factors associated with pledging, such as family structure, faith, and educational performance.

### Not Me, Not Now Program

This is a community-wide media campaign and school curriculum program aimed at encouraging adolescents to abstain until marriage. As part of the program, homework assignments are given to the young people. The assignments are designed to encourage parent-child communication. Another study found in an evaluation that teenage pregnancy rates decreased by over 20% from 1993 to 1996. The proportion of teenagers under 15 years who were sexually active also decreased significantly. A control group of students received instruction in the 'Not Me, Not Now' curriculum, but did not receive the homework assignments designed to encourage parent-child communications (an important part of the program). Compared to this control group, those who participated fully in the program were less likely to intend to have sex prior to finishing high school (Doniger et al 2001)

### Choosing the Best Program

'Choosing the Best' is both a school based and a non-school based abstinence program. The program has in place a curriculum dubbed *Choosing the Best* series, which is used in building the skills of young people to abstain. A longitudinal study was undertaken between 1995-1996 to assess the changes that would have taken place over a year among young people who had been part of the *Choosing the Best* program. The study evaluated 2,541 Illinois public school students aged 13-16 years. The findings revealed that:

- Fifty- four percent of the teens who had been recently sexually active before participating in the program were no longer recently sexually active when surveyed one year later.
- The number of newly sexually active teens one year after participating in the abstinence program was 21% lower than was predicted by their involvement in related risk behaviours, such as smoking or using alcohol or drugs.

Generally, more students agreed that 'secondary virginity' or the decision of a sexually active person to abstain from any further sexual activity until marriage was a viable option (66.7% compared with 54.4%). (Vessey, 1997)

In another study to find out the effectiveness of the program in reducing teen pregnancies in middle schools, data was compared from Muskogee County with that of other large school districts in Georgia that had not enrolled in *Choosing the Best*. All eighth-grade students in the County—1,600 to 1, 800 students per year—had participated in the program since 1996. Research results from 1997 to 1999 revealed that:

- Muskogee County experienced a 38% reduction in teen pregnancies in middle school students over the period.
- Other large school districts in Georgia not using *Choosing the Best* experienced an average of 6% reduction in teen pregnancies in middle school students during the same period. ([www.choosingthebest.org](http://www.choosingthebest.org))

### The 'Save Sex' Program

Under the program, community groups, schools, and faith ministries spread the message that teenagers should avoid early sexual activity along with drug and alcohol use. Activities organised includes abstinence week, use of health professional to teach young people about the risks associated with early sexual activity, raising banners reading 'save sex' in communities, and signing of abstinence pledges by young people.

An evaluation of the program show a decline in the proportion of babies born to teenage mothers, from almost ten percent (10%) in 1995 to less than five percent (5%) in 2001. (www.Foxnews.com, June 2001.)

#### **2.4.4 Conclusion**

The literature related to the topic being investigated, and which has been reviewed indicates that sexual activity is a major sexual and reproductive health challenge of young people and that the increasing public concern about the adverse consequences of adolescent sexuality has led to the organization and implementation of several programs aimed at addressing these needs. The literature underscores the need worldwide for the young, especially young females to abstain from sex either until they are married or matured enough to be able to cope with the exigencies and consequences of pregnancy and child bearing socially, economically, emotionally as well as biologically. It further goes on to establish abstinence only (promotion of virginity) programs as potent strategies for helping these young females. Such programs, among others, must use a name that easily attracts young people and communicates program benefits, making room

for beneficiaries to sign abstinence cards and evolving a strategy (such as home - work assignments) to ensure involvement of parents in the program.

Finally it has been noted in the literature that virginity promotion entails:

- Teaching methods, which present accurate facts and techniques for dealing with risky situations, and emphasise the individual's responsibility to make wise choices
- Teaching that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
- Teaching that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society
- Teaching young people that even if they have already been sexually active, they are still in control of their future actions and that their choices will help determine their future life situation.
- Teaching young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- Teaching the importance of attaining self-sufficiency before engaging in sexual activity

The reviewed literature thus provides some insights, which should inform the researcher in his assessment of the Ejisu Juabeng Virgins program, and to generate the information needed to strengthen the existing program.

## CHAPTER THREE

### 3.0 STUDY METHODOLOGY

This chapter introduces the study area and explains the methods used for data collection and how they were organized to achieve the objectives of the study.

#### 3.1. THE STUDY AREA

The study area is the Ejisu sub - district. It is one of the five sub districts of Ejisu - Juabeng district in the Ashanti Region of Ghana. It is the biggest among the sub districts and has 30 communities. Ejisu is the capital of the sub-district and has a population of 43440 (2001 Projected Population). Tables 3.1 and 3.2 present the distribution of the population by Sub-District.

**Table 3:1 Population by Ejisu – Juabeng Sub- District: 1997-2001**

<b><i>SUB DISTRICT</i></b>	<b><i>1997</i></b>	<b><i>1998</i></b>	<b><i>1999</i></b>	<b><i>2000</i></b>	<b><i>Population 2001(Projected)</i></b>
<b>ACHIASE</b>	13302	13579	14000	14434	124113
<b>BOMFA</b>	20155	29575	21213	21870	18617
<b>EJISU</b>	47162	48145	49637	51176	43440
<b>JUABENG</b>	24320	24827	25597	26390	22340
<b>KWASO</b>	29426	30039	30970	31931	27305
<b>TOTAL</b>	134365	137165	141417	145801	124113

Table 3.2: Distribution of Sub- Districts by Total Population and by population of specified age groups

<i>Sub - District</i>	<i>ACHLASE</i>	<i>BOMFA</i>	<i>EJISU</i>	<i>JUABENG</i>	<i>KWASO</i>	<i>TOTAL</i>
<b>POPULATION</b>	12411	18617	43440	22340	27305	124113
<b>0-11 Months</b>	246	744	1737	893	1092	4965
<b>Under 5 Yrs.</b>	2482	3723	8688	4468	5461	24824
<b>WIFA</b>	2482	3723	8688	4468	5461	24823

*Source: Annual Health Report, Ejisu-Juabeng District DHMT, 2001*

The main occupation of the people in the area is subsistence farming. Food crops grown are cassava, plantain, cocoyam and maize. Cash crops include cocoa and oil palm. Few are employed as factory hands in the wood industry and the oil palm plantation at Juabeng, one of the sub-districts. Many of the women are engaged in trading as a secondary occupation. Weaving is also an important occupation in one of the communities, Bonwire. Generally, incomes tend to be unstable and employment is often seasonal.

### **3.2 STUDY DESIGN**

The study was descriptive in nature using quantitative and qualitative research methods. Data collection covered all the 151 members of the virgins club from the thirty communities as well as other stakeholders of the program such as twelve Queen Mothers and two Project Staff. The survey instruments used was a structured questionnaire, a

Focus group discussion guide and an in-depth interview guide (Please see Appendix for survey instruments).

### **3.3 STUDY QUESTION:**

The study sought to determine the extent to which the virgins' program has met its set objectives?

### **3.4 INDICATORS**

The following indicators were measured to meet study objectives:

1. Number and content of activities undertaken to encourage young girls to delay sexual contact until marriage
2. Number of girls educated on the need to delay sexual contact until marriage
3. Percentage of girls delaying sexual contact until marriage
4. Number of girls who are primary virgins
5. Number of girls who are secondary virgins
6. Number of girls who joined but left the club
7. Number and content of skill training programs undertaken.
8. Number of girls participating in skill training program
9. Number and percentage of girls who report favourably on the skill training
10. Number of Peer educators selected and trained
11. Number and content of peer education programs undertaken
12. Number and percentage of girls who are providing peer counselling services
13. Number of youth counselled by peer educators

14. Number and percentage of club members who demonstrate knowledge / skills relevant to SRH issues
15. Number and percentage of virgins who can identify risk taking behaviours.
16. Number and nature/ magnitude of factors inhibiting project implementation
17. Number and nature / magnitude of factors facilitating project implementation

### **3.5. DATA COLLECTION PROCEDURES**

#### **3.5.1. Training of Research Assistants /Pretesting of survey instruments**

Interviewers were selected and trained to help the researcher administer the survey instruments. The survey instruments were pilot tested and the necessary revision made. The interviewers were supervised by the researcher, through out data collection in the field.

#### **3.5.2. Quantitative Data Collection**

A Structured questionnaire (copy attached as Appendix 1), was administered to Virgin club members, which elicited information on the following:

- Inhibiting/facilitating factors to project implementation
- Activities undertaken,
- Knowledge, Attitudes, Practices / skills (KAPS) of members in relation to SRH
- Community support
- Level of involvement of young people in project related decision-making process.
- Employable skills acquired /utilised

### **3.5.3 Qualitative Data Collection**

Qualitative research methods were employed to produce in-depth data, to provide insight into the operations of the project and also to provide additional information to complement data to be gathered from the questionnaire interviews. Consequently, two Focus Group Discussions ((copy attached as Appendix 2) were held with virgin club members. Another Focus Group Discussion (copy attached as Appendix 3) was also held with twelve queen mothers and two key informant interviews (copy attached as Appendix 4) were conducted with Project staff to generate information on community support, progress of project and inhibiting/facilitating factors.

### **3.6 DATA PROCESING AND ANALYSIS**

During the fieldwork, data collected were sorted manually and checked for correctness and completeness of information on daily basis. Data thus generated were processed, cleaned and entered into computer on daily basis and at the end analyzed with EPI INFO soft ware.

The taped data generated from the Focus Group Discussions were transcribed and translated into English. Transcripts and data from the In Depth Interviews were also coded separately and the information generated was interpreted, put into common themes and used to complement quantitative data.

### **3.7 ETHICAL CONSIDERATIONS**

The consent of the District Health Administration, District Assembly, Queen mothers of the thirty communities, Project Management team and the parents/guardians of club

members were sought before the study was undertaken. Verbal consent of the study participants was also sought. They were given the option to opt out of the study any time they wanted to.

### **3.8 STUDY LIMITATIONS**

On the whole, the study went well although it has some limitations. It was very difficult bringing the queen mothers together for the two planned focus group discussions. They were all kept very busy working on a project with the Asantehene, and as a result only one focus group discussion could be held with 12 queen mothers.

## **CHAPTER FOUR**

### **4.0 STUDY FINDINGS**

#### **4.1 Introduction**

A total of 151 young girls, who are members of the Virgins' Club, constituted the primary target for the survey. In addition, twelve Queen Mothers and two members of the technical Project Management team were also targeted, to provide in-depth information. This chapter presents, and in some instances briefly discusses, the study findings, in the following order:

1. Socio-Demographic profile of respondents
2. Club Membership, Activities and Benefits
3. Attitudes and Perceptions about Abstinence
4. Knowledge and Skills relevant to other SRH Issues
5. Project Challenges and Strengths

#### **4.2 Socio-Demographic Profile of Respondents**

Table 1 presents the socio-demographic characteristics of respondents, in terms of age, educational level, occupation, with whom respondents reside and who is responsible for respondents' upkeep.

## **Age Group**

The majority of respondents (42.4%) were within the 15 – 19 year age group, 37.7% in the 10 – 14 year age group and the 25 – 29 year age group constitute 4 percent. It is evident that girls mostly attracted to the club fall within the 10 – 19 year age group.

<b>Characteristics</b>	<b>Frequency</b>	<b>Percentage</b>
<b>AGE GROUP</b>		
10 – 14	57	37.7
15 – 19	64	42.4
20 – 24	24	15.9
25 - 29	6	4.0
<b>TOTAL</b>	151	100.0
<b>RELIGION</b>		
Moslem	7	4.6
ATR	22	14.6
Christianity	122	87.1
<b>TOTAL</b>	151	100.0
<b>EDUCATION</b>		
Non formal Education	2	1.3
Primary	17	11.3
JSS	123	81.5
SSS	8	5.3
Technical / vocational	1	.7
<b>TOTAL</b>	151	100.0
<b>OCCUPATION</b>		
Still in school	51	33.8
Out of school	100	66.2
<b>TOTAL</b>	151	100.0
<b>WITH WHOM RESIDE</b>		
Both parents	84	55.6
Father/mother only	44	29.1
Other parents	23	15.2
<b>TOTAL</b>	151	100.0
<b>RESPONSIBILITY FOR UPKEEP</b>		
Both parents	80	53.0
Father/mother only	56	37.1
Other relative	13	8.2
Myself	2	1.3
<b>TOTAL</b>	151	100.0

Table 1: Distribution Of Respondents By Background Characteristics.

## **Religion**

The study population was predominantly Christian (87.1%). The next important religious group was traditional religion (14.6%). The Moslem study population formed the minority (4.6%).

## **Educational Level**

The educational profile of respondents showed a relatively good number of educated young girls and this was reflected in their ability to respond adequately to survey questions and participate in the discussions. Out of the total number, about 1.3% had no formal education while 11.3% have had primary education. The majority (81.5%) had completed basic school (JSS).

## **Occupation**

The majority of respondents (66.2%), indicated that they are out of school. Out of this number, 46.5% are involved in various employment activities such as trading/small scale business (8.6%), artisanship (7.9%) and trade apprenticeship (30%). Nineteen point seven percent (19.7%) are unemployed.

## **With Whom Respondents Reside**

Most respondents (84%) live with both parents, with 44 percent of this number living with single parents (either father or mother). The remaining 23 percent were living with other relatives.

## **Upkeep of Respondents**

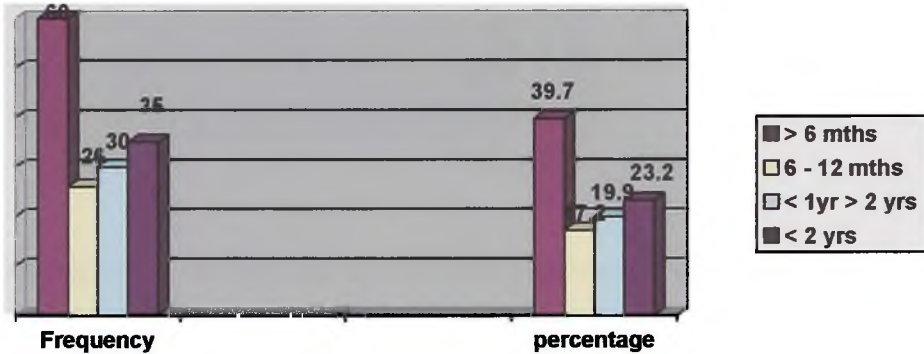
Fifty-three percent (53%) of respondents indicated that both parents were responsible for their upkeep (Table 1). This was followed by respondents who had single parents (37.1%). Eight point six percent (8.6%) of respondents however mentioned relatives as

guardians directly responsible for their upkeep. The remaining 1.3% indicated that they were taking care of themselves.

**4.3 CLUB MEMBERSHIP / PARTICIPATION**

The club was initiated three (3) years ago, with one hundred and fifty members. Only 23.2% of respondents indicated that they have been with the club for more than two (2) years. The majority of respondents (39.7%) said their initiation into the club had taken place within a period of not less than six (6) months ago. Those whose membership dates back to more than one (1) year but less than two (2) years represented 19.9%. The remaining 17.2% joined the club within 6 – 12 months prior to the time of the interview (Figure 1).

**Figure 1: Distribution of Respondents by length of time in Club**

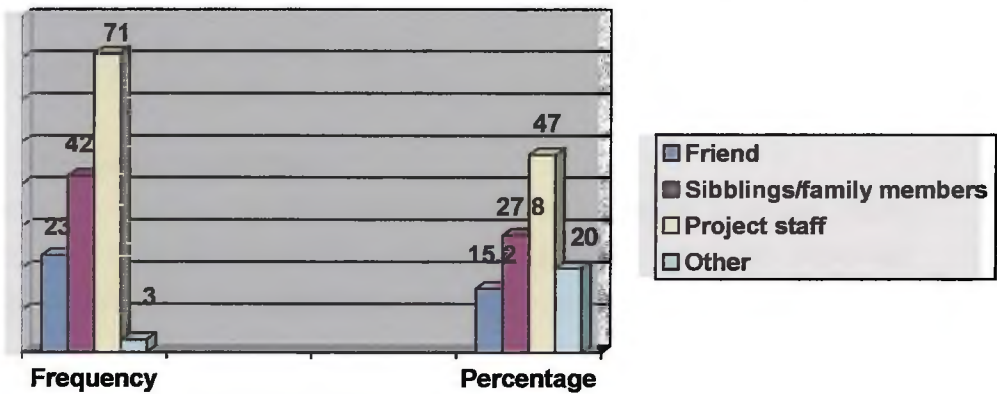


The results seem to point out that the majority of young girls who registered with the program in 2001 have left the club (approx. 100). This was confirmed during the FGD by discussants where they explained why people joined but left the club. The reasons included lack of money to pay for transportation to attend club meetings, inability of some girls to stay as virgins (having gotten pregnant) and some (5) having gotten married. It will be important for project implementers to put in strategies to forestall the

occurrence of undesirable situations among members and also to put in measures to retain club members for a considerable period of time.

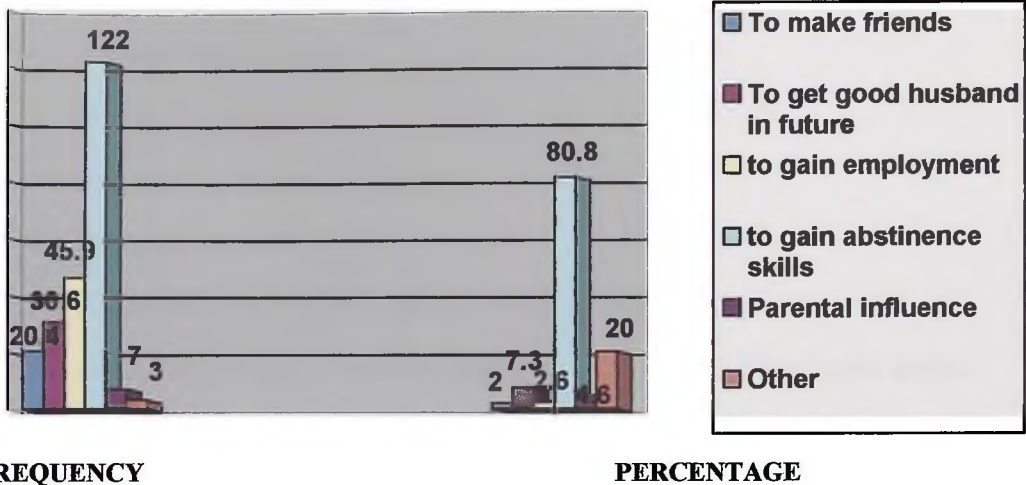
However, the membership drive, which resulted in the recruitment of 39.7% of the girls just within the six months prior to the time of the interview, is encouraging and indicates the inherent potential of the club to attract young people. This potential is reflected, further, in the fact that 47% of respondents mentioned project staff as their source of information on club activities (Figure 2).

**Figure 2: Distribution of Respondents by Source of Information about Club**



It appears that the key club message disseminated by project staff to attract new members is centered on acquisition of abstinence skills. This could be inferred from Figure 3, which indicates that for over 80% of respondents their main reason for joining the club is to gain skills to abstain. This is very important since it ensures that club members are kept focused on the primary objective of the club. This finding, that 80.8 percent of the girls desire to acquire abstinence skills, is a sure indication that most of the young people really want to abstain.

**Figure 3: Distribution of Respondents by Main Reason For Joining The Club**



#### 4.3.1 Membership Classification

The club has two (2) categories of members – members classified as primary virgins (never had sex) and those classified as secondary virgins (ever had sex but abstaining). Virginity status is thus determined by the verbal claim of prospective club members.

The majority of respondents (98.7%) indicated that they had never had sexual intercourse (primary virgins) while the minority of 1.3% were secondary virgins. Secondary virgins indicated that they had their sexual debut before joining the club. The sexual initiation of one took place about one year prior to the interview and was occasioned by a friend while the other respondent had a case of incest, which took place more than a year prior to the interview. The low membership of secondary virgins in the club suggests the club’s preference for primary virgins as opposed to secondary virgins. There is, however, the need to encourage secondary virginity. It is important to note that all respondents, whether primary or secondary virgins are delaying sexual contact until marriage. This is buttressed by responses of the girls to whether or not they are able to abstain till marriage, to which all the 151 girls replied in the affirmative.

### **4.3.2 Club Activities / Benefits**

A number of activities are organized by the club to encourage young girls to delay sexual debut, and these are:

- Employable skill training
- Peer education training
- Health education promotion, and
- Counseling services

The activities are organized and implemented mainly at Ejisu. Club members living in communities other than Ejisu have to commute to attend meetings and participate in other club activities. They are often confronted with problems such as lack of money for transportation and risk involved in traveling. Some club meetings are also held at community levels, however such meetings tend to lack the needed preparation and inputs, as required by the centralized meetings at Ejisu. Most often than not, health talks constitute the only activity undertaken at the community level, while all other major activities take place at Ejisu.

#### Employable Skills Training:

Skills training in Sewing, Hairdressing and Batik and Tie and Dye making are offered to girls. This component however is not functioning properly and suffering major setbacks. Funds are not available to set girls up after the training.

#### Peer Education Training:

Peer education training has been organized just once (in July 2004 when funding was secured from the Ghana AIDS Commission for that purpose). Thirty peer educators

representing the 30 communities have now been trained. Peer counseling/education services are yet to commence.

#### Health Education and Health Promotion:

Health Education and promotion through talks and presentations by various facilitators have been organized. This component seem to be the most successful of all activities organized

#### Counseling:

The two project staff as well as the thirty Queen Mothers, offer counseling services in various areas to the girls, addressing concerns and pertinent issues. Most of the concerns border around friendship, reproductive health and career.

The study detected that there are problems with activities organized, generally. It appears that, with the exception of the recent peer education training, activities organized lack a coherent and well-tailored content material. Activities do not seem to follow any logical sequence and most activities are organized and implemented on ad hoc bases. Every member of the club benefits from club activities, in one way or another and Table 3 presents the various ways in which members believe they have benefited from club activities. According to the results, 13.2% had benefited from employable skills training, 70.9% from health education, 19.8% from peer education training, 12.6% from interacting with important personalities including the Asantehene, 33.1% from making new friends within the club, 52.3% from counseling services and 84.8% from acquiring abstinence skills. Those who have benefited from employable skills training (13.2%) have undergone specific training in hairdressing, dressmaking and tie and dye making.

**Table 3: Distribution of Respondents by Benefits Gained From Club Activities.**

<b>Benefit</b>	<b>Count (N=151)</b>	<b>Percentage</b>
Employable skills training	20	13.2
Health education	107	70.9
Been trained as peer educators	30	19.8
Met important personalities	19	12.6
Media friends	50	33.1
Counseling services offered by program management team	79	52.3
Gained skills to abstain	128	84.8

#### **4.4 ATTITUDES AND PERCEPTIONS ABOUT ABSTINENCE**

Study findings show that respondents' perceptions about abstinence are positive. Their belief that abstinence until marriage is attainable is supported, further, by their assertion that it is possible to abstain even if one has had sexual intercourse before. All 151 respondents believe this is possible.

**Table 4: Distribution Of Respondents By Level of Agreement with specified Statements**

STATEMENT	AGREE		DISAGREE		DON'T KNOW	
	Freq	%	Freq	%	Freq	%
When a girl says No she usually does not mean it.	42	27.8	107	70.9	2	1.3
A young boy/girl who does not have sex becomes a fool	3	2.0	147	97.4	1	0.7
Young boys who abstain from sex would have swollen testicles	5	3.3	141	93.4	5	3.3

However, there are a few wrong perceptions, which need to be corrected. When asked to agree or disagree to statements about sex and abstinence, some of the responses given seem contrary to what one would expect from members of such a club (Table 4).

On whether club members agree or disagree with the statement that when a girl says “no” to sex, she usually does not mean it, 72.2% disagreed while 25.2% agreed. Another 2.6 percent did not know the right response. On the question of whether it was okay for young people from poor families who need money for school to have sex with someone in exchange for money and/or gift, 70.9% disagreed while 28 percent agreed. Only two respondents (1.3%) did not have an idea of what the response could be.

When asked to respond to whether a young boy/girl who does not have sex becomes a fool, 97.4 percent disagreed while 2.0 percent agreed. On whether young boys who abstain from sex would have swollen testicles, 93.4 percent disagreed while 3.3 percent agreed. The remaining 3 percent did not know the answer. The inability of some

respondents (even though the minority) to respond to the statements correctly points to the need for the club to do more to correct myths and misconceptions surrounding sex and abstinence.

#### 4.5 SRH RELATED KNOWLEDGE AND SKILLS

##### Sexually Transmitted Infections (STI)

Table 5 presents data on level of knowledge of respondents on Sexually Transmitted Infections (STI).

**Table 5. Distribution of respondents by knowledge of names of STI**

Type of STI	Count (N=151)	Percentage of cases
HIV/AIDS	151	100.0
Gono	113	74.8
Syphilis	57	37.7
Candidiasis	25	16.6
Herpes	7	4.6
Warts	2	2.0
Don't Know	2	1.3
Total	356	237.1

The most common STI mentioned (unprompted) were HIV/AIDS (100%), Gonorrhea (74.8%) and Syphilis (37.7%). The rest were candidiasis (16.6%), Herpes (4.6%) and warts (2.0%). However, knowledge exhibited on symptoms of STI is found to be not encouraging (Table 6).

**Table 6: Distribution of Respondents by Symptoms of STI Known**

Symptom	Count (N=151)	Percentage of cases
Discharge from Penis/Vagina	74	50
Burning/Pain/Itching genitals	71	48
Sore on genitals	43	29.1
Don't know	48	32.4

Thirty-two point four percent (32.4%) did not know any STI symptom. Only about a third of respondents (50%) could associate discharge from penis/vagina with STI. Less than a third of respondents could mention burning sensation/pain/ itching in and around the genitals (48.0%) as symptoms associated with STI. Thirty two point four percent (32.4%) did not have any knowledge with regards to STI symptoms. Discouraging also are responses provided on ways to avoid STI (Table 7).

**Table 7: Distribution of Respondents by knowledge of Ways To Prevent STI**

Prevention	Count (N=151)	Percentage of cases
Abstinence	136	95.1
Condom use	30	21.0
Avoid casual partner	55	38.5
Be faithful	51	35.7
Other	7	4.9
Don't know	3	2.1

As many as 95.1 percent of respondents mentioned abstinence as a strategy for avoiding STI but only 21% mentioned “Condom use”. Other preventive measures mentioned are “avoid casual partners” (38.5%) and another 35.7 percent mentioned, “Be faithful”. The gap in knowledge raises concern considering the fact that the presence of an STI increases the risk of HIV infection. Even though the club is based on ‘an abstinence only’ principle it is imperative that information on other prevention strategies are widely disseminated among club members.

HIV/AIDS Related Knowledge and Skills

One hundred percent of respondents were able to mention HIV/AIDS as an STI (Table 7), indicating a high level of HIV/AIDS awareness among club members. This notwithstanding, in-depth knowledge about the disease appears to be inadequate. Knowledge on the modes of transmission for instance, was limited to unprotected sex (98.6%) and sharing of sharp objects (91.8%). Other modes of transmission particularly mother to child transmission, was known only by 13.7 percent of respondents (Table 8).

**Table 8. Distribution of Respondents by Knowledge of HIV Transmission Routes**

<b>Transmission</b>	<b>Count (N=151)</b>	<b>Percentage of cases</b>
Unprotected Sex	144	98.6
Sharing sharp instruments	134	91.8
Blood transfusion	74	50.7
Mother to child	20	13.7
Total	372	254.8

**Table 9: Distribution of respondents by knowledge of HIV/AIDS symptoms**

Symptoms	Count (N=151)	Percentage of cases
Loss of weight	136	90.1
Skin lesions	75	49.7
Thinning of Hair	31	20.5
Persistent diarrhea	111	73.5
Persistent cough	55	36.4
Frequently illness	106	70.2
Boils	91	60.3
Other	26	17.2
Don't Know	1	7.0

With regard to symptoms, the majority of respondents identified the disease with consistent weight loss (90.1), persistent diarrhoea (73.5%), frequent illness (70.2%) and other symptoms such as persistent cough and thinning of hair. (Table 9)

The findings as to how HIV infection could be prevented (Table 10) show that most respondents are familiar with abstinence (95.3%) and avoiding the sharing of sharp instruments (70.7%). Other preventive measures mentioned include faithful to partner (40%), avoid blood transfusion (7%), condom use (26.0%) and avoid casual sex (34.0%).

**Table 10: Distribution of respondent by knowledge of how HIV/AIDS could be prevented**

<b>. Prevention</b>	<b>Count N=151</b>	<b>Percentage of cases</b>
Abstinence	143	95.3
Faithfulness to partner	60	40.0
Avoid blood exchange	1	7.0
Condom use	39	26.0
Avoid sharing piercing instrument	106	70.7
Avoid casual sex	51	34.0

A similar pattern in knowledge can be seen in responses to the question on what an infected person needs to do to live positively with the disease (Table11). Most respondents were familiar with seeking medical help (77.3%), as the only measure an infected person can take to prolong his/her life.

**Table 11: Distribution Of Respondents By Knowledge of What An Infected Person Can Do To Prolong Life**

<b>What an infected person can do</b>	<b>Count N=151</b>	<b>Percentage of cases</b>
Eat balanced diet	63	42
Seek medical care	116	77.3
Do regular sex	8	5.3
Don't know	45	30.0

To further assess respondents' knowledge and perception of HIV, the girls were asked to respond to true or false statements on HIV/AIDS (Table 14).

**TABLE 12 Age grouped cross tabulation by knowledge and perception of HIV/AIDS**

STATEMENT	AGE GROUP											
	10 -14			15 - 19			20 – 24			25 - 29		
	True	False	DK	True	False	DK	True	False	DK	True	False	DK
A healthy looking person can carry the AIDS virus	94.7%	5.3%	-	89.1%	9.4%	1.6%	95.5%	4.5%	-	100.0%	-	-
Infection could be through sharing eating utensils with an infected person.	1.8%	96.5%	1.8%	10.95%	89.15%	-	4.5%	95.5%	-	-	100.0%	-
One can get AIDS through mosquito, flea, or bedbug bites	17.5%	80.7%	1.8%	28.1%	70.3%	1.6%	9.1%	90.9%	-	16.7%	83.3%	-

The results indicate that only a minority from the respective age groups had inadequate knowledge and some misconceptions about the disease. For instance, on whether a healthy looking person can be carrying the AIDS virus, 6.7% of respondents (all age groups), had the answer wrong and another 7 percent did not know, while a majority (92.6%) answered the question correctly. However wrong responses were given by 20.8 percent (all age groups), on the question of whether one can acquire the infection through mosquito, flea or bed bug bites. This finding is alarming and needs to be addressed, particularly among the age groups 10 – 14 years (17.5%) and 15 – 19 years (28.1%).

Although the study was primarily descriptive and as such was not expected to generate deep insights into cause and effect relationships, an attempt was made to explore possible relationships using the Chi Square test. It was anticipated that the level of HIV/AIDS knowledge and perception of respondents, as indicated in the True or False statements on HIV/AIDS (Table 14), might have been influenced by the following variables:

- Duration/Period of club membership – (Less than 6 months, 6-12 months, more than 1 year but less than 2 years, More than 2 years)
- Age groups of club members – (10-14years, 15-19years, 20-24years, 25-29years)

However, the results did not show any significant association.

#### **4.6 FACTORS INHIBITING PROJECT PROGRESS**

A number of factors appear to be hindering the potential of the project to achieve desired results, in various degrees, and these include:

- Negative perception of some community members

- Negative perception of some community members
- Lack of well prepared, coherent training/teaching curriculum
- Funding
- Lack of effective follow up of dropouts
- Low involvement of young girls on project management
- Over concentration of project activities at Ejisu

#### **4.6.1 Negative Perception of Community Members**

Some community members, both peers of club members and others have negative perceptions about members of the club and tend to label club members using qualifiers such as fools, liars, house helps, archaic, old fashioned people. The peers of club members in the communities tend to ridicule club members with statement such as

*'When you get pregnant, you will find it very difficult to deliver'*

*'A virgin is someone who has not given birth before, not the one who has not had sex before'.*

A discussant at one of the focus group discussion sessions recounted the ordeal club members go through, in the following words:

*'Friends and other people ridicule and intimidate us. Some think we are fools. They call us names and also sometimes insult us ...they claim we are liars because we all indulge in secret love affairs...It is quite demoralizing and discouraging'.*

#### 4.6.2 Lack of well prepared, coherent Training/Teaching curriculum

It appears that a well-prepared, coherent and well-tailored curriculum to run the club is lacking. For instance educational programs are organized on ad hoc bases, and this affects content and delivery. It is also likely that such an approach may affect the interest of project beneficiaries and may consequently lead them away to other sources for verification of information given the Club. This weakness may account for why respondents failed to unanimously mention the club as their key source of information on sexuality and abstinence (Table 15a and 15b). In both cases, respondents' reference to the club was low.

**Table 12 A: Distribution of respondents by source of information on sexuality issues**

Category label	Count (N=151)	Percentage of cases
School	53	35.1
Church	30	19.9
Family / relations	36	37.1
Virgin's club	84	55.6
Media	106	70.2
Elderly person	4	2.6
NGOs, WVG, PPAG etc	5	3.3
Health personnel	17	11.3

**Table 12 B: Distribution of respondents by sources of information on abstinence**

Category label	Count(N=151)	Percent of cases
School	42	27.8
Church	47	31.1
Family/relations	60	39.7
Virgin's club	97	64.2
Media	112	14.2
Elderly person	3	2.0
NGO'S (WVF, PPAG etc)	6	4.0
Community discussions	3	2.0
Health personnel	7	4.6

### 4.6.3 Funding

The overriding factor that continues to inhibit project implementation is lack of funding. The project seems to be run largely on voluntary basis. The result has been that some project components especially employable skill training have been affected negatively. The words of one of the queen mothers during the focus group discussion summed it all up in the following words:

*‘The provision of employable skills is one of the main ways to empower the young girls. Due to lack of funds, this component is not living up to expectation. We have no money to graduate people trained, let alone to set them up in business. In the eyes of the young girls we have not lived up to expectation and this accounts for why most of them have left the club and why some new ones do not want to join. Even the community members are now laughing at us.’*

The financial handicap also affects the ability of the club to organize more innovative programs and activities for the young girls. The ability of most girls to travel to Ejisu for the monthly meetings and other club activities had been curtailed due to lack of money for transportation.

#### **4.6.4 Lack of Effective Follow Up of Drop Outs**

Apart from five (5) girls who got married and left the club, the majority of girls who had joined the club left within the three-year period. These have not been followed up, to find out the reasons for dropping out of the club.

#### **4.6.5 Low level of Involvement of the Young Girls On Project Management**

It became evident that the young girls are hardly involved in the management of the project and organization of project activities. The management team has no representation of project beneficiaries, and this can have serious implications as far as commitment and sustainability are concerned.

#### **4.6.6 Over concentration of Project Activities at Ejisu**

Even though the project operates in 30 communities in the Ejisu sub-district, activities are heavily concentrated at Ejisu. Club members from the other 29 communities are compelled to commute to Ejisu to participate in club activities. Thus those members who are unable to travel to Ejisu due to financial and other problems do not benefit fully from the project. In the Gyamase community for instance, which is about ten kilometers from Ejisu, only one girl is able to attend the Ejisu meetings, regularly. It is estimated that a

return trip from Gyamase to attend a club meeting at Ejisu would cost a member Five thousand Cedis, which many of club members may not be able to afford.

#### **4.6.7 FACTORS FACILITATING PROJECT PROGRESS**

Although the factors discussed above have been identified as hampering the progress of the club, other factors have also been identified, which have kept the club operational, and these include the following:

- Community Support
- Support of Queen Mothers
- Active Involvement of Village Health Committees
- Commitment of Project Staff
- Club Exit Package

#### **4.6.8 Community Support**

The project receives various forms of support from the community. Some parents attend club meetings to encourage the young girls. Others offer money to cater for the transportation needs of their wards to enable them attend meetings. Some parents have also been very instrumental in personally ensuring the enrolment of their wards into the club. Some community leaders and village health committee members act as facilitators for some of the training programs.

#### **4.6.9 Support of Queen Mothers**

The main pillar behind the entire project appears to be the personal involvement of all the thirty Queen mothers of the Ejisu sub district. They serve as rallying points for the young

girls to join the club and participate in activities. They also provide educational talks and hold counseling sessions. Their financial support to most needy girls for various purposes such as meeting transportation costs, enrolment in skill building program etc. is highly commendable. Moreover, their physical presence at the Ejisu meetings boosts the morale of the young girls. Their technical support to the project is immense. A project staff during an in depth interview summed up the critical role of queen mothers thus:

*‘Perhaps when this pillar collapses, the project may cease to be operational’*

#### **4.6.10 Active Involvement of Village Health Committees**

The village health committee members contribute a lot to sustain the activities of the project. Through the members, information on scheduled club activities reach the young girls. They also help to organize club activities at the community level.

#### **4.6.11 Commitment of Project Staff**

The selfless service rendered by the two key project staff / management team - the Senior Medical Assistant and the Public Health Nurse, both of the Ejisu hospital has provided focus for project implementation and have served as the impetus for club activities to continue in spite of financial constraints. With no remuneration, the two continue to demonstrate a strong spirit of voluntarism to drive the club forward. They promote, as much as possible, free clinical consultation for all project stakeholders and also donate money to finance some aspects of project activities.

#### **4.6.12 Club Exit Package**

The package designed for club members who exit membership as a result of marriage is commendable. It provides the potential to help retain members and to keep them focused. The club exit package for the about to be married members involves a grand community ceremony at which a present and an amount of ₺400,000.00 cedis is given to the exit candidate.

## **CHAPTER FIVE**

### **5.0 DISCUSSION OF FINDINGS**

This chapter presents discussion of the results presented in the previous chapter four. This discussion focuses on membership issues, activities/benefits, knowledge and attitudes, as these relate to Sexual and Reproductive Health as well as the inhibiting and facilitating factors where project Implementation is concerned.

### **5.1 CLUB MEMBERSHIP ISSUES**

#### **Abstinence Among Young People**

According to the literature reviewed, young people worldwide would like to delay sexual debut and are practicing abstinence. This has been confirmed by the study. Findings of this study indicate that young females largely in the 10 – 19 year age group believe in abstinence and are being educated and encouraged to delay sex until marriage. In a study conducted in Ghana to examine young people's attitudes towards premarital sex and STI/HIV/AIDS, over 80% did not consider themselves at risk of HIV/AIDS, giving the reason that they are virgins and are not sexually active (Awusabo Asare K et al. 1999). In another study conducted in Uganda to measure prevention indicators and describe sexual behaviour of young people, the proportion of young people aged 15 – 19 reporting that they never had sex increased from 31% and 26% in 1989 to 56% and 46% in 1995 respectively. The median age at first intercourse increased from 16.6 years to 17.4 years (Asiimwe – Okiror G et al, 1997). It is obvious that, more and more abstinence is

becoming fashionable among young people. Indeed more young people are opting to delay the onset of sexual activity than in the past (UNFPA et al, 2002).

### **Abstinence Pledge / Vow**

All respondents mentioned that they had undertaken a pledge to abstain. According to them the vow motivates them to delay sexual debut. Several studies have confirmed this, indicating that teens who take a public pledge to remain virgins until they marry have been found to be less likely to have sex than adolescents who do not take the pledge (Bearmna et al, 2001). In a Namibian abstinence only club study, for instance, female virgin members of the club were found to have remained virgins 12 months after the program compared to non club virgin members (Stanton et al, 1998). Thus like their counterparts in other parts of the world, a significant number of the members of the Ejisu virgins club could be expected to achieve a delayed sexual debut. If achieved, the Ejisu Township is sure to begin to record low reported cases of teen pregnancy, abortion and Sexually Transmitted Infections.

### **New Club Membership Recorded among 10-14 Years Age Group**

The new club membership of 39.7% recorded among respondents 10 – 14 years is significant. This age group constitutes the HIV/AIDS window of hope for Ghana (Ghana HIV Sentinel Survey, 2003). The window of hope age group presents a clear solution to the country's fight against the pandemic. Young people are the greatest hope for stopping the pandemic, partly because they are more likely than adults to adopt and maintain safe sexual behaviours. Wherever the spread of HIV/AIDS has slowed or even declined, it is

primarily because young men and women have been given the tools and the incentives to protect themselves against the infection (UNICEF, 2003). There is the need for more young people in this age group to be targeted with specific interventions to ensure that as they grow they will exhibit positive behaviours that will enable them to stay out of the hazards of early sexual experience. The Ejisu virgins' intervention presents one of the channels through which Ghana can free herself of the scourge of the pandemic.

### Secondary Abstinence

Abstinence messages may have the most impact on youth who have not yet been initiated into sex. However some older youth appear to respond to the choice of secondary abstinence (Youth Lens 2003). For instance, studies in South Africa and Thailand found that most youth including those who had sporadic sexual activity considered practicing secondary abstinence. These young people chose secondary abstinence because they wanted to protect their health and were not ready to have sex (McCauley A. 2003). The results of this study confirm the preference of young people for secondary abstinence. Two percent (2%) of respondents were found to be practicing secondary abstinence. Even though the percentage is small, it is significant. It is important for the project to open its door wider to secondary virgins. By this more young people in the sub district will be empowered to delay sexual debut.

## **5.2 CLUB ACTIVITIES / BENEFIT**

### **Focus of the Virgins Club**

Studies from different countries acknowledge that interactions aimed at protecting young people from the dangers of early sexual initiation should have multi faceted programs responding to various needs. The studies concluded that a one-way intervention might not be successful. In Haiti for example, the YDI, a youth project operates with a multi sector design addressing young people's needs in a holistic way. The project components include health, agriculture, education and income generation. The project has demonstrated that this approach results in better reproductive health outcomes (Youth Lens 2003).

The World Health Organization (WHO) and other international bodies support a holistic approach to working with the youth. Interventions that focus only on specific problem behaviours such as unsafe sexual activity are less effective because they do not address the antecedents or determinants of the behaviour. Addressing young people's lives in a broader context may ultimately have a stronger impact on reproductive health behaviour than a narrow focus on sexuality (WHO, 1999). In a world wide study to encourage countries to recognize the need for youth to be at the center of STI/HIV/AIDS control strategies, the report commended a combination of various prevention strategies such as advocacy, education, communication, VCT, referral services and improving young peoples economic and social conditions as vital to achieve results (Kiragu K. 2001).

The Focus of Young Adults program also concluded in an end of program report that multiple components of youth developments programs act together to promote a healthy life style for youth. Because they address the whole person and not just his/her

reproductive health, they may be more acceptable to young people than a program that focuses only on reproductive health (Focus on Young Adults 2001). Young people as well are also calling for multisectoral approaches. In a study conducted in Zambia, adolescents saw their environment as having an effect on their sexual and reproductive health and reconfirmed the need for more integrated reproductive health programs that address not only health but also economic development and skill building (Fetters T et al. 1998). Another recent Youth assessment in Tanzania reported that a multisectoral approach is needed in order for young people to accept life-affirming messages regarding youth reproductive health and HIV prevention (Youth Lens 2003).

The Ejisu virgins club demonstrates the ideals of multisector interventions. The findings indicate that respondents are benefiting through participation in the project's multi component activities such as health education, employable skills building and peer education. However, apart from health education, the others, the employable skills and peer education components appear to be suffering setbacks. Less than a quarter of respondents (20%) have benefited from employable skills. Abstinence promotion among others teaches that it is important to attain self sufficiency before engaging in sexual activity. Employable skills building contributes greatly to attaining self-sufficiency especially for Ejisu where jobs are none existent for the youth. The skills building component is therefore critical and should not collapse. Studies have shown that lack of economic empowerment often lead girls into having sex. For instance a study in Uganda revealed among others that in the absence of formal income opportunities, girls often

trade sex for money or gifts. The study further indicated that female desire for gifts/money often led to unwanted pregnancy and HIV/AIDS (Bohmer L. et al, 2000).

### **Peer Education**

Peer education aims at establishing standards for accepting behaviour. In playing a role on developing social and group norms, peer educators serve as positive role models for behaviour change (Population Reports 2001). The peer education component of the project appears to have been non-existent until July 2004 when 30 people were trained to begin providing SRH information and services to their peers in their respective communities. Now that the peer education component of the project is active, peer educators will no doubt manage the existing negative community perception about the project, educate more youth on SRH issues and consequently attract more members into the club.

### **5.3 KNOWLEDGE AND ATTITUDES RELEVANT TO SEXUAL AND REPRODUCTIVE HEALTH**

Even though the overall sexual and Reproductive Health knowledge and attitude results among respondents looks quite impressive, the results of others showed traces of misconceptions and myths. This trend is not restricted to this study but also is reflected in several other studies. In another study in Ghana, HIV/AIDS was the best known STI (with awareness almost universal) but significant misconceptions was exhibited by respondents – few people knew that one could get HIV from blood transfusion and from the mother to child. (G. S. M. F et al 2000). In a study in Zimbabwe, 78% could name at

least one STI, but knowledge of symptoms (17%) and consequences of STI's was low (15%). Seventy three percent knew about HIV/AIDS but misconceptions about modes of transmission were common (Kasule J. et al 1997). One of the major findings in another study revealed that whereas awareness of AIDS was high, fewer than half of young women in Burkina Faso, Mali and Senegal could indicate correct knowledge of HIV/AIDS preventive strategies (Maty M. et al 2002).

It appears that adolescents are ill informed rather than uninformed about sexual and reproductive health facts. Perhaps lack of a well-tailored system to consistently provide accurate information in the case of the Ejisu project may have affected the performance of the respondents. Many interventions worldwide have documented the necessity of such a system (simple curriculum) in improving the SRH knowledge and skills of young people (Bearman et al. 2001; [www.lifeway.com](http://www.lifeway.com); [www.choosingthebest.org](http://www.choosingthebest.org); [www.foxnews.com](http://www.foxnews.com)). Equally important to enhance the knowledge and skills of club members is the organization of training programs in relevant areas for project staff/facilitators.

#### **5.4 INHIBITING / FACILITATING FACTORS**

Every evaluation of a given project brings out indicators that either inhibit or facilitate the implementation of activities. Knowledge of such issues is to help strengthen the project. The study identified a number of such factors, key of which are community support as a facilitating factor and lack of involvement of young people in youth interventions as an inhibiting factor.

### Community Support

Health and educational programs for young people can accomplish little unless communities acknowledge that young people need special help and guidance to become sexually responsible adults (Population Reports 1995). The Study findings indicated that Community Support through the instrumentality of thirty Queen Mothers, Village Health Committee members and two health personnel have sustained the activities of the Ejisu Virgins program, even in spite of major setbacks. This goes to support of several programs worldwide that have documented the instrumental role of community support in project implementation. For instance, in Mexico a program enlisted community leaders to serve as outreach workers in poor communities and as a result the program achieved results (Population Report 1995). In Jamaica, the use of community leaders in the design, implementation and monitoring of health services for young people ensured that the program was accepted in an area where community dissension had undermined previous efforts (Vadies E et al, 1990). Ensuring community support is both vital and challenging for reproductive health programs for young people. It requires helping parents and leaders to understand health issues inherent in young peoples sexual behaviour, to recognize the need for program action to agree on solutions and to work with and trust health professionals to carry them out (Brindis, C. D 1991).

### Involvement Of Club Members In Management Issues: Youth Involvement

While youth are increasingly included in the design and implementation of interventions, adults in youth – serving organizations have made fewer efforts to involve youth in

policy, management and evaluation issues (Youth Lens 2003). This is a case identified by the survey. From the findings of this study, it is clear that club members are not involved in the planning and implementation of club activities. The need to involve young people in youth interventions cannot be over emphasized. Increasingly donors and non governmental organizations involved in reproductive health issues are attempting to make young people a more prominent part of programming (Youth Lens 2003).

It is very important for the Ejisu program to consider youth involvement. The World Health Organization has advised that youth should be involved from the start as full and active partners in all stages from conceptualization, design, implementation, feed back and follow up (WHO, 2001). Literature indicate that involving young people in programs helps them form higher aspirations, gain confidence, attain resources, improve skills and knowledge, change attitudes and develop more meaningful relationships with adults (Rajani R 2000). For example a study in the Mathare Youth Sports Association (MYSA) of Kenya reveal that the success of the youth led club was based on the fact that the club treats the skills and ideas of Youth as its strongest resources. The MYSA offers reproductive health education while operating football teams and other community projects. The club was founded on principles carefully formulated by youth themselves. The office uses the skills of youth members to carry out management duties and utilizes a bottom-up structure for decision-making (Transgrad R, 1998).

Involving Youth in reproductive health programs can assist the programs themselves, increase credibility, visibility and publicity (Senderowitz, 1998).

## CHAPTER SIX

### 6.0 CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 CONCLUSIONS

Based on the findings of the study, the following conclusions have been reached:

- Between June 2001 and June 2004, a total number of 251 young girls identified themselves with the ideals of the project. However the majority of these young girls (100) who registered with the program in 2001 left the club, bringing the current club membership strength to 151.
- The lack of money to pay for transportation to attend club meetings, getting pregnant and having had the opportunity to get married accounts for some of the reasons why some girls joined but left the club.
- Of the current total club membership, majority of girls (98.7%) are primary virgins. Secondary Virgins constitute a minority (1.3%).
- The most successful of the project components has been Health education, which has been accessed by all club members. The Peer education component is yet to take off while the employable skills component has benefited only 20 (twenty) young girls so far.

- A number of factors appear to be hindering the potential of the project to achieve desired results, among which are:
  1. Negative perception of the project by some community members.
  2. Lack of well-prepared, coherent training/teaching curriculum.
  3. Inadequate Funding.
  4. Lack of effective follow up of drop outs.
  5. Low involvement of young girls on project management.
  6. Over concentration of project activities at Ejisu.
  
- Other factors have kept the club operational. These include:
  1. Community Support by Queen Mothers, Village Health Committee members and other opinion leaders.
  2. Commitment of Project Staff
  
- Program activities have largely influenced the HIV/AIDS - related knowledge, attitudes, and behaviors of club members but there a few gaps that needs to be addressed.
  
- The existence of the project is a clear demonstration of what communities can do to contribute to the national response to the HIV/AIDS pandemic. Communities do not always have to wait for government or external support before undertaking health interventions. As has been the case of the Ejisu program, communities can initiate interventions, operate the project on a small

scale, which can easily attract external support, at a later stage. When this example is emulated by other communities country – wide, Ghana will soon be covered with effective community programs aimed at protecting young people from the threat of HIV/AIDS/STI, as well as from teenage pregnancy.

- The findings have clearly outlined what it takes to improve young peoples' Sexual and Reproductive Health in relation to helping them to delay sexual debut. A holistic approach addressing the antecedents or determinants of particular behaviors is a requisite.
  
- Finally the project, in the wake of the identified and almost insurmountable challenges, has not folded up but continues to serve the needs of young people in the communities.

## **6.2 RECOMMENDATIONS**

Again, based on the findings and the conclusions reached, the following are recommended to strengthen the project:

**6.2.1** To help address the financial and logistical challenges of the project, the following strategies should be considered:

- Market the project through organization of tours to some notable organizations that provide technical/financial support for adolescent Sexual and Reproductive Health activities such as the Planned Parenthood

Association (PPAG), Ghana AIDS Commission (GAC), Action Aid, Ghana.

- Some NGO's such as Planned Parenthood Association Ghana operate Sexual and Reproductive Health franchising program where they provide technical and logistical support to CBOs, NGO's involved in the provision of information and services to young people. The virgins project could access such support programs.
- Develop and market proposal to agencies for funding.
- Cultivate the support of Transport Unions in the 30 project communities to help provide free or subsidized transport for girls to attend club meetings.

**6.2.2** There is the need to ensure the use of a simple guide or curriculum to ensure consistency and

accuracy of education provided to club members. The content should include:

- Teaching methods, which present accurate facts and techniques for dealing with risky situations, and emphasise the individual's responsibility to make wise choices.
- Information and skills on how young people can reject sexual advances.
- Information on behaviours such as drinking of alcohol and drug use that increases vulnerability to sexual advances.

- Information on the importance of attaining self-sufficiency before engaging in sexual activity
- Facts to the effect that:
  - Abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems.
  - Bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society.
  - Even if young people have already been sexually active, they are still in control of their future actions and that their choices will help determine their future life situations.

**6.2.3** Periodic training programs and refresher courses should be organized for project staff and facilitators in relevant areas such as ASRH, Communication Skills, Youth Friendliness and Community Mobilization.

**6.2.4** Most club members live with parents (84%). The project should seize this opportunity to promote increased parental involvement. Club members for instance, could be given home assignments that will require parental assistance.

**6.2.5** There is the need to emphasize education on STI and the relation between STI and HIV/AIDS.

**6.2.6** There is the need to organize periodic advocacy activities in each of the 30 communities and not in Ejisu alone as the norm has been. The activities should gear towards providing accurate information about the project, correct wrong impression about the project and finally to whip up community support for the project. Channels such as durbars, festivals, church services, School P.T.A meetings, general assembly activities of school etc could be used.

**6.2.7** Implementation of Behaviour Change Communication activities in each of the 30 communities to attract more members especially the 10 – 14 years age group and secondary virgins.

Suggested mediums to be used should include:

- Periodic route marches by club members through the town carrying abstinence messages
- Signing of abstinence cards during rallies and also during “bragoro” (puberty rite) ceremonies.
- Holding talk shows on the local FM Stations.

**6.2.8** To help provide regional and national awareness, the following activities could be organized.

(These activities also constitute potential sources of attracting support.)

- An organized trip to visit important personalities such as President of Ghana, Minister of Health, Regional Minister of Health etc.

- Participation in popular educative TV talk shows such as Mmaa Nkomo (GTV) and Love Web (TV3).
- Inviting a journalist to monitor and report project activities in the media. Success stories/human interest stories are important areas to be featured in the media. This also has the potential to attract support for the project.

**6.2.9** To make club membership more youth appealing and fashionable the following should be considered:

- Getting sponsorship to provide customized T-Shirts for members.
- Providing more edutainment activities.
- Getting Sponsorship for the provision of free health insurance for members.

**6.2.10** Of overriding importance is the need to decentralize the project system into the communities. Instead of concentrating all major activities at Ejisu, each community should be empowered to operate. This will solve so many problems such as lack of money to pay for transportation etc. All activities whether major or minor should be held in each community unless for a convention or other purposes which will require all the members to convene at one location. An effective monitoring system should be put in place by the project staff.

**6.2.11** The current club membership shows a decline in the population of girls who joined the club at its inauguration in February 2001. They constitute only 23.2% of respondents. It is important for project implementers to research into this phenomenon and employ strategies to retain old members.

**6.2.12** The Ejisu – Juaben DHA, should disseminate the findings of this study at an assembly meeting at the District Assembly to enable local government and assembly persons have first hand information on the project. The forum should also be used by the DHA to acknowledge the support of all stakeholders who have helped to advance the course of the project namely:- Queen mothers, the Village Health Committee members and the two Project Staff.

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## **APPENDIX**

**APPENDIX 1**

**ASSESSMENT OF EJISU VIRGINS PROJECT  
QUESTIONNAIRE – (MEMBERS OF VIRGINS CLUB)**

<b>IDENTIFICATION</b>
LANGUAGE USED IN INTERVIEW 1=ENGLISH 2=AKAN 3=OTHER (SPECIFY).....
INTERVIEWER NAME.....
SUPERVISOR SIGNATURE.....
DATE OF INTERVIEW.....

**INTRODUCTION**

Hello, my name is ..... and I represent the School of Public Health, University of Ghana. Thank you for taking the time to talk to me. The virgins club project has been ongoing for sometime and it is important that it is assessed so that lessons learnt will be used to modify, expand or replicate it in order that it will be beneficial to many more youth. I will be asking you questions about yourself, your ideas, attitudes, and behaviour on various issues.

This is not a test. Your experiences are important. I want you to be honest and truthful in answering the questions. Your answers will be confidential. Your parent/guardian, family members, project managers, or anyone in the community will not see the form I will fill out or know any answers you give to my questions.

Some of the questions I will ask you are personal. Nothing you say will shock me; it is most important to me that you are truthful and feel comfortable. However, your participation is entirely voluntary, and you don't have to answer any questions you don't want to. But your co-operation and assistance will be very helpful in developing programs for young people here and in the entire country.

I will first ask you my questions. After that, if you have any questions for me, you can ask.

Is there a place we can go where the discussion will be private? **(SUGGEST A PLACE IF RESPONDENT DOES NOT.)**

001. Do I have permission to continue?

1=yes

0=no (END THE INTERVIEW)

002. **TIME INTERVIEW BEGINS. .... :AM / PM INTERVIEW ENDS ..... AM / PM**

**SECTION 1. BACKGROUND INFORMATION**

101. Please answer the following questions about yourself. How old are you now?

.....years

102. What is your religion?

1=Moslem                      3=Catholic  
2=African tradition    4= other Christian    5=other                      (*specify*  
.....)

103. With whom do you live **most** of the time?

1=both parents                      3= other relative                      5=Friend  
2=father only/mother only                      4= my self                      6 other  
(specify.....)

104. Who is the **main** person responsible for your up keep?

1=both parents                      3= other relative                      5=Friend  
2=father only/mother only                      4= my self                      6 other  
(specify.....)

105. What is the highest level of formal education you have reached?

1=Never been to school                      3= JSS/Middle                      4=technical/ vocational/  
commercial  
2=Primary                      4=S/Secondary                      5=other (*specify*.....)

106. Are you currently in school?

1=yes →section 2                      0=no

107. If no, what is your **main** occupation?

1=salaried worker                      4= artisan (trade master)                      7=unemployed  
2=farming/fishing                      5=trade apprentice                      8=other  
(specify.....)  
3=trading/small scale business                      6=casual worker



**SECTION 2: THE VIRGINS CLUB**

Now I would like to ask you some questions about your club

201. How did you learn about the virgin’s club?

- 1= Friends
- 2=Siblings/Family member
- 3=Project staff

202. When did you become a member of the virgin’s club?

- 1=less than 6 month
- 2= 6 to 12months
- 3= More than 1 but les than 2 years
- 4= More than 2 years

203. What was your **main** reason for becoming a member?

- 1=To make friends
- 2=to get good husband in future
- 3=To gain employable skills
- 4=To gain skills to abstain
- 5= Parent/Guardian asked me to join
- 6=Other (Specify.....)

204. What are some of the benefits you have had since you joined the club? (**PROBE ANYTHING ELSE? CIRCLE ALL MENTIONED**).

- 1=Employable Skills Training
- 2=Health education
- 3=Been trained as Peer Educator
- 4=Met important personalities
- 5=Made Friends
- 6=Counselling
- 7=Gained Skills to abstain
- 8=Other (-----)

205. What challenges have you had since you joined the club?

- 1=Friends tease me
- 2=Unable to mix with opposite sex
- 3=Boys do not ask me for date
- 4=Other

(specify.....)

**SECTION 3: SEXUAL PRACTICES & BEHAVIOUR**

301. Sometimes young people have sex. They do this for different reasons -- for love, for urges, or because they are convinced, forced or tricked. Have you ever had sex?

- 1=yes
- 0=no →311

302. How old were you when you had sex for the **first time**? (**PROBE FOR AGE IN YEARS**)

- ..... years
- 97=don’t know

303. What was your relationship to the first person you had sex with?

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1=boyfriend  
2=girlfriend

3=family member (incest)  
4=teacher

5=other (*specify*.....)

304. When was the last time you had sex?

1= < 3 months  
2= 3 to 6 months

3=> 6 months to 1 yr  
4= >1 year

305. What was your relationship to the **last person** you had sexual intercourse with?

1=spouse  
2=girlfriend  
3=boyfriend

4=family member (incest)  
5=teacher  
6= friend

7=employer  
8=stranger  
9=commercial sex worker  
10=other (*specify*.....)

306. Since you joined the club, have you been pressured by anyone to have sex?

1=yes

0=no→310

307. Did you have sex as a result of the pressure?

1=yes

0=no→308

308. When you had sex as a result of the pressure, did you talk to any of your project managers or club members about it?

1=Talked to Project Staff  
anyone

2=Talked to club member

3=Did not talk to

309. Give reasons for not talking to any of them?

1=Felt shy  
anyone

3=Ashamed to do so

3=Did not have confidence to tell

2=Did not consider it important

5=Other

(.....)

310. What did you do to avoid having sex despite the pressure?

311. If you should ever have sex as a result of pressure, will it be very easy, easy, somewhat difficult, or very difficult to tell another club member or a project staff about it?

1=Very Easy  
Difficult

2=Easy

3=Somewhat Difficult

4=Very

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**SECTION 4: ATTITUDE AND PERCEPTION ABOUT ABSTINENCE**

Now I would like to ask you some questions about abstinence

401. Do you think it is possible to abstain even if you have had sexual intercourse before?

1=yes                      0=no

402. Are you able to abstain till marriage?

1=yes                      0=no

403. What is the **main** reason for your response?

- 1=To avoid getting STI/ HIV/AIDS                      3=To concentrate on trade/school  
 2= It is against God’s will/sin                      4=To avoid unwanted pregnancy  
 5=Other.....

404. I would like to ask you a few questions about sex and abstinence. I will read some statements and I would like you to tell me whether you agree or disagree with the statement. **(READ EACH STATEMENT. ASK “DO YOU AGREE OR DISAGREE?” TICK THE APPROPRIATE BOX.]**

STATEMENT	AGRE E	DISAGR EE	DON’ T KNO W
a. When a girl says “no” to sex, she usually doesn’t mean it.			
c. Its okay for young people from poor families who need money for school or learn a vocation to have sex with someone in exchange for gifts or money			
d. A young boy or girl who does not have sex becomes a fool			
f. Young boys who abstain from sex would have swollen testicles			

405. I am now going to read some issues to you and I want you to tell me the main person you would discuss the issue with and where you go to get the issue addressed. Use responses given in Ejisu virgins project

**codes in table**

ISSUE	411. Who would you talk to	
a. Problems related to sexual urges		
b. Problems related to pressures to have sex		
c. If you mistakenly have sex		
<b>CODES</b>	<b>1=parent</b> <b>2=sibling</b> <b>3=Other relative</b> <b>9=other(specify.....)</b>	<b>6=pastor/Imam</b> <b>7=Project staff</b> <b>8=teacher</b>

406. Do you receive adequate support/encouragement from the project staff to enable you abstain from sex?

1=yes

0=no→SECTION 5

**SECTION 5: STDs & HIV/AIDS**

501. Please tell me the names of any diseases you know that one can get through sexual intercourse. **(PROBE: "ANYTHING ELSE?" CIRCLE ALL MENTIONED).**

1=HIV/AIDS

5=herpes

2=gonorrhoea

6=warts

3=syphyllis

7=don't know

4=Candidiasis/White

8=other(specify.....)

502. Please tell me what symptoms a person might have that suggest that he or she has a sexually transmitted disease (**apart from HIV/AIDS**). **(PROBE: "ANYTHING ELSE?" CIRCLE ALL MENTIONED).**

1=discharge from penis/vagina

4 = warts

2=burning, pain, or itching in penis/vagina

5 =other (specify.....)

3=sores on penis/vagina

6=don't know

503. What are the ways one can avoid getting STDs? **(PROBE, "ANYTHING ELSE?" CIRCLE ALL MENTIONED)**

1=abstinence

3=avoiding casual partners

5=don't know

2=use of condom

4=Being faithful to partner

6=other (specify

.....)

**CHECK Q 301: EVER HAD SEX**

**IF YES**

**IF NO**

↓  
**CONTINUE BELOW**

↓  
**GO TO Q509**

504. The last time you had sex, did you do anything to avoid getting an STD?

1=yes

0=no [GO TO Q508]

7=don't know (GO TO Q508)

505. What did you do? (**PROBE: "ANYTHING ELSE?" CIRCLE ALL MENTIONED**).

1=used a condom

3= used a contraceptive method

(specify.....)

2=washing/douching

4= other (specify.....)

**GO TO Q509**

506. What is the **main** reason you did not do anything? ( **ASK FOR THE ONE MAIN REASON**)

1=did not know what to do

3=condoms not available

5=embarrassed to

purchase condom) 2=partner is faithful

4=partner was a virgin

6= other

(specify .....

507. Please mention all the ways in which HIV/AIDS is transmitted. (**PROBE: "ANYTHING ELSE?" CIRCLE ALL MENTIONED**).

1=sexual intercourse

4=mother to fetus transmission in utero

2=sharing needles, unsterilised

5=other (specify .....

medical/shaving equipment

97=don't know

3=blood transfusions

508. How can people protect themselves from getting HIV/AIDS? (**PROBE: "ANYTHING ELSE?" CIRCLE ALL MENTIONED**).

1=avoid sex completely, abstinence

6=avoid sharing needles/sharp objects

2=stay faithful to each other partner

7= avoid casual sex

8= avoid blood exchange

97=don't know

4=use condoms for every sexual intercourse

10=other

(specify.....)

Ejisu virgins project

509. Please mention all the Symptoms that suggest that a person has AIDS

- 1=loss of weight
- 2=skin lesions  
(specify.....)
- 3=thinning of hair
- 4=persistent diarrhoea
- 5=persistent cough
- 6=frequent illness
- 7=Boils
- 8=other
- 9=don't know

510. About how long does it take someone who has acquired HIV to develop AIDS?

.....years                      97=Don't 'know

511. What can a person who has HIV/AIDS do to prolong his/her life? (CIRCLE ALL MENTIONED).

- 1=Eat balanced diet
- 2=seek medical care
- 3=Do regular exercises
- 4=other (specify.....)

512. I am now going to read some statements to you about HIV/AIDS. As I read each statement, tell me if you think it is true or false. (READ EACH STATEMENT. ASK, "IS THIS TRUE OR FALSE?" TICK THE APPROPRIATE BOX.)

STATEMENT	TRU E	FALS E	DON' T KNO W
A. A healthy looking person can be carrying the AIDS virus.			
D. Infection could be through sharing eating utensils with an infected person.			
E. One can get AIDS through mosquito, flea, or bedbug bites.			

513. Do you think you are at risk of getting HIV?

1=yes                                      0=no

514. Give reasons for your response?.....

.....  
.....

**SOURCE OF INFORMATION ON ABSTINENCE/ SEXUALITY/HIV/AIDS/STD**

515. Mention three (3) key sources of information on:

SEXUALITY (Number relevant answers in order mentioned)

Ejisu virgins project

.....  
.....  
.....

ABSTINENCE (Number relevant answers in order mentioned)

.....  
.....  
.....

HIV/AIDS (Number relevant answers in order mentioned)

.....  
.....  
.....

**THANK RESPONDENT AND END INTERVIEW**

Ejisu virgins project

## APPENDIX 2

### ASSESSMENT OF EJISU VIRGINS PROJECT

#### FOCUS GROUP DISCUSSION GUIDE (*MEMBERS OF VIRGIN CLUB*)

##### **Introduction:**

We are grateful you have made time for this exercise. Please be assured that your presence is very important to us and everything you say will be confidential. We will be discussing issues relating to The Virgin's club. Please I'm interested in all ideas, comments and suggestions you offer. In this discussion there are no right or wrong answers. All comments both negative and positive are welcome.

*Thank you.*

- a. *Introduction of Moderator and Discussants.*
- b. *Explain rationale.*
- c. *Purpose of recorder.*
- d. *Rules for the discussion .*
- e. *Role of Moderator and Assist Moderator.*

Make sure all the discussants are well seated. Check the recorder to make sure it is working. The recorder should be placed such that it can pick all the voices of participants.

Ejisu virgins project

What do you think about the traditional puberty rites?

Do you think it has a role in the present?

Any suggestions to improve or adapt ways of doing things?

What are the objectives of the virgins club?

What were your motivations for joining the club?

Tell me about all the activities you undertake as a member of the virgins club. If not mentioned Ask about Peer Education

Employable skills training

Health Promotion activities

How many have undergone employable skills training and what are their views about the program?

In the past 3 months have you received any information from the club in any of the following? (for each probe for content)

Puberty and associated physical and emotional changes

Sexuality

STDs/HIV/AIDS

Ejisu virgins project

What changes have you observed in your lives since you joined the club? (Positive, Negative)

What are your perceptions of those who are not members of the club? What about those who were once members but had to leave for one reason or the other?

How many of us have girl friends who do not belong to the club

How do your friends who are not members of the club perceive you? (Probe for reasons)

What are some of the ideas they have about virginity?

How many of us here have boy friends or friends who happen to be boys?

How would you describe your relationship with the opposite sex since you joined the club?

What are some of the benefits of becoming a member?

What are some of the challenges/disadvantages of being a member of the club?

Give suggestions for improving the programme.

## APPENDIX 3

### ASSESSMENT OF EJISU VIRGINS PROJECT

#### FOCUS GROUP DISCUSSION GUIDE (Queen Mothers)

##### Introduction:

We are grateful you have made time for this exercise. Please be assured that your presence is very important to us and everything you say will be confidential. We will be discussing issues relating to The Virgin's club.. Please I'm interested in all ideas, comments and suggestions you offer. In this discussion there are no right or wrong answers. All comments both negative and positive are welcome.

*Thank you.*

- b. *Introduction of Moderator and Discussants.*
- c. *Explain rationale.*
- d. *Purpose of recorder.*
- e. *Rules for the discussion .*
- f. *Role of Moderator and Assist Moderator.*

Make sure all the discussants are well seated. Check the recorder to make sure it is working. The recorder should be placed such that it can pick all the voices of participants.

What are the objectives of the project?

What are your perceptions of the various components (Peer Education, Health Promotion, Employable skills training) of the club's activities?

What is the role of the traditional puberty rite in the project?

In what ways do the community members (Community leaders, parents etc) support the project?  
(eg funds, in kind contributions, positive public statements about project etc)

What support system is available for girls who turn 25 years and are unmarried? Do these cease to be members of the club?

What are some of the strengths/benefits of the programme? (To girls and community)

What are the major weaknesses/challenges of the project?

How has the project performed so far?

How do you intend to sustain the program?

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## **APPENDIX 4**

### **ASSESSMENT OF EJISU VIRGINS PROJECT**

#### **INDEPTH INTERVIEWS (PROJECT MANAGEMENT TEAM)**

What are the objectives of the project?

Who are the stake holders and what are their various roles in the project?

How is the project supported? Who are the sponsors (financially, in kind)

How are girls enrolled into the programme (criteria for selecting members)

How many girls did you start with? How many were primary virgins and how many were secondary?

How many girls are on enrolment currently?

How many successfully went through the programme until they got married?

Has there been any dropout since the project began? (Probe for reasons for dropouts)

Were girls who dropped out followed-up and what were the results of the follow up?

What provision has the programme to support girls who are not very successful in abstaining?

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What is the purpose of the support groups? How many have so far been formed?

How many girls have benefited from the various activities available? Peer Education, Health Promotion, Employable skills training).

How are the young virgins involved in the decision-making processes regarding the management of the project?

What support system is available for girls who turn 25 years and are unmarried?

What happens if any girl is found to have engaged in sexual intercourse after joining the programme?

What are the next steps after the girls undergo the employable skills training? What support system is in place to help them start on their own?

What are some of the strengths/benefits of the programme?

What are the major challenges of the project?

What is the way forward? Future plans

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