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Localizing the international: examining how fieldworkers combat adolescent pregnancy in northern Ghana

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**Localizing the international: examining how fieldworkers combat
adolescent pregnancy in northern Ghana**

A Capstone Project Submitted in Partial Fulfillment of the Requirements of
the Renée Crown University Honors Program
Syracuse University

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Abstract

International aid is often ineffective because it is delivered without an understanding of local ideologies and contexts. My Capstone examined whether or not international aid in northern Ghana could be effective when addressing adolescent pregnancy. The Ghanaian programs I address in my Capstone are six non-governmental organizations, a government sub-district clinic and government junior high schools. The majority of my data was collected through interviews with individuals at all levels of the organizations, including directors, staff members, volunteers and individuals seeking the organization's services. Alongside interviews I also spent time in the field, participating in youth group discussions, visiting regional training centers for skill-based education, and observing the daily interactions at a maternal healthcare clinic. I also examined the developmental history of northern Ghana to gain a better understanding of the contexts within which this aid was utilized.

My findings show the ways northern Ghanaian fieldworkers utilize international funds, and how ideologies and volunteers ensure that the services' northern adolescent women and mothers can access are specific, multi-faceted, and effective. They work not only to decrease adolescent pregnancy rates, but also to improve the livelihoods of marginalized women across the North. Fieldworkers are able to utilize this aid while simultaneously juggling local customs, a history of systematic underdevelopment, and a disconnect from southern Ghana. Despite these constraints, this network is imperative to the northern community, especially when governmental efforts to address adolescent pregnancy thus far have been inadequate and unable to meet the needs of the North, despite over fifty years of unification as a nation. The network demonstrates that international aid can be effective so long as it is channeled by local fieldworkers, who can better adapt Western aid to specific, local needs and adapt the ideologies of the aid to the local worldview.

Executive Summary

In recent decades, adolescent sexual and reproductive health has become a main focus of international debate. In Ghana, these debates have been met with policies addressing the rights of adolescents, improved health care for young adults, and increased awareness about contraception use. The attempts to improve the nation's health, however, have not been equally distributed. While adolescent pregnancy rates in southern cities and regions have steadily decreased, rates in the three northern regions have either stagnated or increased. With so many young women becoming pregnant between ages 15-19, the government's services are inadequate, leaving many adolescent girls stranded and in need of proper care.

Northern Ghana, however, receives multi-faceted support from international funds and organizations, some of which are dedicated to providing preventative services and to alleviating the problems associated with adolescent pregnancy. With an awareness of the double-edged sword of Western volunteerism, I was drawn to the North and its international organizations. I set out see whether or not international aid could effectively address adolescent pregnancy. My capstone argues that more than a century of systematic underdevelopment of northern Ghana has increased its disparities with southern Ghana. That, in combination with local culture has led to the under-education of the population, especially girls. This in turn has produced a problem of adolescent pregnancy, which governmental institutions and organizations are incapable of addressing on their own. Northern Ghanaian organizations and fieldworkers have stepped in, utilizing international ideologies, funds and resources to advance adolescent pregnancy prevention and promote care within their own local cultural contexts.

Towards the end of the 19th century, British colonial officials acquired the northern region as a Protectorate. Unlike its Gold Coast Colony, Great Britain stunted all economic growth in the North. Northerners were valued only as slave labor in the Colony; as a result, British officials developed almost no infrastructure and limited the number of schools developed. This underdevelopment not only hindered the Protectorate economically, but also ensured that traditional religious and family-rearing practices continued well into the 20th century, impacting the current state of adolescent pregnancy.

Upon the unification of the Gold Coast and the Northern Protectorate, the southern half was far more developed than the northern half. President Nkrumah attempted to solve this issue through improving education in the North. Ghana simultaneously developed family planning policies and programs. In reality, though, educational development was stopped before it really began, family planning programs were underfunded, and the policies were ineffective, leaving the North further distanced from the South. The North-South divide is still apparent today, and Northerners see themselves as disconnected from their Southern countrymen.

By understanding the history of northern Ghana's development, it is easier to understand the intricacies and nuances organizations and fieldworkers must navigate when going to communities to provide services or implement programs. The programs I address in my Capstone are six non-governmental organizations, a government sub-district clinic and government junior high schools. The majority of my data was collected through interviews with individuals at all levels of the organizations, including directors, staff members, volunteers and individuals seeking the organization's services. Alongside interviews I also spent time in the field, participating in youth group discussions, visiting

regional training centers for skill-based education, and observing the daily interactions at a maternal healthcare clinic.

The services provided by all eight organizations were either to prevent adolescent pregnancy or to help adolescent mothers. These services were supported by a variety of international influences, including financial support, international ideologies, and international volunteers. Although the services were supported by international influences, all fieldworkers I met were local northern Ghanaians. They campaigned to local leaders to implement these programs and manipulated Western ideology so that it was well received. They also directed the extent to which international volunteers could go into the field. Because of their diligence, international influence was administered in such a way that it did not harm adolescent girls, mothers, or their communities.

Community members and NGO fieldworkers viewed the preventative services provided by the governmental organizations as inadequate. The Ghana Education Service (GES) failed to provide students with accurate information on sexual reproductive health or to keep girl students in the classroom. The Ghana Health Service (GHS), although it had created adolescent-friendly programs, could not provide as much care as was needed to a majority of adolescents. To supplement these services, organizations and fieldworkers created programs based on Western-style sexual education and “safe sex” over abstinence. These programs were either held in the Tamale Municipal, or introduced to communities under the approval of local leaders through youth ambassadors. Fieldworkers also were often trained to be “youth-friendly” and to guide adolescents towards appropriate contraceptive methods without imposing their own views.

The government services provided for adolescent mothers were also seen as inadequate. The GHS nurses I worked with stressed the effort they made to help young mothers feel comfortable and to provide them with as much care as possible. Unfortunately, the North's rural environment meant that clinics such as these were few and far between. This forced NGOs to go out into the communities and establish support networks that could transport mothers to clinics or even to build clinics in communities where none existed. After mothers gave birth, little effort was made by the government to reintegrate them into the school system, even though many adolescent mothers are only in junior high school. Organizations attempted to rectify this situation by providing opportunities for girls to obtain an education or find employment close to where they lived, making it easier to care for their infants.

Although northern Ghanaian fieldworkers are constrained by their disconnect from the South, which is made more difficult by the historical systematic underdevelopment, the ways in which they utilize international funds, ideologies, and volunteers ensures that the services northern adolescent women and mothers can access is specific, multi-faceted, and effective. Services not only decrease adolescent pregnancy rates, but also improve the livelihoods of marginalized women across the regions. This network of services is imperative to the northern community, especially when governmental efforts thus far have been inadequate and unable to meet the needs of the North, despite over fifty years of national unification. Ultimately, international aid can be effective so long as it is channeled by local fieldworkers, who can better adapt Western aid to specific, local needs and adapt the ideologies of the aid to the local worldview.

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List of Abbreviations

AIDS – acquired immunodeficiency syndrome
ASRH – adolescent sexual and reproductive health
CHT – Community Health Team
DANIDA – Danish International Development Agency
DfID – Department for International Development (United Kingdom)
GES – Ghana Education Service
GHS – Ghana Health Service
GIGDEV – Girls Growth and Development
GNFPP – Ghana National Family Planning Program
FOMWAG – Federation of Muslim Women’s Associations
IUD – intra-uterine device
JHS – junior high school
HIV – human immunodeficiency virus
IPPF – International Planned Parenthood Federation
LPS – Life Planning Skills
MCH – Maternal and Child Healthcare
MDG – Millennium Development Goal
NGO – non-governmental organization
NORSAAC – Northern Sector Action on Awareness Center
PPAG – Planned Parenthood Association of Ghana
PSG – Pregnancy Support Group
RAINS – Regional Advisory Networking Systems
RME – Religious and Moral Education
SRH – sexual and reproductive health
SIT – School for International Training
STI – sexually transmitted infection
UN – United Nations
UNICEF – United Nations Children’s Fund
UNPF – United Nations Population Fund
USAID – United States Agency for International Development
WERSD – Women Empowerment and Relief Services for the Destitute
WHO – World Health Organization

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Chapter 1

Introduction

In 2007, the World Health Organization (WHO) published a report on the global realities of adolescent pregnancy. It addressed the physical, mental and social health problems adolescent girls faced as result of adolescent pregnancy; documented the care adolescent girls sought throughout and after their pregnancy; detailed the existing programs that cared for adolescent mothers; and recommended policies or programs that could be implemented to further help adolescent mothers and eventually decrease rates of adolescent pregnancy. The study was published because between 1985-2000, “an estimated 14 million young women aged 15-19 years gave birth every year...with 12.8 million births occurring to adolescents in the developing countries” (WHO 2007, viii). These alarmingly large numbers, as well as the numerous problems that these 14 million girls faced, spoke to the fact that adolescent pregnancy is an international problem that must be addressed. It is but one of the many reports on adolescent sexual reproductive health (ASRH) that have been issued in the past decades, calling upon the international community to raise awareness of these issues and do everything in its power to help these vulnerable young adults.

When the WHO publishes reports like this, with the intent of bringing together an international community, the response is never quite as ideally ‘international’ as one wishes it would be. This is because of those 14 million adolescent mothers, over 90 percent of them live in the “developing world,” the global South which for the past half century has been on the receiving end of international “help.” In an effort to end problems such as adolescent pregnancy, countries which have been classified as

“developing” receive immense amounts of aid in the form of money, organizations, and volunteers from the more fortunate “developed” countries. This Western aid is always well intended; it comes in an effort to provide relief to those who are struggling. When addressing adolescent pregnancy, this international aid often comes bearing Western contraceptives, Western-educated doctors and health professionals, and programs designed to provide adolescent mothers with the best care Western money can provide. Upon arrival, however, Westerners find that the aid they wished to provide does not help as planned. Rather, this foreign aid continues the cycle of Western intrusion into non-Western societies, where countries once under colonial occupation still rely upon the colonizers for money, aid, and direction that never truly gets to the root of the problems. In the realm of adolescent pregnancy and ASRH, this vicious cycle has been ongoing since the introduction of international family planning programs in the fifties and sixties.

International efforts to end international problems such as adolescent pregnancy struggle because while the problems themselves might be global, the causes for them are deeply rooted in the local. Although blanket statements such as under-education and poverty are cited as causes of adolescent pregnancy, each community has a different history as to why its girls are under-educated and poverty stricken. One must look at the pre-colonial traditions, the colonial history, and the post-colonial development of the country one is aiding if one is to truly understand the societal reasons behind why adolescent pregnancy is such a problem. Often one must go even beyond the national level and look at regional or community-level histories in order to accurately understand the situation one is getting into. Thus, when one understands that adolescent pregnancy is

an international problem with a local causation and influence, one would then assume that international care must be guided and influenced by the local as well.

Despite the seemingly obvious correlation that local problems must receive locally-guided care, international aid still struggles to make a positive impact when working to address adolescent pregnancy. It brings to light the inadequacies of international organizations and individuals who utilize international funds in an effort to provide services for problems that are as foreign to them as they are to the places in which they work. Unfortunately, though, this inadequate care is sometimes the only care provided for adolescent mothers, especially in rural and impoverished areas. What, then, should the international community do? How can international donors and volunteers consciously allocate their resources so that they provide services that are realistic, effective, and long-term? How, then, can the international community help?

These are the questions I asked myself when I arrived in Tamale, the capital of Ghana's Northern Region. The Northern Region, as well as the two other northern regions (Upper East and Upper West), make up almost half of Ghana's landmass (Pellow 2014). Despite its size, the North is far less densely populated; Tamale is the largest and busiest city in the area, making it the unofficial capital of the area. While the city is rapidly growing and urbanizing, the northern regions still remain largely rural and unindustrialized. They are also far more impoverished than Ghana's southern half, an impossible detail to miss as I journeyed the 12-hours between Accra and Tamale. Because of its history of poverty, Tamale is the epicenter through which international aid is distributed across the North. This, too, was impossible to miss; evidence of this international presence is everywhere, from the billboards advertising international

organizations that lined the main streets towards Tamale center, to the young white do-gooders navigating the art markets. In Tamale, international aid is seemingly everywhere. With an interest in ASRH, as well as an awareness of the double-edged sword of Western volunteerism, I was drawn to Tamale and its international organizations. I set out to contextualize the city and its people, to understand how their development led to the creation of a multi-faceted network of care that utilized the local, the national, and the international to address adolescent pregnancy. In doing so, I hoped to discover if and how international aid could be effectively utilized to provide locally-guided care to some of Ghana's most marginal and vulnerable girls. My capstone argues that more than a century of systematic underdevelopment of Northern Ghana has increased its disparities with Southern Ghana. That, in combination with local culture has led to the under-education of the population, especially girls. This in turn has produced a problem of adolescent pregnancy, a problem which governmental institutions and organizations are incapable of addressing on their own. Northern Ghanaian non-governmental organizations and fieldworkers have stepped in, utilizing international ideologies, funds, and resources to advance adolescent pregnancy prevention and promote care within their own local cultural contexts.

Chapter 2

Methodology

This paper combines analyses of historical, academic, and governmental documents as well as research I collected while studying abroad in Ghana with the School for International Training (SIT). During the spring 2014 semester, I spent six weeks conducting independent research in the Northern Region, as well as examining the sexual education curricula of government public junior high schools. The original purpose of the research was to conduct a comparative analysis between organizations that received international funds and those that did not. After completing my time in Ghana, however, I found all non-governmental organizations (NGOs) and governmental organizations I worked with had contact with some form of international influence, be it ideological or economic or with individuals.

I conducted the majority of my research in Tamale. The city boasts numerous international and local NGOs, many of which are no more than a few miles from the city center. By working out of Tamale, I had access to multiple organizations, without having to travel a far distance, and was also able to utilize connections I made at one organization to gain access to and information about other local organizations that were not a part of my preliminary research. I also spent two days working in communities surrounding Tamale Municipal. I was able to visit income-generating skills training centers in Tolon, Bognayili, and Savelugu, none of which is more than an hour away from Tamale city center.¹ Throughout this time, I worked with six NGOs and one Ghana Health Service (GHS) clinic, as well as one Ghana Education Service (GES) school in the

¹ See Appendix 1 for a map of Northern Ghana and the surrounding communities I visited.

Kumasi Region. Although the school I worked with was not located in Tamale or northern Ghana, the curriculum used was a national one, and thus would be the same material taught at public schools in the North.

The six NGOs I researched were: the Planned Parenthood Association of Ghana (PPAG), a branch of the International Planned Parenthood Federation (IPPF); Girls Growth and Development (GIGDEV), dedicated to providing skills-based and primary education for marginalized girls and adolescent women in the Tamale area; the Northern Sector Action on Awareness Center (NORSAAC), which implements ASRH education in and outside of school systems, as well as fosters community support networks for mothers in areas where access to health care is limited; the Regional Advisory and Information Networking Systems (RAINS), which finds innovative ways to educate young adults on ASRH and break down the stigma of contraception; the Federation of Muslim Women's Association of Ghana (FOMWAG), which utilizes Islam as a means to empower women to educate themselves and their daughters on a variety of issues; and Women Empowerment and Relief Services for the Destitute (WERSD), which introduces marginalized women to advocacy, empowerment, and education about their legal rights. The two governmental organizations I researched were the Kalpohin Health Centre, a GHS sub-district clinic that catered to maternal and child healthcare (MCH) and the Senkyi Junior Secondary School, a village school in Kumasi.

By including both governmental and non-governmental organizations, I compared the ways in which the two types of organizations utilized the international and the local to address, prevent, and treat adolescent pregnancy. I was also able to examine the ways in

which governmental and non-governmental organizations interacted with each other in an effort to achieve the same goals.

The majority of my research was obtained through formal and informal discussions had with various informants. I was able to talk with directors of NGOs, staff of NGOs, nurses, teachers, clinic patients, adolescent mothers, and constituents of NGOs. I spoke with NGO directors because I assumed they would have the most direct contact with international influences. I believed they would be the individuals reaching out to international donors, creating and managing programs, and hiring the staff who went into the field. They were often also the first individuals I contacted when reaching out to an organization, and they provided me with the contacts necessary to go into the field and interact with staff and constituents. I spoke with staff, including teachers and nurses, because they implemented organizations' programs and had the most direct contact with the communities that directors hoped to impact. I believed they would be the individuals who understood the challenges or successes of introducing potentially controversial programs into traditional communities. I spoke with constituents to better understand the local reception of these programs. I believed that individuals seeking preventative or care-based services would provide me with an idea of how successful these organizations were at doing their jobs. In compiling information from all levels of an organization, I was able to obtain a better understanding of the work it did.

At the beginning of the interview all participants were informed that should they feel uncomfortable with a question, they could refuse to answer or redirect the conversation in another direction. The most common local language spoken in Tamale and the surrounding districts is Dagbani, and many of the individuals I interviewed spoke

Dagbani rather than English. An individual who spoke Dagbani was present at all interviews to assist with translation. Because any child under the age of 18 must have consent to be formally interviewed, and most adolescents I met were not with their parents or guardians, all mothers mentioned in this paper were currently of age to be interviewed. Adolescent mothers' surnames have been excluded for reasons of confidentiality. All interviews occurred face-to-face.

The research I conducted was participative and observatory. I sat in on check-ups for infants and their adolescent mothers, classrooms engaged in discussions on contraception, and three skills-based training programs. I conducted my own discussions with young adults about their perceptions on ASRH and adolescent pregnancy in their community as well as conducted group discussions about the experience of adolescent mothers. However, due to an inability to obtain consent from parents, all individuals quoted specifically in this paper are at least 18 years of age and legally consented to discussions.

Most research collected in the field was qualitative in nature. Thus, when analyzing the data, I compared the discussions I had with various individuals from the different organizations. Although this made it difficult to provide quantitative measures of success, such as how many adolescents partook in youth group discussions with the PPAG, it provided an effective way for the interviewees to define the success of their organizations and programs on their own terms.

Chapter 3

Contextualizing Northern Ghana

Pre-colonial northern Ghana

Pre-colonial northern Ghana was ethnically and linguistically diverse. Large chief-centered kingdoms co-existed with smaller, acephalous groups, surviving predominantly through subsistence farming and hunting. Of the cephalous groups, the Dagomba was one of the largest. The Dagomba spoke a dialect of Mole-Dagbani, a prominent linguistic group in the North. Dagomba kingdom originated in what is today northwestern Ghana. They were ruled by the Ya-Na, the paramount chief, followed by divisional and village chiefs (Staniland 1975: 15-16). The Dagomba established a formidable kingdom by the 15th century, and by the 18th century, they controlled the majority of smaller ethnic groups surrounding their territory (Levitson 1968: xv)². The peoples of northern Ghana, including the Dagomba, worshipped “earth-shrines” (Levitson 1968). Each community worshipped a specific god or goddess, usually connected to the land, who was contacted via a priest. Although the chief held more power than the priest, the priests still played important roles in the community (Staniland 1975: 16).

Pre-colonial northern peoples did not face a problem of adolescent pregnancy because the concept of adolescence as we know it did not exist. There was no transitional period between childhood and adulthood in which young Dagomba women were teenagers. Rather, northern peoples believed that once a girl had her menarche and was physically capable of reproduction, she was seen as a woman and ready to be married

² For a more complete history of the Dagomba kingdom, see Staniland 1975.

(Oppong 1974: 35). Sometimes a girl was betrothed as a child, her menarche signaling “[her] maturity and readiness to take up residence or commence sexual relations with [her] waiting husband” (Oppong 1974: 35). Marriage ceremonies amongst northern peoples, particularly the Dagomba, were not elaborate (Goody and Goody 1967: 239), potentially because men often had multiple wives. Some groups practiced bridewealth, a custom where the groom’s family paid the bride’s family money or goods for the hand of their daughter; other groups sent their brides off with dowries to the groom’s family (Goody and Goody 1967). Regardless of whether or not bridewealth or a dowry was given, almost all ethnic groups in northern Ghana were patrilineal. After marriage, the bride would relocate to her groom’s house, where she would spend the majority of her married life (Lentz 2006). Despite the lack of adolescent pregnancy in pre-colonial Ghana, pregnancy outside of wedlock may still have been taboo. There is no evidence, however, that northern peoples exiled or punished young women who became pregnant outside of wedlock.³

Another important aspect of traditional Dagomba family life was the joint-family household. Mothers raised their children alongside sisters-in-law, grand mothers, their husband’s other wives, and other older children. With so many women, especially older women, living alongside them, younger mothers found the primary child-rearing responsibilities taken on by other women. It was assumed that if a mother raised her children, they would grow up to be spoiled.

Centuries after the establishment of the Dagomba kingdom, northern Ghana experienced its first significant international influence: the emergence of Islam. At the

³ See Steegstra 2002 for information on Krobo puberty rituals and treatment of premarital pregnancy.

beginning of the 17th century Hausa traders began to create small communities in northern Ghana (Wilks 1965). Hausa traders came from Sudan, an area already under the influence of the Islamic empire. Slowly after Hausa traders settled, other Islamic groups established themselves as well, trading with northern groups and creating their own communities. The Islamic groups often separated themselves from the communities with which they traded. As Levitzon notes, Muslims established *zongos*, communities where they could “live in distinct societies under the jurisdiction of their own law but in subordination to local chiefs” (1967: 7). The term *zongo* is still used today, especially in northern Ghana, to define a neighborhood or area of town that is inhabited primarily by Muslims.

Zongos developed on the outskirts of established cities in order for chiefs to monitor trade (Levitzon 1968: 23). Although they were designed to be centers of trade, they also became centers of Islamic development. Mosques were built and households established. Muslims even built Quranic schools in the *zongo*, as a way to educate younger members of the community (Trimingham 1959: 157). In this way, Muslims established the first formal educational system in northern Ghana. Quranic education is still popular today among boys and girls.

By the 18th century, indigenous groups including the Dagomba began to practice Islam (Wilks 1965). Rather than abandon their indigenous religions, though, the Dagomba and other groups syncretized their beliefs with Islamic beliefs. Festivals were merged, earth-shrines worshipped alongside the traditional Islamic calls to prayer, and individuals were allowed to follow either customary or Islamic laws of inheritance and other matters (Wilks 1965: 91). In many groups, the chief and his family would be the

only individuals to outwardly convert to or continue on with Islam; the rest of the community would continue on as before (Trimingham 1959: 37).

Although Islamic custom altered some aspects of northern people's marriage and family practices, for the most part they remained unchallenged and unchanged. Both indigenous and Islamic societies practiced polygyny, betrothal before menarche, and bridewealth (Trimingham 1959: 165-166, 171). Indigenous groups prior to Muslim contact, though, did not practice one Islamic marriage custom: the protection of the bride's virginity. The acceptance of this custom, however, was not universal because not every ethnic group or individual converted to Islam (Trimingham 1959: 173).

The traditions established by indigenous groups and Islamic influence are contemporaneous. Today, Dagomba peoples hold the ethnic majority, especially in Tamale, and Dagbani is the common language amongst most northerners. The Ya-Na and other chiefs maintain legitimate power over Dagomba citizens, regardless of the new legislative systems in place. Marital and family practices hold fast as well; it is not uncommon for men to have multiple wives, even more than the four traditionally allotted by Quranic tradition (Pellow 2011: 137). Child betrothal and bridewealth are still practiced in rural communities. As families become more nuclear and live apart from their kin, extended families are still expected to care for each other's children, particularly daughters (Pellow 2011). Longstanding tradition creates an environment that proves conducive for the problem of adolescent pregnancy. These, however, are not the only influences that shape the frontier of adolescent pregnancy, as well as its prevention and care, in today's northern Ghana.

Northern Ghana as a British Protectorate

Northern Ghana remained free of European control for hundreds of years. In the south, European traders and settlers had exploited resources and peoples as early as the 1400s. The British government gained full control of the South in the 1860s, claiming the Gold Coast as one of its numerous colonies. Eventually, the British turned their attentions northwards, desiring the region for its strategic placement against French and British colonizers (Brukum 1998: 118). The area was easily accessible: in defeating the Asante kingdom (the largest indigenous power in the Gold Coast), the British gained access to the Asante's conquests, one of which was the Dagomba kingdom (Pellow 2014). Northern Ghana officially became a protectorate of Great Britain in 1901 (Brukum 1999: 102). Upon arrival, the British began systematically and intentionally under-developing the area, a practice which proved detrimental to northern Ghana's future.

Despite obtaining the northern region for its strategic positioning, British officers still sought economic value in the region. Northern Ghana is located in the arid sub-Saharan region. Although the climate was not conducive to large crop production, the area and its people had a rich tradition of shea nut and kola production (Pellow 2014). The British, though, determined that this production was not profitable and began to exploit the region in other ways.

The primary 'export' of the northern region was human labor. The majority of the able-bodied men were sent to the Gold Coast to work "in the cocoa and mining industries" (Brukum 1998: 121). These northerners were used as unpaid laborers; none of the work they did brought money back to the north, let alone to the families of the men forced to work in horrible conditions. The British relied upon the manpower of the north

so heavily that at one point northerners made up 90 percent of the Gold Coast Regiment, the colony's military unit that would serve in both World Wars (Brukum 1998: 121). For individuals who were not subjected to this forced labor, any waged labor in which they engaged brought half of the earnings of laborers from the Colony (Brukum 1998: 121). The use of northerners as slave labor continued well into the 20th century and did not end until the Protectorate and the Colony united on the eve of independence.

As human exports continually exited the Protectorate, British officials ensured that little would enter. Brukum notes that "the West Africa section of the London Chamber of Commerce which had influenced the occupation of the area expressed the view that North was commercially unimportant" (1998: 120). As a result, as little money as possible was spent on the North's development. Projects to create roadways between Tamale and important Southern cities began but were never completed due to lack of funds (Brukum 1998: 127). There were discussions of a trans-colonial railroad, but the project never came to fruition because it was believed that the lack of commercial value would make a railway irrelevant (Brukum 1998: 122). Without roads or railways, goods could not move from the South to the North, or vice versa, and the movement of information and communication between Colony and Protectorate was prevented. The British idea of northern Ghana as an area full of individuals who were good for nothing but unpaid labor was how southerners imagined the North and its people.

Alongside the lack of infrastructure, the North was also denied educational development. Because the northern populations were viewed as labor reserves, the British government made little effort to develop the area's formal educational system. For the first ten years of rule, the government built no schools in the Protectorate (Thomas 1974:

428). The first schools were opened and operated by the White Fathers, a group of French Christian missionaries (Thomas 1974: 429). The White Fathers' schools fluctuated between operation and cessation. The British government took issue with the opening of a missionary school, claiming "hostility to the establishment of a Christian mission in a predominantly Muslim area" as cause for concern (Der 1974: 42). That the missionaries were French was most likely the true reason behind the "hostility" demonstrated towards the White Father's schools; thus, the government forced the schools to shut down or limited their curricula to only religious instruction (Der 1974).

In 1912, the government established the first primary school in the Protectorate. As one school was too small for the Protectorate's numerous children and often too far away for most families to send them, the school's educational value was limited (Thomas 1974: 430). Although more primary schools, and a few vocational schools, were eventually opened in the region, they had strict governmental regulations. The only teachers who were hired were northerners who received education in the Protectorate. The government feared that teachers who were educated in superior training colleges in the Colony would bring the emerging ideologies of Ghanaian independence and anti-colonialism northward (Thomas 1974). Schools' curricula were also restricted. The British wanted to educate the Protectorate only enough to "produce citizens who were prepared to respect those institutions and to work within rather than against them" (Thomas 1974: 438). "Those institutions" were the ones that strategically underdeveloped the Protectorate, hoarded its populations for unpaid labor, and kept them disconnected from the growing consciousness of the Colony.

This neglect and exploitation continued into the 1950s. At this time, the Colony was prepared for full-fledged revolt and independence. The Protectorate, though, “had only four institutions of higher learning, one university graduate, no extractive or productive industry, a rudimentary system of communication and agriculture that was predominantly still at the subsistence level” (Brukum 1998: 117). Despite the area’s underdevelopment, Kwame Nkrumah, the first president of the independent Ghana, viewed the Protectorate as a valuable addition to the soon-to-be independent Ghana. Upon the union of North and South, however, the stark contrast between the Colony and the Protectorate would unfortunately only worsen.

North and South collide

In 1957, the Republic of Ghana officially gained independence from Britain, and Nkrumah decided that the Republic included both the Gold Coast colony and the Northern Protectorate. Although Nkrumah hoped for an easy transition of the Colony and the Protectorate into one nation, the differences between the two would prove a challenge to this change.

Northern labor sent to the Colony allowed for the development of an economy that was more lucrative than any in the Protectorate. Once the British left, agricultural and mining ventures in the Colony were successful and provided economic production. The complete lack of a northern economy, however, meant that all independent growth at the time of independence must come from the southern and central regions. Today, this disparity has only worsened. In the decades since independence, Ghana has undergone economic reforms to reduce national poverty and raise the northern economy to the same level as the South’s (Pellow 2011: 136). Such efforts have proved ineffective. Jatoe et al.

note that between 1991-2006, “the rate of economic growth in northern Ghana was only 35 percent of that for southern Ghana” (2012: 2). They attribute this disparity in part to the “limited access to infrastructure,” indicating that Britain’s intentional underdevelopment of the area has had a lasting impact on the area’s development (Jatoo et al. 2012: 3). The “limited access to infrastructure” manifests itself in other ways as well. The lack of proper roads and railways from north to south has not improved much in the decades since independence. There is still only one main road between Tamale and Kumasi, which hinders efficient transport of goods and materials and negatively impacts northern Ghana’s economy.

A second difference between north and south is a religious one. As mentioned earlier, until the arrival of the White Fathers in the 20th century, the Protectorate was dominated by indigenous and Islamic religions. British officials limited the extent to which the White Fathers could develop schools and proselytize, thereby reducing the degree to which northern Ghana could be Christianized. The Gold Coast, however, had been under European influence, and thus a Christian influence, since the 15th century. By the time the Colony had reached independence, it had a vibrant Christian presence, notably including the creation of churches that syncretized indigenous religions with evangelical Christian traditions. Christianity even played, and still plays, a role in the formation of government and educational policies. Christianity has since spread to the North, and there are dozens of churches within the Tamale Municipal alone. But, the region still has a much larger Islamic presence, keeping it further separated from southern Ghana.

Education, however, was the biggest discrepancy between North and South. At the same time that the Protectorate only had “4 institutions of higher learning” (Brukum 1998: 117), the Colony boasted 535 schools, only 20 of which were exclusively run by the British government (Epstein 1944: 248). Education was influenced not only by the British government and Christian missionaries, but also by international scholars. Even before independence, the University of Ghana at Legon was internationally renowned. As the independence movement gained speed and eventually came to fruition, members of the African diaspora came to Ghana to teach, learn, and share ideas with young Ghanaian scholars. Nkrumah was one such scholar. Upon coming to power, Nkrumah was well aware of the critical differences between North and South. If northern regions were to catch up to the South, Nkrumah believed education was paramount. Nkrumah “sought to rectify these inequalities by making education compulsory and, in the North, completely free” (Pellow 2011: 136). Nevertheless, these efforts had little lasting impact after “[Nkrumah] was overthrown by a coup and during the ensuing period of instability” (Titagya Schools 2015).

Efforts have been made since the Nkrumah area to increase education in northern Ghana. Much like the efforts to improve the economy, however, they have remained relatively ineffective. Northern Ghana’s literacy rate is 23 percent, whereas, the nation’s is 71 percent (Titagya Schools 2015 and CIA 2014), and while the literacy rate is problematic, the education of girls is a much more intense drawback. National statistics show that equal amounts of boys and girls are attending primary and secondary school (UNICEF 2012). In the North, however, girls are far less likely to attend school, especially past the primary classes, than boys. In part, this disparity stems from the

“[c]ultural resistance to educating girls in [northern Ghana, which] has been particularly strong.... The feeling persists that a girls does not need education” (Pellow 2011: 137). Instead, girls are encouraged to remain at home with husbands and to rear children, a problem that fosters an environment in which adolescent pregnancy is almost acceptable.

International pressures: Their impact on family planning and public youth policy

Ghana’s independence, as well as the multiple Republics and coups that followed this independence, put the nation in the international spotlight. International forces, including the United Nations (UN), NGOs, and other foreign governments, pressured Ghana into reforming its political, economic, and civil service systems. It was also an era in which a national system of family planning was introduced.

“Family planning” is a broad term utilized to describe national efforts to manipulate population sizes; increase spacing between children; foster safer prenatal, birthing, and postnatal care; and control the spread of sexually transmitted infections (STIs) since the HIV/AIDS outbreak of the 1980s. In 1970, Ghana initiated the Ghana National Family Planning Programme (GNFPP) to “stem the high rate of population growth in order to facilitate socio-economic development” (Gyimah et al. 2011: 1). The GNFPP used contraception as the primary way to “stem population growth.” Under the Nkrumah era, contraceptives were outlawed, as they were seen as undermining the efforts to build a strong, independent nation; in 1970, contraceptives were legalized and provided by government hospitals and clinics, private clinics, and state-owned stores (Caldwell and Sai 2007: 383, 385). Alongside providing physical contraceptives, the GNFPP also provided family planning counseling for couples “to encourage and promote” girl-child education and female empowerment, to maintain connections with

international family planning organizations, and “to be [an] integral part...of social and economic planning” (Caldwell and Sai 2007: 384).

The GNFPP hoped to improve the nation’s development through family planning, but the manner in which it implemented its programs, however, proved to be flawed and ineffective. The GNFPP was attached to the Ministry of Finance and Economic Planning rather than the Ministry of Health, which ensured that socio-economic development would come before the physical care of individuals receiving contraceptives or attempting to “plan” families. What resulted was a system of under-funded agencies that failed to adequately add sexual and reproductive health (SRH) to their agendas and health workers who “dragged their feet” when trying to provide health care (Caldwell and Sai 2007: 385). The program, which was under-funded and improperly organized, may have conceivably “over-emphasized the supply side of the family planning component” (Gyimah et al. 2011: 1). This possibility meant that more attention was paid to providing contraceptives than was paid to instructing individuals, many of whom had never before used contraception, on the proper usage of specific contraceptives. Lastly, the government steered away from advertising that the GNFPP had contraceptives because it believed these items would “encourage sexual immorality among the unmarried population” (Caldwell and Sai 2007: 387). The combination of all of these mishaps fortunately led to a decrease in birthrates from 7.0 in 1970 to 4.3 in 1998, but a decrease that was only noticeable among urban populations (Caldwell and Sai 2007). Northern Ghana severely felt the brunt of the GNFPP’s ineffectiveness, because it was and remains extremely rural, which makes it less connected to southern Ghana.

Due to the government's inability to adequately implement family planning initiatives, multiple international agencies and funds were ushered in to support northerners instead. The United States Agency for International Development (USAID) and the United Nations Population Fund (UNPF), two international agencies, provided funds for contraceptives and other family planning initiatives (Caldwell and Sai 2007: 386). Unfortunately, these agencies issued their programs much like the government, through supplying contraceptives without providing proper patient counseling or follow-ups. The USAID, the UNPF, and other diverse international influences have subsequently laid the groundwork for the extensive network of international organizations and funds that assist the North today.

Despite the ineffectiveness of early family planning programs, the GNFPP and other international agencies were the first to sponsor SRH programs and care designed specifically for adolescents. Alongside providing services, albeit inadequate ones, specifically for adolescents, as well as beginning the conversation about sending young girls to school, the GNFPP raised the legal age of marriage in Ghana to 20 (Caldwell and Sai 2007: 390). While these efforts, like other GNFPP initiatives, had little success in rural and presumably northern regions, it was still a step in the right direction.

Thirty years after the GNFPP created these programs, the government issued the Adolescent Reproductive Health Policy in October 2000. The policy defined reproductive health as “[a] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and processes” (Republic of Ghana National Population Council 2000). The policy outlined that adolescents, individuals aged 10-24 years, have a right to adequate SRH information,

to make informed choices as a result of this information, to services specific to their needs as youth, and to be a part of planning their own SRH programs. In addition, the policy mandated that a “multi-sectoral approach” be taken. These sectors, which included “health, education, social welfare, media, justice, sports, labour, religious bodies, women and children’s groups, non-governmental organizations, traditional authorities, communities and families [sic]” were encouraged to participate in the development of a health ASRH culture (Republic of Ghana National Population Council 2000)

After outlining the goals and the current state of ASRH in Ghana, the policy issued a number of targets it wished to meet by 2010. The targets, which included “increasing the age of onset of sexual activity” and “reducing the proportion of females below 20 years who give birth by 50 percent,” mimicked the goals outlined in the United Nation’s Millennium Development Goals (MDGs).⁴ Although there is no explicit mention of the MDGs in the Adolescent Reproductive Health Policy, they occur elsewhere in Ghana’s youth education policies and support other governmental endeavors to promote female education. They are representative of the ways in which government policy, specifically regarding SRH, has been and is influenced by international pressures and funds.

The situation today

As a result of colonial maltreatment and an absence of support from the central government, northern Ghana is a rural, sparsely populated area that is deeply affected by

⁴ See the United Nation’s *Millenium Development Goals and Beyond 2015*.

poverty, lack of education, and detachment from the South. Due to this neglect, it is also an area that has maintained traditional family and marriage. As previously mentioned, local custom holds that girls do not need education in the same way as boys. In the period between childhood and when a girl is ready for marriage, she is often sent to her “auntie”⁵ to serve as a domestic helper. Maintaining the tradition of children being raised by women other than their mothers, girls as young as four or five are sent to an auntie for an extended duration, usually until they are eligible for marriage. Amina Ahamadu, whose sisters were sent to live with aunties, says,

The girls were taken away by aunties. And the aunties were not educated. And the trouble about giving your child up to somebody is that it is assumed 100 percent that he or she would look after the interests [of the child]. So it was not customary for you to interfere. So even if you wanted – like the old man, my dad, with a burning desire wanted all of his children to go to school, knew that his sisters who were taking his daughters were not looking after them in school, he couldn’t do anything. He could not interfere. It is not Dagomba custom (5 Dec. 2005).

Ahamadu’s story demonstrates the hold custom has over Northerner’s actions. It is also just one of the reasons why northern girls do not go to school; even those who are not sent to aunties are prevented from going to school because of other economic and cultural reasons.

⁵ Auntie is a term of respect for older Ghanaian women. While it can refer to one’s maternal or paternal aunt, it can also refer to a non-related older woman as well.

The combination of these factors – traditional family life, absence of education, and lack of opportunities outside of education – developed into a situation in which adolescent pregnancy is part of everyday life in northern Ghana. In the Northern Region, 23 percent of 15-19-years-old girls, which covers the age bracket of “adolescence” as defined by the Adolescent Reproductive Health Policy, “are already mothers or are pregnant with their first child” (Ghana Demographic and Health Survey 2008). This is 10 percent higher than the national average. Northern Ghanaian women also marry much earlier than the rest of the country, with the average age of women marrying in the Upper East region at 17.8 years – still part of the legally defined age of adolescence (Ghana Demographic and Health Survey 2008). Alongside having the highest rates of adolescent marriage and pregnancy, Northern Ghana has the lowest rates of exposure to family planning practices and ideologies. Only six percent of married women in the Northern Region utilize any form of family planning, including consultation or contraceptives (Ghana Demographic and Health Survey 2008).

The current state of ASRH in northern Ghana impacts the nation on an international level as well as a domestic one. In 2013, the Minister for Gender, Children and Social Protection claimed that Ghana’s high rates of adolescent marriage hinders the nation’s ability to reach MDGs (Adoboe 2013). Minister Lithur cited adolescent pregnancy and childbearing as a facet of adolescent marriage that is particularly troubling.

Northern Ghana’s history has not only created a situation of poor ASRH and adolescent pregnancy, but affects the ways in which the organizations and fieldworkers engage with communities, initiate preventative programs, and provide adolescents with

access to care that is specific to their needs. By knowing the history of the region, it is easier to understand the complexity of the ways in which local northerners utilize international funds, ideologies, and individuals to provide real help to young women in need.

Chapter 4

Findings

The services available: Preventative versus treatment

The problems associated with adolescent pregnancy and ASRH are multi-faceted. Thus, the services provided by the organizations and fieldworkers must be as well. To organize the types of services offered by the six NGOs and the two governmental organizations, I divided them into two categories: preventative services and treatment services. Preventative services, those designed to help adolescents prevent pregnancy, include the provision of contraceptives, group or individual counseling sessions, sexual education courses, and mediated discussions between parents and daughters. Treatment services, those meant to help adolescents and their families safely through the antenatal, birth, and postnatal processes, include adolescent-specific clinic visits, community support groups, post-natal guidance for new mothers, and school and work facilities with provisions for mothers and infants.

Preventative services

Of the governmental organizations, both schools and the Kalpohin Health Center provide preventative services. GES aids in the prevention of adolescent pregnancy through its national curriculum on ASRH. This education began in JHS with the Religious and Moral Education (RME) class. Because sex education is taught within the RME curriculum, it situates adolescent pregnancy within a moral setting. One RME textbook introduces ASRH under “Living a Chaste Life.” The textbook stresses that any pre-marital sex is immoral and can result in a multitude of societal problems, including adolescent pregnancy; it teaches students to avoid adolescent pregnancy by abstaining

from sex, listening to their parents, staying in school, and engaging in worthwhile activities and pastimes (Bonsa, “Chastity and Immorality”). As a means to increase girls’ enrollment and retention rates in basic education, the GES also began a Girls Education Unit in 2007, designed to help reduce adolescent pregnancy through education (GES 2012).

The Kalpohin Health Center, a sub-district clinic located just outside downtown Tamale, offers family-planning counseling as well as contraceptives to young adults. Aliyatu Zakaria, a midwife and nurse at Kalpohin, said that adolescents come to the center to receive counseling, as well as a variety of contraceptives, including implants, injectables, pills, and condoms (29 Apr. 2014)⁶. Although the family planning services for adolescents at GHS clinics are the same as those provided for adults, the Adolescent Health Policy mandates that programs specific to adolescents be offered at all government clinics (National Population Council 2000). Despite Zakaria’s positive attitude towards providing prevention to adolescents, no such programs exist at Kalpohin.

Of the six non-governmental organizations researched, four afford some form of preventative services, with the PPAG offering the most. The Jisonayili center has an attached clinic that provides a wide variety of contraceptives, including pills, condoms, injectables and intra-uterine devices (IUDs), as well as counseling for individuals desiring contraceptives. The center also has a hotline, staffed by a young male and a young female, which adolescents can call if they have any questions during the day. Alongside contraceptives, the PPAG has extensive educational programs. The Jisonayili center boasts a Young and Be Wise center. Young and Be Wise programs are designed to

⁶ See Appendix 2 for images of the Kalpohin Health Centre

teach adolescents multiple ASRH topics, including puberty, reproductive processes, and proper contraceptive use. During the spring of 2014, the Young and Be Wise center hosted two youth groups. The Life Planning Skills (LPS) course was for boys and girls. Led by a trained youth facilitator, LPS allowed youth to create their own curriculum and foster peer-led discussions about various ASRH subjects, including adolescent pregnancy (PPAG 2006). Created for girls only and led by a trained female youth facilitator, the second youth group was the Girls-Girls club, which focused on many LPS issues specific to adolescent girls in an effort to help them feel comfortable enough to ask and answer questions.⁷

NORSAAC and RAINS provide similar prevention programs based on sexual education to help youth “understand and embrace their sexuality and make positive choices that will help build the region” (NORSAAC 2014). The sexual education programs, which are more biologically than morally based, encourage young adults to make their own informed decisions regarding sex (Tijani, 25 Apr. 2014).

FOMWAG takes a different approach to prevention. Hajjah Hazara Telly, FOMWAG’s national president, believed that education should begin in the home. She encourages members, many of whom are mothers of adolescent girls, to learn about ASRH and teach what they learn to their daughters. She emphasizes that “if the mother [doesn’t] get this training, then she won’t be able to teach her daughter” (20 Apr. 2014). Unlike the other NGOs, FOMWAG is a religiously based organization, and like the GES curricula, preaches abstinence to its young women. FOMWAG, however, believes that without mothers verbalizing the importance of abstinence to their daughters, and without

⁷ See Appendix 3 for images of the Jisonayili center and youth groups.

talking to them about premarital sex and its possible consequences, adolescent girls will not truly understand these ideas.

Treatment services

The Kalpohin Health Centre is the only government organization I worked with that provided treatment services for adolescent mothers. Kalpohin recognizes that adolescent mothers need “special care and much attention” during their pregnancy and during postnatal care (Zakaria, 29 Apr. 2014). Thus, they pay closer attention to these young mothers throughout the entire process in an effort to give them the best care possible. Two adolescent mothers who attended Kalpohin had planned caesarean sections to deliver their babies, because nurses feared their bodies were not developed enough for a safe vaginal delivery (Zakaria, 29 Apr. 2014). Kalpohin did not have the resources to perform caesarean sections, though, and the girls were referred to the Tamale Teaching Hospital to deliver. When those mothers returned for postnatal care, multiple nurses instructed them on how to properly breastfeed their infants.

Of the NGOs, NORSAAC is the only one that provides treatment similar to that of the clinics. NORSAAC helps communities to form Community Health Teams (CHTs) and Pregnancy Support Groups (PSGs). CHTs consist of traditional birth attendants, women group leaders, and community-based surveyors. Their objective is to work with PSGs to encourage women to attend GHS clinics for antenatal care and delivery and to build GHS clinics in communities where none existed (Issah, 23 Apr. 2014). Although neither CHTs nor PSGs specifically target adolescent mothers, both create an environment in which young mothers receive the care and support they need. The PPAG

also has clinics that offer healthcare services for adolescent mothers and their infants; the Jisonayili clinic, however, is not one of these places (Emmideme, 15 Apr. 2014).

GIGDEV provides a very different kind of treatment for adolescent mothers. It serves as a training school that teaches students income-generating skills, such as hairdressing and dress making; information and communications technology, such as “Surfing the Web” classes; and basic literacy and numeracy, as many of the young women left school when they became pregnant or had never been enrolled in formal education (GIGDEV). The training centers allow women to begin GIGDEV courses at any time during their pregnancy. Even if they leave during their pregnancy, they are allowed to re-continue training when they are able (Hazara, 28 Apr. 2014). Attached to the Jisonayili Regional Training Center is a kindergarten and primary school, where mothers enrolled in GIGDEV can send their children (Abdulai, formal interview, 23 April 2014). Mothers also bring their children, especially those who are still nursing, with them to work.⁸

FOMWAG and WERSD do not provide adolescent mothers with treatment or postnatal services themselves. They do, however, encourage young mothers to continue their education after they give birth or to seek other forms of employment. Hajjah Azara Mahamadu, patron of WERSD, works specifically with *kayayos*⁹, many of whom return home pregnant after being unable to support themselves. Mahamadu introduces the *kayayos* to vocational experts who can teach them income generating skills, and connects

⁸ See Appendix 4 for images of mothers at GIGDEV.

⁹ *Kayayo* is the local term for teenage girls, usually from the northern regions, who travel South in an effort to find better employment or money-gaining opportunities. *Kayayos* are uneducated or quit school before completing JHS.

them with training schools or shea butter cooperatives to provide further skills training (19 Apr. 2014).

International influences present

International funds

The most concrete international influence is funding. International funds are most commonly used by NGOs, on which they have the greatest impact. Funds primarily come from foreign governmental institutions or large private donors. USAID, the Danish International Development Agency (DANIDA), the United Kingdom's Department for International Development (DfID), and STAR Ghana (a fund sponsored by all three aforementioned agencies as well as the European Union) are the governmental agencies that provide the most funding to NGOs; IBIS West Africa and Tzedek (a UK Jewish organization) provides the most private donor funding.

All of these donors contribute project-based funding, meaning that organizations write grants and proposals to obtain a set amount of money for a certain period of time to implement a specific project. NORSAAC's CHTs, for example, were part of a three-year project sponsored by STAR Ghana (Issah, 23 Apr. 2014). Project-based funding poses challenges to the NGOs. When the funding runs out, organizations either apply for more funding or leave the community (Emmideme, 14 Apr. 2014). Because donors supply financial support, it is possible they could change programs fieldworkers attempt to implement, although no directors report this happening to their programs.

The PPAG is the only NGO that has a different relationship with international donors. As a member of the IPPF, the PPAG receives a core grant from the Federation

every year. Each PPAG zonal officer creates a budget plan for how they intend to utilize the core grant and sends it back to IPPF for approval, ensuring some form of monetary support each year (Dakurah, 14 Apr. 2014).

Governmental organizations receive international funding as well. The GES receives financial aid to support Ghana's basic education division from DfID, USAID, UNICEF, and other international donors. This money also supports the Girls Education Unit. The extent to which these funds are utilized specifically for the Girls Education Unit, however, is unknown. Although no information is available about specific international funding given to the GHS's Family Health program, their Finance department is responsible for allocation of funds from "external agencies," and thus receives international support at various levels (GHS 2014).

International volunteers

Despite the plethora of international volunteers present in Tamale, only RAINS and GIGDEV hosted international volunteers during the spring of 2014. RAINS receives the bulk of its international volunteers from International Service, a British organization that sends volunteers to join Ghanaian volunteers for a short period of time. Their most recent group of volunteers worked to increase RAINS' marketing and social media presence. Hardi Tijani, one of the organization's program directors, says that international volunteers bring "diversity" to RAINS, "which is very important to the work we do. We get to see other perspectives on development" (25 Apr. 2014). RAINS' international volunteers spend no time implementing programs in the field.

GIGDEV's volunteers work more directly with the young women. Selina Iddi Abdulai, GIGDEV's Programme Coordinator, explains that recent volunteers assisted in

teaching classes to GIGDEV students, worked in the primary school at the Jisonayili center, and helped with proposal and grant writing (23 Apr. 2014). Like RAINS, GIGDEV acquires volunteers through international organizations that pair volunteers interested in working in a specific field with local NGOs. I did not see any of GIGDEV's international volunteers in the field during my time in Ghana.

The lack of international volunteers present in this network of NGOs is intentional. Prince Imoro Issah, NORSAAC's project officer for SRH, is concerned about the integrity of international volunteers going into the field. He emphasizes that volunteers should not be here [in Ghana] just to "build careers. They must be here to contribute something to the organization" (23 Apr. 2014). Issah thus limits volunteer's work to strengthening NORSAAC from within, training staff members in information and communication technology, and improving human resource (Issah, 23 Apr. 2014).

International ideologies

The term 'international ideologies' refers to the various foreign beliefs, educational curricula, and treatment methods utilized by the NGOs and the governmental organizations. These ideologies, while the least concrete to pinpoint, were the most visible international influences during my research period. I find these ideologies so important because they often contrast with 'traditional' ideologies about ASRH, specifically with how ASRH should be taught to young adults. As a result, ideologies were the most difficult international influence to integrate with the local communities.

The exemplary international ideology utilized is the Western style of sexual education. As mentioned before, this education is the type taught in most American middle and high schools, with a focus on the biological aspects of puberty and sexual

relations rather than the moral causes and effects of adolescent sex. When discussing adolescent pregnancy prevention, the Western approach informs adolescents about all types of contraception, including abstinence, yet encourages young adults to use the form of contraception that is best for them. The Western method is in direct contrast with the ‘traditional’ sexual education course taught in national RME curricula. NORSAAC, PPAG, and RAINS all utilize this education in their prevention programs.

Another foreign ideology is the concept of youth-friendly services and counseling. Traditional communities in northern Ghana, as well as across the world, dictate that children, especially girls, of any age should listen to their elders and follow a strict set of morals; a specific moral they must follow is abstaining from sex until marriage. Traditional ideologies often also do not share the concept of adolescence. For example, when a girl is physically ready for marriage and childbirth she is a woman. In the West, however, we acknowledge a period of time between childhood and adulthood where girls and boys gain independence, experience a distancing from parents, and sometimes begin to experiment sexually. Youth-friendly services, take this period of time into account when giving family planning and pregnancy care to adolescent girls. Khadija Emmideme, a community health nurse who works for the PPAG youth clinic, offers youth-friendly services by giving girls her phone number in case they feel uncomfortable asking for contraceptives in front of other students (15 Apr. 2014). Zakaria provides a similar type of youth-friendly care, allowing adolescent mothers to come for appointments after the clinic has officially closed in case they are embarrassed about their condition (29 Apr. 2014).

The PPAG example

That many of the NGOs I worked with effectively utilize international funds to support programs, find ways to ethically incorporate international volunteers, and introduce international ideologies into communities is in part because of the efforts made by the PPAG. Formed in 1967, the PPAG is the oldest international family planning organization in Ghana. At its inception, the IPPF sent international volunteers to provide services and contraceptives directly to Ghanaians (Caldwell and Sai 2007: 386). As time went on, IPPF volunteers instructed local health workers and community members on how to administer the same services and care, including how to transition towards offering youth-friendly and more comprehensive SRH services. Today, the IPPF provides the PPAG with curricula for all of its programs, including Young and Be Wise, as well as with manuals on how to train future volunteers (Dakurah, 14 Apr. 2014). The PPAG now provides curricula for NORSAAC's and RAINS sexual education programs and serves as a model on how to train community members who wish to engage in this kind of work. The template set forth by the PPAG creates an environment in which organizations I researched were directed and staffed by local Ghanaians from Tamale or the three northern regions, yet they have implemented programs with deep international influence.

How governmental organizations incorporate international with the local

Both government clinics and schools were under pressure--from both the Ghanaian government and international forces, such as the MDGs--to improve the quality of life for adolescent girls. The government responded to these pressures with policy change and national discussion. I understood when I began my research that the north faced serious disadvantages that complicated the translation of policy into action, I

expected northern schools and clinics to be proactive in helping young women. What I saw, however, was inadequate services provided by government organizations.

When comparing the two government organizations, schools did the least to incorporate international influences to improve ASRH and adolescent pregnancy rates. Northern fieldworkers were in the process of creating a Western-style sexual education course to be implemented in JHS science curricula. It would be designed to enhance, rather than replace, the RME sexual education course. The GES, however, had reservations about promoting protection, rather than abstinence, within a SRH course in school (Issah, 23 Apr. 2014). In the year since I left Tamale, no further progress has been made on this curriculum. Despite the responsibility of Northern schools to reincorporate adolescent mothers into school after the delivery of their babies, little has been accomplished. The National Youth Policy identifies adolescent mothers as a target group that must be “well catered for” and one that needs “a framework followed to encourage completion of at least secondary education” (Ministry of Youth and Sports 2010, Section 7.0). The policy also states that the Ministry of Youth and Sports is responsible for monitoring the implementation of these policies. Although both FOMWAG and WERSD encourage women to return to continue education after delivery, neither mentions any effort made by the government to get girls back into school. Among the mothers I talked to who had been to school, none mentioned any effort either. Naima, one mother who dropped out of school for different reasons, noted, “[M]y teachers said that if I was going to miss so much I might as well stay at home. So, that is what I did” (24 Apr. 2014).

Even mothers who could be encouraged to return to school would probably find it logistically impossible to do so. It would be expected that the government, in its efforts to

improve universal access to basic education, would attempt to build schools in a region that has lacked them for over a century; however, throughout my research, there was no evidence of this taking place. As a result, many mothers feel the distance it takes to walk to school was too far to make it worthwhile, even if they wish to return (formal interviews, April 2014). There is also no effort made by the government to reach out to families with daughters, many of who might not be enrolled in school, even though the Girls Education Service claimed it would do so.

The Kalpohin clinic makes more of an effort to reach out to adolescent girls, yet still struggle in their efforts to provide adequate care. Zakaria says that community health nurses often go into schools to discuss ASRH, contraceptives available to prevent pregnancy, and tests they can take if they believe they might be pregnant; many girls return to the clinic to seek these services (29 Apr. 2014). Biddlecom et al., however, note that young Ghanaians across the country feel uncomfortable obtaining contraceptives from GHS clinics because health providers and staff are not friendly towards them (2008). Although none of the adolescents I spoke with explicitly stated their fear of going to a GHS clinic for contraceptives, they did not mention it as a place where they would go, especially when organizations such as the PPAG exist (16 Apr. 2014).

Kalpohin also attempts to reach out to adolescent mothers. Community health nurses go into communities surrounding the center, visit the homes of pregnant adolescents, and encourage them to come to the clinic to receive antenatal services. Zakaria believes that the majority of adolescent mothers they reach out to come to the clinic after these home visits (29 Apr. 2014). Kalpohin Health Centre and its nurses, however, seem not to be the norm. Memonatu, an adolescent mother I spoke with at

GIGDEV, said that she and the other students live far away from the clinics. Although they walk to get to them most of the time, they are sometimes carried on their husband's bicycles (24 Apr. 2014). The effort involved in going to a clinic to receive care often mean these mothers receive infrequent clinic care; some even have to deliver their children at home.

Government schools and clinics are mandated to provide services that cater to the needs of adolescent girls and mothers. They receive international funding and are part of a larger international network that encourages nations to improve the quality of life for its marginalized citizens. The situation I witnessed varies from sheer neglect on the part of schools to inadequate attempts on the part of clinics and nurses and demonstrates the inability of governmental organizations to properly incorporate international influences and improve local conditions for adolescent girls and mothers.

NGOs to the rescue

The work done by the six NGOs is not just in response to the increasing adolescent pregnancy rates in northern Ghana. It is done because of the increasing inability of government services to lower these rates, as well as to alleviate the problems that in part cause adolescent pregnancy. The services they provide are thus guided by international aid, local necessity, and in response to previously failed governmental efforts.

The PPAG, NORSAAC, and RAINS, while influenced by international ideologies and funding, implement their specific sexual education curricula in response to the inadequacy of the GES curricula. Because GES curricula only discusses ASRH on a

moral level and provides little to no information about methods of contraception other than abstinence, the only way students can receive accurate ASRH education is through the curricula implemented by the PPAG, NORSAAC, and RAINS.

The PPAG youth center I worked with was located adjacent to a local primary and junior high school, which makes it easily accessible to many students and also allows Youth Center workers to build relationships with the school children and their teachers. The PPAG is not only a center-based organization. It executes a number of community outreach programs in order to access individuals who might not live close to a PPAG youth center. PPAG staff go into schools and train peer leaders on Young and Be Wise programs, such as the LPS classes.

NORSAAC and RAINS utilize a community outreach approach when introducing their programs. NORSAAC begins by identifying youth leaders within the community and trains them on sexuality and SRH education, expecting leaders to bring this information to their peers. NORSAAC also developed educational pamphlets written in English and Dagbani with pictures of the information being described so that individuals of all literacy rates can comprehend the material. RAINS focuses its outreach on GES teachers. Working outside of schools, staff members train teachers to educate adolescents using curricula shared by the PPAG and NORSAAC. All three organizations, whether working out of a center or with a community group, utilize the same curricula, ensuring that adolescents receive a unified sexual education. The shared curricula also allows students who might not be able to walk the distance to schools, or who might not be enrolled in school, to receive some form of sexual education.

Because the sexual ideals they promote go against traditional ideals of abstinence, the PPAG, NORSAAC, and RAINS went to extra lengths to ensure that the entire community was in agreement with the programs they were about to implement. Before beginning any program, fieldworkers introduce themselves and the curricula to community leaders, such as chiefs or district assemblymen. They then work to include these leaders, as well as other adults in the community, in the implementation of programs. NORSAAC, for example, reached out to “peer mother educators.” Ampofo notes that both young men and women spend more time with their mothers than their fathers; thus, most sexuality education received within the home comes from the mother (2001: 206). NORSAAC also recognizes this tradition. “If young people are so close to their mothers, why shouldn’t we [NORSAAC] educate mothers on sexuality so they can impart this education on their children” (Issah, 23 Apr. 2014). This is the same ideology espoused by the leaders of FOMWAG; although they promote abstinence, they encourage mothers to educate themselves as well so as to better educate their daughters.

Efforts to include entire communities in the implementation of sexual education not only allow programs to be successful, but also encourage their continuation after organization staff members have left the area. During my time in Ghana, no mention was made of schools or clinics in the area, with the exception of the work done by the Kalpohin Health Center, reaching out to more remote communities and adolescents.

As organizations that sponsor both educational and medical services, the PPAG and NORSAAC provide services in an effort to supplement the work (not) being done by GHS clinics. The youth-friendly services that the PPAG clinic is known for developed

out of the perceived unfriendliness of government health workers and nurses.¹⁰ The PPAG also utilize community-outreach programs as an opportunity to go into local clinics and select a “core group of staff” to receive training on how to offer more youth-friendly services to adolescents in the area (Dakurah, 14 Apr. 2014). NORSAAC offers a similar type of training to individuals who become part of their PSGs or their CHTs. It is hoped that when a community learns about the importance of proper prenatal care, it encourages all of its mothers, including adolescent mothers, to seek that help. In building clinics where none existed, NORSAAC took over a job that should be implemented by the GHS.

GIGDEV and WERSD, which provides a different type of postnatal care than clinics, still supplements the care that adolescent mothers should receive from GES schools. GIGDEV’s programs offer adolescent mothers formal and skills-based education. In order to promote its programs, particularly to women in rural communities, GIGDEV reaches out to community assemblymen and traditional leaders, who Abdulai calls “the mouthpiece of GIGDEV” (23 Apr. 2014). These assemblymen then inform young women about the opportunities available at GIGDEV, giving them the opportunity to continue their education after giving birth. GIGDEV goes even further to give adolescent mothers access to education; aside from its headquarters in the Jisonayili neighborhood of Tamale, GIGDEV has three other regional training centers in the Northern region. All of the efforts made by GIGDEV should be done by the GES under its campaign to provide more marginalized women with access to education.

¹⁰ See Awusabo-Asara et. al. (2004) for research on Ghanaian adolescents’ perceptions of GHS service-workers and their attitudes towards adolescent contraception usage.

Unlike GIGDEV, WERSD had no training centers to which it can send adolescent mothers. Instead, Mahamadu sends adolescent girls and mothers with whom she works to the Campaign for Female Education (CAMFED), an organization originally founded in the UK that provides financial support to girls who would otherwise not be able to afford school fees (CAMFED 2014), and to the School for Life, a Ghanaian NGO that offers “mother-tongue” education to children ages 8-14 (School for Life). While Mahamadu does not explicitly mention the inability of GES schools to educate adolescent mothers, that she does not encourage any of the young women she works with to return to GES schools might say something about the inadequate education they would receive at those institutions. At the very least, her silence at least demonstrates the GES schools’ inability to reach out to adolescent mothers.

The amount of supplementing and replacing of government work by nongovernmental fieldworkers paints a picture of the two as perpetually at odds. In reality, though, opportunities arise when the two work in tandem to provide more comprehensive support to adolescents. The Kalpohin Health Center, for example, staffs a nurse who is trained to perform abortions. The PPAG clinic at Jisonayili, which has no nurse or abortion facility, refers adolescent girls to the Kalpohin clinic and the nurses that work there (Zakaria, 29 Apr. 14). The PPAG also works extensively with government schools and clinics, although no specific schools were mentioned aside from the one located next to the Jisonayili youth center. Unfortunately, the moments of cooperation between governmental and non-governmental organizations occur far less than the moments of NGOs picking up the slack left by governmental organizations.

To say that the NGOs I researched “came to the rescue” of northern society might be extreme. From what I saw, however, this is exactly the case. NGOs not only have to navigate the intricacies of limited funding, begin projects that might not be well-received locally, and keep those projects going after funding stops, they also have to do all of this in order to supplement or replace services that should be provided by the government. I believe that without the efforts being made by NGOs, the situation for adolescent girls and mothers in northern Ghana would be even worse.

Imperfect heroes: The struggles NGOs face

The network of services available to adolescent girls and mothers is impressive. Girls can receive contraceptives, counseling that is sensitive to their needs, proper prenatal care and advice, and continue their education even after the child is born, often without having to travel too far from their villages. That being said, this network is far from perfect. Its flaws are evident and unfortunately hinder organizations from providing the best care possible.

Communication between the NGOs is one of the biggest problems. While some organizations interact on a daily basis, others are left to fend for themselves. On the one side, GIGDEV refers its adolescent girls and mothers to PPAG for health care; NORSAAC and RAINS share “tool kits” for ASRH education programs; the PPAG refers adolescent mothers to the Kalpohin Health Center for services they can not provide; and, together with NORSAAC and RAINS, the PPAG works directly with GES schools and faculty to enhance the sexual education programs students receive. On the other side, WERSD vocalizes a need for more connections with training schools to

provide adolescent mothers with more opportunities (Mahamadu, 19 Apr. 2014); FOMWAG too experiences this problem. GIGDEV, however, is openly accepting adolescent mothers in need of skills training and can satisfy the needs of WERSD and FOMWAG. But, no communication exists between the three organizations. As a result, WERSD and FOMWAG's needs that could be met by GIGDEV to unresolved.

The differences in communication levels might be attributed to the amount of international funding and volunteers each organization receives. The PPAG, NORSAAC, RAINS, and GIGDEV at one point received help from international volunteers, many of whom worked to strengthen the organizations' infrastructures, which could have led to better forms of communication. They also receive continual international funds, sometimes from the same donors, who might have foster communication as well. FOMWAG and WERSD never had or have international volunteers, and only WERSD mentioned receiving some funding from the WHO to enact programs unrelated to ASRH (Mahamadu, 19 Apr. 2014). Therefore, unless they make an effort to contact other NGOs, WERSD and FOMWAG do not seem to be aware of the services other organizations provide that they could utilize.

Another problem that the organizations cannot overcome is the distance adolescent girls and mothers have to travel in order to receive services. The organizations I worked with, and the communities they reach out to, have access to facilities within a reasonable distance of the Tamale Municipal. GIGDEV and NORSAAC even have facilities in communities where none existed. Despite their efforts, there are a terrific amount of adolescent girls who do not live close enough to access these facilities. Faisa, an adolescent mother I met at one of GIGDEV's training centers, states that "in rural

communities, people want to do the work like what is done at GIGDEV, but they do not have the resources. There are more mothers out there than those at GIGDEV” (28 Apr. 2014). The mothers she refers to are most likely those who live farther north from Tamale, especially those in the Upper East and Upper West Regions, where population density is even sparser than in the Northern Region.

The physical distances between rural adolescents and facilities are replicated in the communicational distances between northern organizations and southern organizations. No NGO I worked with had any contact with donors, resources, or other organizations in the South. Even the PPAG, which has two other zonal branches in the country that most likely implement the same IPPF curricula and programs, did not mention working with either of the two southern branches, which demonstrates that the ways in which these organizations address adolescent pregnancy is deeply rooted in local communities and traditions. It also, perhaps, hinders these organizations from accessing resources that can be more easily obtained locally than those obtained internationally.

Northerners perceive the lack of a connection between North and as intentional. I had multiple informal conversations with individuals who feel that southerners view them as backwards and less “modern” because of their lower education and literacy rates, and because of their history as Gold Coast laborers. They feel it is the southerners’ perceived superiority that hinders them from helping their northern neighbors; northern problems are issues that cannot be addressed in the South. This perceived superiority complex might explain why organizations, such as the PPAG, do not reach out to potential southern partners, even if it means missed opportunities to share ideas, programs, or resources.

In spite of the perceived lack of empathy from the South, northerners are extremely prideful of their culture and their traditions. This pride, however, sometimes hinders organizations from addressing more difficult issues related to adolescent pregnancy. When asked what the biggest challenge his organization faced, for example, Tijani became visibly angry when discussing outsider's perceptions on the North's "handling" of young girls. He was particularly upset about a UNICEF report that stated child marriage was still a growing problem in the North, because "our culture does not promote child marriages" (25 Apr. 2014). Tijani's insistence that child marriage was not a part of the northern culture unfortunately did not disprove the data, which shows that northern girls get married far younger than their southern counterparts (Ghana Democratic Health Survey 2008). It is also an attitude that might prevent NGOs, such as RAINS, from implementing programs to address child marriage.

Another situation similar to northern child marriage is the treatment of *kayayos*. While WERSD works hard to ensure that *kayayos* get settled upon returning home, it only addresses some of the reasons why *kayayos* need to seek work in the South at all. WERSD understands that due to the poverty issue, lack of employment opportunities and local acceptance of the absence of education for girls, many girls saw no prospects for themselves in their natal villages (Mahamadu, 19 Apr. 2014). WERSD also recognizes that when girls cannot support themselves, they seek the support of "sugar daddies," which is how many of the girls returned home pregnant (Mahamadu, 19 Apr. 2014). WERSD does not recognize, however, that many uneducated girls spend the majority of their childhood working for their aunties and then leave for the South because they either grow too old to work for the aunties or because they are mistreated while in the aunties'

care, which are very serious realities for many northern adolescent girls (Ahmadu, 05 Dec. 2005).

The problem, though, that is perhaps the most detrimental to NGO's care network is the inability to quantitatively articulate their success. When asked whether they thought their organizations were successful, all directors and fieldworkers said yes. GIGDEV's Abdulai, for example, cited the organization's ability to provide women with income-generating skills, which allow mothers to support themselves and their children, as a measurement of its success (23 Apr. 2014). GIGDEV's students also echoed this faith in their ability to succeed in the future as a result of their education (Memonatu, 24 Apr. 2014). FOMWAG's Telly vocalized a similar story of her organization's success. She felt that the supportive environment she provides allows mothers and daughters to more openly discuss sex within the home, feel secure in their ability to return to school after getting pregnant, and instills in them a belief that Islam is a religion in which they are free to learn and control their futures as much as their male peers (20 Apr. 2014). Qualitatively, all six NGOs demonstrated success in providing effective services for adolescent girls and mothers.

Of the six NGOs, however, only three directors were able to provide quantitative data about the results of their programs. NORSAAC's Issah told me that a year after sexual education programs were implemented in communities, local schools reported a decrease in adolescent pregnancy from six to eight girls per year to one or two girls per year; some schools reported that no girls were pregnant at all (20 Apr. 2014). NORSAAC also reported that from 2012-2013, the rates of mothers attending GHS clinics for

deliveries increased in all communities where CHTs and PSGs were implemented (NORSAAC 2013).¹¹

Peter Dakurah, the Zonal Manager of the Northern section of the PPAG, gave me a summary of the progress made in the Northern Zone for 2013. None of the data presented in the summary, however, related specifically to decreased adolescent pregnancy rates as a result of the PPAG's services. RAINS' Tijani noted that after implementing ASRH education programs in Savelugu, no new pregnancies had been reported (25 Apr. 2014). He did not provide me with any information about the success of the organization's programs as a whole.

Quantitative data is not completely representative of an organization's success, and the qualitative success demonstrated by the six NGOs must not be overlooked. Without quantitative success, though, the extent to which the NGOs succeeded at lowering rates of adolescents is difficult to determine, and poses a problem to future donors and projects. Issah, for example, commented that donors are working on a timeline and that he needed to regularly report back to them in order to continue receiving funding. The "public sector," however, did not operate on the same timeline; in one community where CHTs were initiated, Issah had not received any information about the success of the program in over six months (formal interview, 23 April 2014). Stories like these demonstrate NGO's needs for quantitative data in order to provide donors with the information necessary to justify continued program funding. Without this funding, the qualitative success of their programs is threatened.

¹¹ See Appendix 5 for NORSAAC's CHT and PSG data.

Chapter 5

Conclusions

In the final moments of our interview, RAINS' Tijani told me that adolescent pregnancy “is an area that a single way of intervention cannot work. You must have a comprehensive program to target children and their families to make it work” (25 Apr. 2014). Each fieldworker I met echoed Tijani's idea, if not verbally then through actions. The need for a multi-faceted, widespread program was obvious during a group discussion when Martha, from the PPAG, encouraged adolescent girls to talk about contraception and their ability to say “no.” The need was clear when Hajja Telly encouraged FOMWAG members to talk to their daughters about sex, even if Islamic tradition kept quiet on such matters. The need was apparent when Nurse Zakaria told adolescent mothers to come to the clinic after hours. The need was evident when Issah utilized funds to implement NORSAAC's sexual education programs and PSGs in the same communities. The need was plain when Hajja Mahamadu brought *kayayos* together in the hopes that through mutual support, they could find work at home. The need was unmistakable when mothers took sewing classes at a GIGDEV training center at the same time their children were attending primary school. The care that fieldworkers offer for adolescent girls and mothers is varied, but most importantly it can effectively provide some form of relief to a region struggling to manage adolescent pregnancy.

The services afforded by fieldworkers and organizations are not the only comprehensive aspect of this network of care; the ways in which international influences are utilized are comprehensive as well. International funds are allocated for a variety of programs in multiple communities, yet are implemented entirely by local staff, which is

made possible by the effective communication, usually in the form of grant-writing, between NGO directors and their international benefactors. The past decades of training provided by IPPF volunteers allows the PPAG to set an example for other organizations; today, local volunteers go into the field to implement projects while international volunteers work behind the scenes, lowering the chances of cross-cultural miscommunication. Despite being contradictory to traditional education, fieldworkers find ways to introduce Western sexual education programs not just to adolescents, but to entire communities, giving more individuals an opportunity to gain something from sexual education. All of the ways in which international influences are utilized are respectful of local customs and traditions, and directed by individuals who not only understand customs, but also live within them as residents of northern Ghana. Ultimately, international aid *can* be utilized effectively and consciously, so long as it is under the direction of local individuals who understand the needs of the community.

This network of care, however, is far from perfect. Firstly, organizations, despite being located only miles apart from each other, lack the communication necessary to aid each other in providing services for adolescent girls and. As the same donors fund many of the organizations, I argue that international donors need to be more cognizant of who they fund. Upon seeing that they are funding similar programs in multiple organizations, donors need to be more involved in linking these organizations together. USAID, for example, funds work done by the PPAG and NORSAAC. In the future, if USAID knows it will be funding a NORSAAC program, it can alert the PPAG as well so that the organizations can work together.

Fieldworkers also avoid difficult cultural traditions, such as child marriages and living with aunties. Addressing these traditions is crucial if northern Ghana is to truly create an environment in which adolescent pregnancy rates decrease. While none of these problems are hindered by international aid, that international aid does not address them might mean these ideas are still foreign to many Westerners, or perhaps deemed too challenging to tackle. If the international community wishes to address these problems, I recommend that they do so in a way that is similar to the example set by organizations implementing sexual education programs. Western sexual education programs, despite being contradictory to local customs, were developed to be understandable to community members regardless of literacy rate, approved by community leaders after they digested the material, and then dispersed throughout the entire community, not just to adolescent girls. This same ‘translation’ from Western to the local—that is, acceptance by community leaders, and then introduction into an entire community—must be utilized if programs that focus on child marriage and living with aunties are to be successful.

A third problem that local fieldworkers can address utilizing international aid is the issue of program monitoring and quantitative data collection. The lack of quantitative data is largely in part due to the miscommunication between the community and organization. Creating a more succinct and effective method of collecting data would be a task suitable for international volunteers, particularly those working to improve organizational infrastructure. Once fieldworkers discussed their concerns with volunteers and detailed what they need from a data collection system, volunteers could devise a collection system that they would test in the communities, which would report back to volunteers with what works and what does not. This work would be extremely beneficial

to organizations; it would also allow international volunteers to aid without overstepping boundaries and potentially doing more harm than good.

My findings highlight more than the ability of international aid to be effectively utilized when addressing adolescent pregnancy in northern Ghana. They also highlight the failures of the national government to provide adequate care to its most vulnerable citizens. The damages done to the North as a result of the century and a half of systematic underdevelopment should not continue on today, especially when governmental policies and programs that aid adolescent girls and adolescent mothers are in place. Yet, the northern regions still do not have enough schools so that all students, let alone girls, can travel a suitable distance to attend class; they lack clinics, forcing too many young mothers to walk for miles or sit on bike handlebars just to receive a check-up; and they are still not viewed as equal to regions in the South. In addition, government officials are not visiting communities to encourage families to send their girls to schools, even seven years after the implementation of the Girls Education Unit, or to encourage adolescent mothers to attend clinics, with the exception of the one nurse I spoke with at the Kalpohin Health Center. Despite receiving international aid to address these issues, the government had been inadequate providing preventative or treatment programs.

The international influences, both monetary and ideological, the government receives are perhaps ineffective because of their size. While the NGOs utilize specific international aid for specific tasks, it is much more difficult to grasp an influence such as an MDG and apply it on a national level. Or the international aid might not be strong enough, on a physical and mental level, to bridge the North-South gap. Regardless of why international influences do not translate into government action, the situation in

northern Ghana must be changed. Policies and programs that are national must truly be national. They must account for its northern citizens as much as they do for their southern citizens. Whether the international community is powerful enough to aid in such a task, however, is unsure.

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- Hazara. Formal interview about her experience as a young mother training at Girls in Growth and Development. Translated by Zacharia Zaid Ibrahim. GIGDEV Regional Training Center, Tolon, Ghana. 28 April 2014.
- Hazara. Formal interview about her experience as a young mother training at Girls in Growth and Development. Translated by Zacharia Zaid Ibrahim. GIGDEV Regional Training Center, Bognayili, Ghana. 24 April 2014.
- Kadiri, Mariam Adam. Informal interview about the role of women in educating their children about sexual and reproductive health. Near the University for Development Studies Graduate School campus, Tamale, Ghana. 20 April 2014.
- Mahamadu, Azara. Formal interview about the Women Empowerment and Relief Services for the Destitute and the work it does with adolescent mothers in Northern communities. CLIPS Regional Office, Tamale, Ghana. 19 April 2014.
- Mariam. Formal interview about her experience as a young mother and training at Girls in Growth and Development. Translated by Zacharia Zaid Ibrahim. GIGDEV Regional Training Center, Savelugu, Ghana. 24 April 2014.
- Memonatu. Formal interview about her experience as a young mother training at Girls in Growth and Development. Translated by Ibrahim. GIGDEV Regional Training Center, Bognayili, Ghana. 24 April 2014.
- Moshi. Formal interview about her experience as a young mother training at Girls in Growth and Development. Translated by Zacharia Zaid Ibrahim. GIGDEV Regional Training Center, Savelugu, Ghana. 24 April 2014.
- Naima. Formal interview about her experience as a young mother training at Girls in Growth and Development. Translated by Zacharia Zaid Ibrahim. GIGDEV Regional Training Center, Bognayili, Ghana. 24 April 2014.
- Telly, Hajara. Formal interview about the Federation of Muslim Women's Associations of Ghana and the work it does with adolescent mothers. Near the University for Development Studies Graduate School campus, Tamale, Ghana. 24 April 2014.
- Tijani, Hardi. Formal interview about the Regional Advisory and Information Networking Systems and the work it does to help adolescents and adolescent mothers. RAINS Headquarters, Tamale, Ghana. 25 April 2014.
- Zakaria, Aliyatu. Formal interview about her experience as a midwife working with adolescent mothers at a Ghana Health Services clinic. GHS Clinic, Tamale, Ghana. 29 April 2014.

Appendix 1

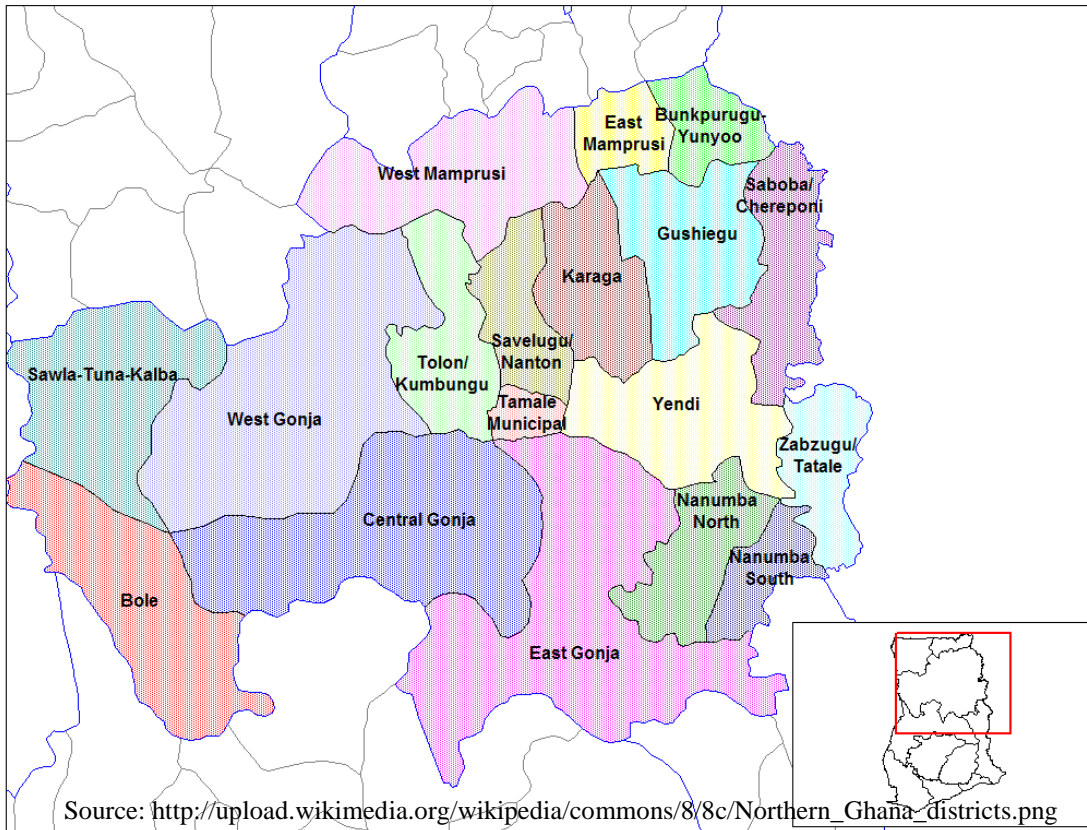


Figure 1: Map of Northern Region of Ghana. Fieldwork took place in Tamale Municipal, Savelugu/Nanton, and Tolon/Kumbungu

Appendix 2

Images from the Kalpohin Health Center*



Figure 2: Courtyard of the Kalpohin Health Center



Figure 3: Family Planning consultation room at Kalpohin

* - Unless cited otherwise, all photos taken by Alexandra Sloss.

Appendix 3

Images from the Jisonayili youth center



Figure 4: Khadija Emmideme, youth-friendly nurse at Jisonayili.



JHS students at a Young and Be Wise class.



A book of contraceptives providing information for an IUD.

Appendix 4

Images from GIGDEV's Regional Training Centers



Mothers and their children at the Savelugu Regional Training Center.



Mothers and their children at the Bognayili Regional Training Center.

Appendix 5

Posters containing data from communities where NORSAAC implemented CHTs and PSGs.

NAME OF COMMUNITY	YEARS	DELIVERIES		CHANGE IN %
		HOME	FACILITY	
NYONG-NAVILI	2012	35	17	33% - 46%
	2013	29	25	
WANTUGU	2012	21	7	25% - 38%
	2013	18	11	
YIPIELGU	2012	16	5	23% - 66%
	2013	9	18	
GUMONAAVILI	2012	8	6	42% - 61%
	2013	7	11	
GUNAAYILI	2012	12	4	25% - 39%
	2013	11	7	
Kumoayili	2012	21	5	19% - 22%
	2013	24	7	
Dimabi no. 1	2012	14	5	26% - 59%
	2013	9	13	
Pulo	2012	11	8	42% - 95%
	2013	1	20	
Nangbaguyapala	2012	10	7	41% - 58%
	2013	8	11	

Data from communities where CHTs are implemented.

STATISTICS IN SOME OF OUR IMPLEMENTING

NAME OF COMMUNITY	YEARS	DELIVERIES		CHANGE IN %
		HOME	FACILITY	
NYONG-NAYILI	2012	35	17	33% - 46%
	2013	29	25	
WANTUGU	2012	21	7	25% - 38%
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	2013	1	20	
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	2013	8	11	

Data from communities where PSGs are implemented.