UNIVERSITY OF CAPE COAST

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AMONG DRESSMAKERS AND HAIRDRESSERS IN THE ASSIN SOUTH DISTRICT

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature……..... Date:...…….....

Name: SAMUEL ASIEDU OWUSU

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

This study explored how dressmakers and hairdressers in the Assin South District of Ghana receive education on sexual and reproductive health. It sought to identify the various educative programmes that are specifically designed for dressmakers and hairdressers and the contribution of stakeholders in providing such education.

An individual interview schedule was used to gather data from 119 dressmakers and hairdressers who were randomly sampled for the study. Four focus group discussions involving 29 discussants and in-depth interviews with five key informants were the other methods of data collection.

Most of the participants had their first sexual intercourse at age 16. Most of the respondents would consult a qualified health professional when faced with problems in sexual and reproductive health. Majority of the dressmakers and hairdressers did not deliberately receive sexual and reproductive health education programmes nor discussed them at their work places. No structured education programme(s) on sexual and reproductive health existed for the participants, at least within the study period.

Respondents agreed that sexual and reproductive health education should be integrated into their training. It is recommended that training in sexual and reproductive health education should be given to supervisors to build their capacities and to enable them educate their apprentices. A detailed study on sexual and reproductive health education in the informal economy of Ghana is recommended to inform policy formulation and programming.

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The people mentioned in this work are not liable for any shortcoming and errors that might exist in this work. Any such shortcoming and errors remain mine.

DEDICATION

To my wife Rebecca, brothers and Professor Albert M. Abane

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ACRONYMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ASD	Assin South District
ASDA	Assin South District Assembly
ASDHD	Assin South District Health Directorate
AYA	African Youth Alliance
BAC	Business Advisory Centre
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CEDEP	Centre for the Development of People
CEDPA	Centre for Development and Population Activities
CHPS	Community-based Health Planning and Services
FGD	Focus Group Discussions
FGI	Futures Group International
FM	Frequency Modulation
FLE	Family Life Education
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GHABA	Ghana Hairdressers and Beauticians Association
GNTDA	Ghana National Tailors and Dressmakers Association
GPRS	Ghana Poverty Reduction Strategy
GSMF	Ghana Social Marketing Foundation

GSS	Ghana Statistical Service
GTV	Ghana Television
HeHaHo	Healthier Happier Home
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDI	In-Depth Interviews
IE&C	Information, Education and Communication
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
JHS	Junior High School
JSS	Junior Secondary School
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MOEYS	Ministry of Education, Youth and Sports
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NBSSI	National Board for Small Scale Industries
NFPP	Ghana National Family Planning Programme
NGOs	Non-Governmental Organisations
NPC	National Population Council
UNHCR	United Nations High Commissioner for Refugees
PATH	Program for Appropriate Technologies in Health
PFLE	Population and Family Life Education

PHC	Population and Housing Census
PIEC&M	Population Information, Education, Communication and Motivation
PoA	Programme of Action
PPAG	Planned Parenthood Association of Ghana
PRB	Population Reference Bureau
RCH	Reproductive and Child Health
REP	Rural Enterprises Project
SHS	Senior High School
SPSS	Statistical Product for Service Solutions
SRH	Sexual and Reproductive Health
SRHE	Sexual and Reproductive Health Education
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases
TEMAK	Teenage Mothers and Girls Association of Kenya
UCC	University of Cape Coast
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION TO THE STUDY

General Background to the Study

The population of the world was projected to grow from an estimated 6.6 billion in the middle of 2007 to a projected 9 billion in 2042 (Population Reference Bureau [PRB], 2007) with India, China and Africa accounting for more than 73% of the total. On the contrary, there is a remarkable gradual reduction in fertility rates partly due to improvements in public health and medical technology (vaccines and antibiotics) resulting in lower mortality rates as well as increased access to formal education and use of modern contraceptives (Sai, 1995; Antwi, 1999; Kinder, 2007).

One of the major characteristics of the world's population is the dominance of both children and the youth especially in the developing countries (CARE International, 2003). Young people, particularly those aged between 10 to 19 years account for more than one-fifth of the total population in less developed countries and one-seventh of the population in more developed countries (Lamptey, Wigley, Carr, & Collymore, 2002).

An accelerated and improved educational system is considered as one of the effective tools that could be employed to speed up the overall development of an individual and the human resources of every country. Education equips a

person to be an independent and a discerning thinker. An educated person is provided with opportunities such as securing better jobs which are not as widespread to those without or those with little educational attainment (Ghana Statistical Service [GSS], 2005).

Education is not only confined to the school facility but can also be acquired informally through the family or an organised group even though formal education is regarded as the best pathway to accelerated development. It is perhaps in recognition of this that education has become a major priority to most governments in the world. That there are still masses of the youth not enrolled in schools in many countries is definitely worrying.

Health is a developmental issue that contributes to the development of a nation, a community and individuals. According to the World Health Organisation (WHO), health is not the mere absence of diseases or infirmities but includes the complete state of physical, emotional and social well being of a person (World Health Organisation [WHO], 1946). A healthy population will, for instance, significantly increase productivity and reduce the cost of providing health care to free some resources for other developmental projects. Despite the pledge in the 1970s by health officials to attain health for all by the dawn of the 21st century, available statistics reveal that good health has still eluded billions of people across the globe (Murphy, 2005).

The international community, governments and non-governmental organisations (NGOs) have, over the years, adopted and implemented a number of policies and programmes aimed at quickening the pace in the provision of quality

education and health care to the people. For instance, the 1994 International Conference on Population and Development (ICPD) (United Nations [UN], 2007), The Fourth World Conference on Women in 1995 and the Millennium Development Goals (MDGs) (UN, 2000) all aimed at promoting and safeguarding the general welfare of humanity. Three of the eight MDGs specifically target maternal mortality, infant mortality and the fight against HIV/AIDS.

The study area

The area selected for this study is the Assin South District (ASD) in the Central Region of Ghana. The district was carved out of the then Assin District and has Nsuaem-Kyekyewere as its administrative capital. The district is bounded on the west by the Twifo-Hemang Lower Denkyira District, the south by the Abura-Asebu-Kwamankese and Mfantsiman Districts, on the east by the Asikuma-Odoben-Brakwa and Ajumako-Enyan-Esiam districts and in the north by the Assin North District. The Assin South district is one of the rural districts in Ghana and has about 900 settlements categorised into six area councils. Figure 1 is the map of the Assin South District.

According to the 2000 Population and Housing Census the population of the district was 98,228 with a sex ratio of 99 males to 100 females. The estimated annual population growth rate of the district is 2.9 %. The age distributions are 16.7 % for children under 5 years, 15.9% for 5-9 years, 62.6% for the 10-59 year olds and 4.8% for those above 60 years. The majority of the adult population (72.2%) are predominantly cash crop farmers who are mainly into the cultivation

of cocoa, oil palm and citrus. The other important economic activities in the district are dressmaking, hairdressing, artisanship and petty trading.

The district is served by six Health Centres, two Health Posts and three Community-based Health Planning and Services (CHPS) Zones. These facilities provide general health services including sexual and reproductive health care and counselling. Currently, there are fifty nine Early Childhood Development Centres, eighty eight Primary Schools, fifty six Junior High Schools (JHS) and four Senior High Schools (SHS) in the district. The district is also host to a major tourist site, the Assin Manso Slave Reverence Garden which played a key role in the history of the Trans Atlantic Slave Trade.

Any district could have been chosen for this study because the thrust of the study is not peculiar to Assin South. However, the choice of Assin South District was informed by some reasons. For instance, it appears potential respondents in the Cape Coast Metropolis have been burdened by both student and institutional researchers due to the presence in Cape Coast of research institutions such as the University of Cape Coast and the Cape Coast Polytechnic.

Again, the St. Francis of Xavier Hospital located at Assin Fosu in the Assin North District has played a major role in the dissemination of sexual and reproductive health education in the Central Region of Ghana. It is one of the first health institutions in Ghana to offer services in HIV/AIDS.

The then Assin District was the target for this study. However, it was divided into the Assin North and South districts just when the study was about to commence. The Assin South District was randomly selected as the study area.

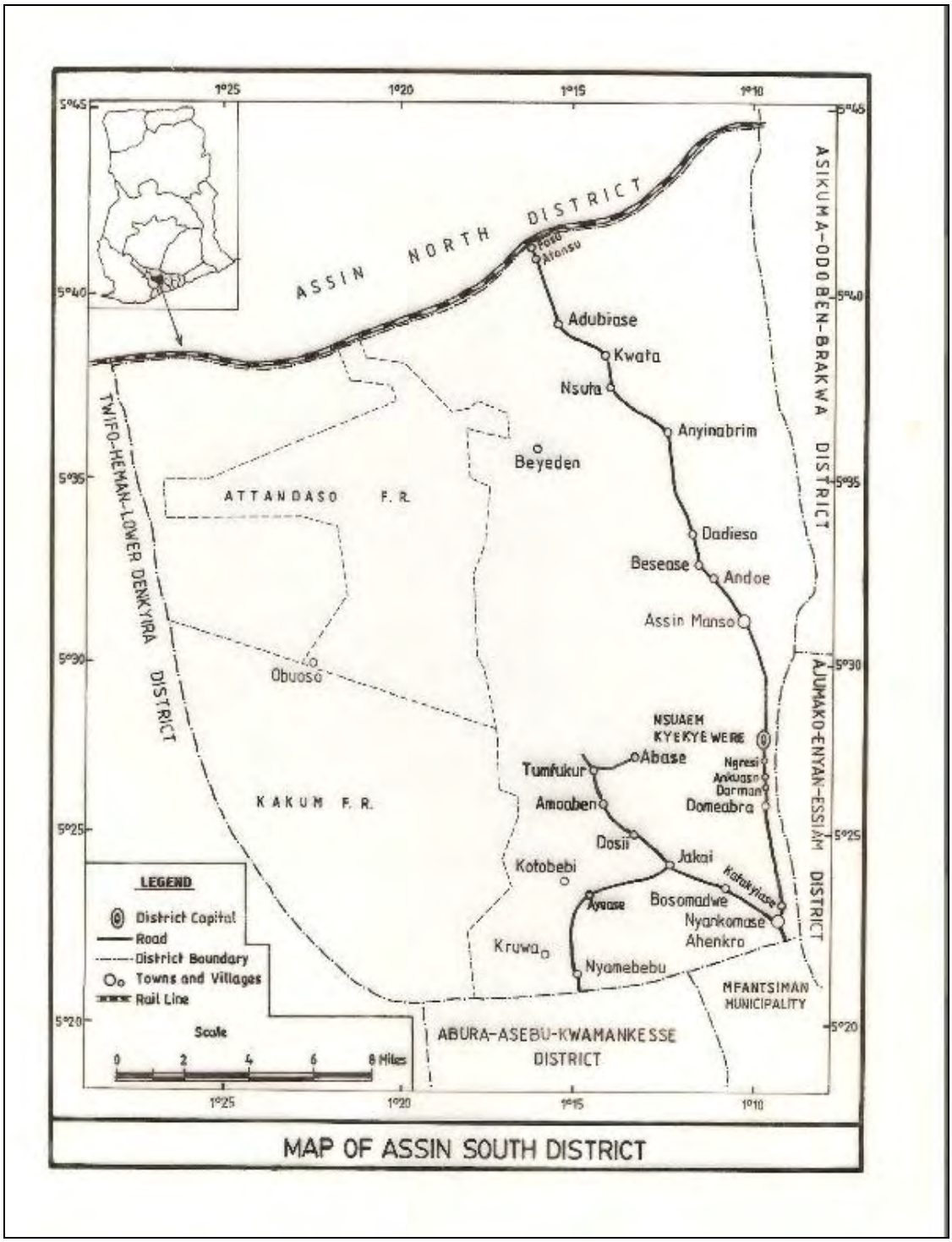

Figure 1: Map of the study area (Assin South District)

Source: GIS, Remote Sensing and Cartography Laboratory, UCC

Statement of the problem

The 2000 Population and Housing Census (PHC) conducted in Ghana returned a population of 18, 912,079 for the country. The youth (10-24 years) constituted about 31% of the population (GSS, 2005). Currently, the population of Ghana is estimated at 23,000,000 with an expected rise to about 47,000,000 by 2050 (Population Reference Bureau [PRB], 2007). The proportion of the population aged less than 15 years had declined from 45% in 1984 to 41.3% in 2000 (National Population Council [NPC] ,1994; GSS, 2005). There is therefore the urgent need to create all the favourable conditions that would enhance the growth and development of the young population. One of the major threats to the achievement of this dream is the negative consequence of poor sexual and reproductive health of the people.

Reproductive health seeks to ensure that people are able to have a responsible, satisfying and safe sex life as well as having the capability to reproduce and the freedom to decide if, when and how often to do so (UN, 2007). Reproductive health also enjoins men and women to be well informed on sexual and reproductive health issues including having access to safe, effective, affordable and acceptable methods of family planning and other methods of their choice for fertility regulation. It also includes having appropriate health-care services that will enable women to go safely through pregnancy and childbirth (UN, 2007; Roudi, 2001).

Indeed, a commitment made by the 1994 International Conference on Population and Development held in Cairo (Egypt) was the need to identify and

address sexual and reproductive health problems of the people through the provision of appropriate services and counselling. The conference also highlighted the urgent need of ensuring that comprehensive and factual information on reproductive health are made accessible, affordable, acceptable and convenient to all users through policies, programmes and collaborations with all stakeholders.

In response to this commitment, the government of Ghana formulated an Adolescent Reproductive Health Policy in 2000 with the broad objective of promoting a healthy environment and policy framework within which young people can obtain information and services on reproductive health (Awusabo-Asare, Abane, & Kumi-Kyereme, 2004; Luke, 1998; NPC, 2000). The policy identified some stakeholders including parents, the media and NGOs to educate the youth on sexual and reproductive health.

Sexual and reproductive health education in Ghana was initially focused on the adult population due to some factors including inadequate knowledge about human sexuality, cultural taboos and negative attitudes towards sex and sexuality. The youth were particularly vulnerable because of their lack of information and access to relevant reproductive health services. They are forced to make decisions about their sexuality without adequate information and with little support (CARE International, 2003). It is therefore worrying that most parents, teachers and other adults have failed to equip the youth with the needed information, skills and resources to ensure healthy transition into adulthood (Greene, Rasekh, & Amen, 2002).

Education on sexual and reproductive health in Ghana gained some prominence after the adoption of the 1994 Population Policy. As part of efforts to promote quality sexual and reproductive health services for children and the youth, the Ministries of Health and Education and other collaborators such as the Planned Parenthood Association of Ghana (PPAG) implemented a number of public programmes to encourage the youth to adopt healthy reproductive lifestyles and attitudes.

Currently, sexual and reproductive health education issues form an integral part of the curriculum in all the levels of education in Ghana (Awusabo-Asare, 1999; Awusabo-Asare et al, 2004; Jocelyn, Bonnie, Farzaneh, & Ashford, 2007; NPC, 2000; NPC, 1994; Roudi, 2001). There are however a sizeable proportion of the population of school going age who are not in school but engaged in economic activities in the informal economy.

In a study on the role of women policy makers in the Sekyere-East District of Ghana, Owusu (2003) observed that most leaders in the informal economy such as dressmakers and hairdressers in the district lacked the knowledge and competencies to adequately educate their trainees on sexual and reproductive health issues because they considered such issues as non prioritised issues.

Some questions therefore arise to which answers ought to be found. For example, to what extent does the working environment expose dressmakers and hairdressers to risky sexual behaviours? How do this young person's cope with the interplay of work environment, pregnancy and its related complications including abortions and reproductive infections? What peculiar obstacles confront

dressmakers and hairdressers in their desire to access sexual and reproductive health care? Are there structured educational programmes on sexual and reproductive health designed specifically for dressmakers and hairdressers? How is information on sexual and reproductive health discussed at dressmaking shops and hairdressing salons? Is there an institutional support for sexual and reproductive health programmes among such people operating in the informal economy? The quest for answers for these and other related questions which target the people engaged in dressmaking and hairdressing constituted the basis of this study.

Objectives of the study

The principal objective of the study was to assess the delivery of sexual and reproductive health education to dressmakers and hairdressers as well as their knowledge in sexual and reproductive health issues. Specifically, the study sought to:

- identify the sexual and reproductive health education programmes being implemented by stakeholders among dressmakers and hairdressers in the study area;
- determine the sources of information on sexual and reproductive health available to dressmakers and hairdressers in the study area;
- assess the communication pattern(s) on reproductive health among the dressmakers and hairdressers at their workplaces;

- critically analyse the reproductive health seeking behaviours of dressmakers and hairdressers;
- evaluate the contribution of institutions/organisations in the provision of sexual and reproductive health education to dressmakers and hairdressers; and
- Recommend, where necessary, measures that could be adopted to ensure effective delivery of sexual and reproductive health education to dressmakers and hairdressers.

Rationale for the study

This study will be particularly relevant to all stakeholders who are concerned with providing quality information and education on sexual and reproductive health to the youth of Ghana. It has the potential to unearth the major obstacles dressmakers and hairdressers in the study area face in accessing quality information on sexual and reproductive health.

A study of this nature will expose the knowledge and competencies of both the apprentices and their supervisors in sexual and reproductive health education issues which will in the end inform policy makers on the appropriate areas to address and measures to be adopted to empower the supervisors and their apprentices with the needed skills to disseminate appropriate knowledge to their counterparts in other sectors of the informal economy.

The government of Ghana intends to institutionalise an apprenticeship programme to equip the youth with knowledge, skills and technology to prosper

in the global economy (Republic of Ghana, 2004). The intended programme will directly target the youth who would not be able to further their education at the Senior High School (SHS) level. This study will therefore provide some baseline guidelines on how sexual and reproductive health education issues could be integrated into the proposed training programme. It will also identify some of the challenges that could thwart the success of the programme and offer practical recommendations on how the programme could achieve some results.

The general aim of sexual and reproductive health education is to provide data and information to people on how they could make informed choices to help them improve their quality of life. This study is particularly relevant in this direction as it seeks to assess how sexual and reproductive health education is offered to dressmakers and hairdressers and how the sexual and reproductive health issues could be integrated into their training to enhance their quality of life.

Finally, the study would also serve as a basis for further research on sexual and reproductive health education to dressmakers and hairdressers and other vocations of the informal economy in Ghana.

Choice of dressmakers and hairdressers

A dressmaker is a person who makes women's cloths, especially as a job while a hairdresser is a person whose job is to cut, wash and shape hair (Hornby, 2000). In more specific terms, a seamstress refers to a woman who can sew and make clothes or women whose job is sewing and making clothes while a tailor is a person whose job is to make men clothes. Barbers, on the other hand refer to

people whose job is to cut men hair and sometimes to shave them. Notwithstanding the differences, dressmaking and hairdressing vocations were generically used in this study as comprising all persons whose vocation is to sew men and women clothes as well as cutting, washing, plaiting or shaping peoples hair in exchange for money.

Dressmaking and hairdressing apprentices form a large group of youth in the informal economy and a large proportion of them are sexually active. They have little or no financial sustenance and it becomes difficult for them to negotiate for safer sex with their sexual partners. This situation makes them very vulnerable to unhealthy sexual and reproductive practices that largely expose them to Sexually Transmitted Diseases including HIV/AIDS.

Dressmakers and hairdressers are among a few groups whose practitioners have had some form of formal education to at least the basic level, and have had the advantage of receiving some basic education on sexual and reproductive health. Besides, some dressmakers and hairdressers are targets of the state and NGO sponsored programmes on sexual and reproductive health education. In Ghana, some dressmakers are regarded as “informal counsellors” on sexual and reproductive health and non-traditional distributors of condoms (Essandoh, 2004; Ghana Social Marketing Foundation [GSMF], 2007; Johns Hopkins University, 2006).

Lastly, dressmaking shops and hairdressing salons are sometimes the venues where young people congregate to discuss sexual and reproductive health issues (Essandoh, 2004). The dressmakers and hairdressers have well organised

and structured associations with a strong membership base. These unique features about the dressmakers and hairdressers contributed to the decision to use the two vocational groups for this study.

Chapter Organisation

The study is divided into six chapters. Following Chapter One is Chapter Two which concentrates on Ghana's Population Policies and Programmes on sexual and reproductive health, the informal economy and the conceptual framework. The third chapter introduces the methods and procedures employed in the data collection. The basic characteristics of the respondents as well as their knowledge on reproductive health are discussed in the fourth chapter.

Chapter Five interprets the findings of communication patterns on sexual and reproductive health in salons and shops and analyses the contributions of stakeholders in providing sexual and reproductive health education to the respondents in the study area. Chapter Six concludes the study with summaries and conclusions; while recommending steps for improving education on sexual and reproductive health for dressmakers and hairdressers, as well as areas for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Public discussions on sexual and reproductive health issues have generally been considered a taboo due to the high value society puts on sexuality and virginity before marriage and the belief that talking openly about sexual and reproductive health might encourage unmarried youth to engage in premarital sex (Jocelyn et al, 2007).

There is also the perception that providing sexual and reproductive information to the youth would place them in a moral danger and give rise to sexual experimentation which is likely to result in unwanted pregnancies and the spread of sexually transmitted diseases (STDs). These concerns sometimes have religious, cultural or political underpinnings. For example, in Ghana, the various religions have several teachings and practices on sexual and reproductive issues that have, in a way, shaped the sexual and reproductive attitudes and behaviour of their followers. Politically, sexual and reproductive issues such as abortions normally take the centre stage in choosing political leaders in some countries.

There are also some cultural taboos that inform the extent to which one can openly talk about sexual and reproductive health issues. But reviews of sex education programmes worldwide have concluded that sex education does not

encourage early sexual activity

Rather it delays first sexual intercourse, lead to more consistent contraceptive use and safer sex practices (Jocelyn et al, 2007). Currently, there are a number of countries that have adopted sexual and reproductive health policies as well as a myriad of programmes which are being implemented as a means of ensuring the total development of their people.

This chapter reviews three of such policies in Ghana which are deemed relevant to this study and some of the sexual and reproductive health education programmes. The chapter also discusses the concept of the informal economy in relation to sexual and reproductive health education and ends with the conceptual framework.

The 1969 Ghana Population Policy: Population Planning for National Progress and Prosperity

The 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, is, perhaps, widely regarded as the turning point for a number of countries in incorporating population issues into their development programmes as a means of addressing the major negative impacts of population on development **(**Luke, 1998).

In Ghana, however, a definitive population policy had already been adopted in 1969 to “manage population resources in a manner consistent with government’s ultimate objective of accelerating the pace of economic modernisation and improving the quality of life of Ghanaians” (NPC, 1994). The

policy was at the period the third population policy in the world (Luke, 1998). The policy sought to ensure that population issues were integrated into all aspects of the development planning and implementation process to facilitate the process that will lead to economic growth, poverty reduction and enhancement of the quality of life of all citizens in the country.

In a case study on reproductive health in Ghana, Luke (1998) reported that prior to the adoption of the 1969 Population Policy the Christian Council of Ghana had commenced a programme in the 1960s to address some sexual and reproductive health problems facing their members and as a tool for promoting healthy Christian family living.

The 1969 policy was also promulgated to provide policy implementers with a clear direction in curbing the seemingly high fertility and rapid population growth that had characterised the population of Ghana in the 1950s (Mba, 2002). The policy focused on reducing population growth rate from an estimated 3.2 percent to 2.0 percent per year, and a further reduction of the total fertility rate from 4.6 to 4.0 children per woman by the year 2000.

The implementation of the policy led to the introduction of the Ghana National Family Planning Programme (NFPP) in 1970 to implement a wide range of population programmes and provide family planning services. However, the initiative could not achieve its intended objectives soon after its establishment partly due to improper coordination and unclear definition of roles by key implementers. There was enough evidence to suggest that the population of Ghana had almost doubled with a corresponding slow economic growth after 25

years of implementation of the 1969 Population Policy.

Analysts opine that the policy failed to effect the needed changes due to lack of political commitment; the notion that the policy was donor driven; and an overemphasis on family planning at the expense of other population-related issues such as women's roles, the environment and urbanization. In spite of the pitfalls, the programme raised the awareness of the people, especially urban residents, to family planning issues (Luke, 1998; NPC, 1994; Shannon, 1998).

An evaluation of the 1969 policy in the late 1980s led to a recommendation for a redefinition of the policy's objectives, implementation strategies, institutional framework and an incorporation of some emerging population issues such as teenage pregnancy, environmental degradation and Human Immunodeficiency Virus and Immunodeficiency Syndrome (HIV/AIDS) which were not originally factored into the policy. Another suggestion was the creation of an independent body to be named The National Population Council to advice government on all population and related issues.

Ghana promulgated and adopted the fourth Republican Constitution in 1992 when she opted for a democratic form of governance. The constitution categorically states that "the state shall maintain a population policy consistent with the aspirations and development needs and objectives of Ghana" (Republic of Ghana, 1992; NPC, 1994).

In response to the shortcomings identified in the 1969 population policy and the government's resolve to formulate a comprehensive, dynamic and explicit population policy that will not only affirm the 1969 policy but also to incorporate

the emerging issues of population and environment, reproductive health, the aged, youth and persons with disabilities, a revised National Population Policy was adopted in 1994. There was no explicit policy direction in the 1969 policy to provide targeted and structured education and services on sexual and reproductive health to dressmakers and hairdressers or the people who work in the informal economy.

The 1994 Revised National Population Policy of Ghana

The promulgation and adoption of this policy, in a way, coincided with the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994. The outcome of the conference was a phenomenal global awareness of population management. Major developmental issues such as population and poverty, population and environment and patterns of production and consumption were highly acknowledged during the conference.

The ICPD- Programme of Action (PoA) urged participants to meet the needs of women and men by ensuring gender equality, women's empowerment and the rights and needs of individuals including their sexual and reproductive health (NPC, 2006). One can conclude that the 1994 policy was remarkably progressive in focusing on areas later addressed at the ICPD, including sexual and reproductive health (Luke, 1998).

The 1994 policy acknowledged the youthful nature of the Ghanaian population and a progressive increase of the aged in the country. The 1984 census showed that nearly half (45%) of the population was below 15 years. The 2007

population data sheet produced by the Population Reference Bureau indicates that the proportion had dropped to 40%. However, the 2003 Ghana Demographic and Health Survey confirmed this when the returns showed that the proportion of the population under 15 years has decreased from 47% in 1970 to 41% in 2000. The 2000 Population and Housing Census conducted in Ghana also indicated that the proportion of the population aged 10-24 was 31%. It is significant to note that this high proportion of the population will require a number of programmes and activities to ensure their total development.

The revised policy was aimed at instituting measures that could facilitate the implementation of programmes targeted at reducing the high morbidity and mortality rates in the country. It also sought to promote general sexual and reproductive health for the citizenry including the elimination of all discriminatory laws and cultural practices that are inimical to the general wellbeing and self esteem of women. The policy again intended to provide the necessary information and education of the value of small family sizes and sexual and reproductive health.

As an implementation strategy, the policy called for the introduction of population and family life education (PFLE) at the formal, informal and out of school training to prepare the youth for responsible adulthood. Additionally, the policy proposed the development of population information, education, communication and motivation (PIEC&M) materials in the various local languages to meet the needs of local people to complement the activities of radio, television and newspaper discussions on sexual and reproductive health issues.

The National Population Council (NPC) was inaugurated in November 1992 as the highest body with the mandate to advise government on population issues. The Council was to collaborate with other agencies such as District Assemblies, NGOs, and multinational donor organizations such as the United Nations Fund for Population Activities (UNFPA) in the discharge of its duties.

Even though some progress was made during the implementation of this policy, the pace of decline in fertility seems to be slow while both maternal and infant mortality remain unacceptably high. Another major source of worry for implementers of the policy is the difficulty in securing sustained funding for population activities in the country (NPC, 2006).

One would have thought that specific actions could have been outlined in the policy to address the specific needs of the teeming youth and children as well as informal economy workers on issues that affect their sexual and reproductive health, but a critical study of the document suggests that such provisions were not explicitly made.

The 2000 Adolescent Reproductive Health Policy

Attention on the overall development of children and youth took the centre stage during the mid- 1990s. There was therefore the need for separate policies and programmes on sexual and reproductive health to focus on the young population. The National Population Council, in particular, led the Ministries of Health (MOH), Education, Youth and Sports and other collaborative institutions and agencies such as the Centre for Development and Population Activities

(CEDPA), UNFPA and the Universities of Ghana and Cape Coast to develop an Adolescent Reproductive Health Policy in 1996 (Greene et al, 2002).

An Adolescent Reproductive Health Policy which is directed at the population aged 10-24 in Ghana was adopted in October 2000, to provide broad guidelines for policy makers, programme implementers and the general public on reproductive health among adolescents and young people.

The policy provided the framework through which the sexual and reproductive health needs of young Ghanaians could be met. It was also designed to inculcate in the youth the idea of responsible sexual behaviour, the small family size norm, pursuit of career, values of responsible adulthood and mutual respect for people of the opposite sex (Odoi-Agyarko, 2003).

The policy was formulated to assist in implementing and evaluating programmes and services that addresses the sexual and reproductive health needs of adolescents and the youth (NPC, 2000). The Adolescent Reproductive Health Policy explicitly makes reference to the right of young people to information, services and involvement in planning of sexual and reproductive health education programmes. It also made provision for guidelines for government and non-governmental agencies implementing programmes across sectors with specific targets for the youth's wellbeing such as reductions in early marriage and childbirth (Greene et al, 2002).

Poor sexual and reproductive health leads to a less healthy, less educated and less productive workforce. It is therefore imperative that the youth and children who form the majority of the population are provided with in-depth

information and accurate services in sexual and reproductive health as a means of safeguarding their future and grooming them unto responsible adulthood. The policy document thus aimed at promoting programmes that will enhance the knowledge base of the young people on sexual and reproductive health to enable them develop responsible attitudes toward sex and sexuality.

A key implementing strategy of the policy was the need to strengthen the teaching of sexual and reproductive health issues in schools and the creation of avenues to enable out-of-school adolescents to benefit from such programmes (NPC, 2000).

It is obvious that teachers will primarily be responsible for teaching sexual and reproductive health issues at the formal education setting, however, implementers of similar programmes for out-of-school youth were not specifically identified. It could be assumed that the services of other implementing organizations/partners such as the media, religious bodies and community based organizations (CBOs) or NGOs could be relied on for the provision of such education.

The adoption and implementation of the above policies as well as others such as the 1998 Children's Act, the 1999 Youth Policy and the 2001 National HIV/AIDS and Sexually Transmitted Infection (STI) Policy have not been without problems; including the lack of resources, gender inequalities, cultural diversity and reluctance to acknowledge youth sexual activity (Greene et al, 2002).

Despite these challenges some efforts have been made to implement a number of sexual and reproductive health education programmes in Ghana which are specifically targeted at the youth to educate, inform, counsel or provide them with services consistent with the objectives and targets in the population and adolescent reproductive health policies. Some of such programmes are discussed below.

Sexual and reproductive health education programmes

In 1967, a group of professionals in Ghana, notably, physicians and demographers, formed the Planned Parenthood Association of Ghana (PPAG) as an NGO affiliated to the International Planned Parenthood Federation (IPPF) with the mission to provide the youth with the knowledge and means of exercising their basic rights to decide freely and responsibly on their sexual and reproductive health as a means of improving the quality of life of Ghanaians (Planned Parenthood Association of Ghana [PPAG], 2008).

Barely a year after the formation of the PPAG, the Ministry of Finance and Economic Planning (MOFEP) established the Manpower Board in 1968 to coordinate the population activities of Ghana. The Board, in implementing the 1969 policy, launched the Ghana National Family Planning Programme (NFPP) in 1970 to offer broad-based population programmes and family planning services to majority of the people compared to the limited coverage of the PPAG. The programme, as the name suggests, focused mainly on family planning for adults with little attention given to the other components of sexual and reproductive

health (Ministry of Health [MOH], 1997; Luke, 1998). The youth were, to a large extent, excluded from the programme until 1994 when the Population Policy was revised (Awusabo-Asare et al, 2004).

The implementation of the programme rated Ghana as the third country in Sub-Saharan Africa to develop a population programme with the aim of providing family planning information and services to couples who needed such services (Awusabo-Asare et al, 2004). The seemingly universal awareness of contraceptive methods in Ghana (GSS et al, 2004) and low usage levels (14% or 15%) of modern contraceptives by women in their reproductive years in Ghana (PRB, 2007; GSS et al, 2004) could be traced to the initial activities of the NFPP.

The NFPP, however, did not achieve its objectives and targets. It was plagued by "personality conflicts, poor institutional coordination especially between the MOH and the NFPP, an ineffective family planning service delivery system and competition among donor organizations working through different ministries" (Luke, 1998, pp.5).

Another setback to the success of the programme was the political instability in Ghana during the period. Even though there are a number of outlets such as government and private hospitals, polyclinics, health centres, family planning clinics, fieldworkers, pharmacy or drug stores, maternity homes, friends or relatives (GSS et al, 2004; GSS and Macro International [MI], 1999) from where one could obtain family planning services, the programme could not achieve much of the expected results. The rather low usage of family planning methods in the country, coupled with a high rate of unmet need for the services

(GSS et al, 2004), call for the re-introduction of family planning programme in a way that would be both attractive, relevant and sustainable (Awusabo-Asare et al, 2004).

The Ghana Social Marketing Foundation (GSMF) initiated a social marketing programme in 1985 with assistance from the United States Agency for International Development (USAID). A social marketing programme promotes and sells products, ideas or services that are considered to have a social value, using a variety of outlets and marketing approaches.

The GSMF, together with its partners including The Futures Group International (FGI), PPAG, John Hopkins University and the NPC of Ghana, has become a major marketer and distributor of contraceptives and other health products through their social marketing and other behaviour change techniques (GSMF, 2007). The GSMF has undertaken a number of projects such as 'Stop AIDS Love Life' campaign, 'Things we do for Love' and 'Life Choices'. The latter was aimed at boosting the use of modern family planning methods in urban, peri-urban and rural areas through the collaborative efforts of opinion leaders.

The promotion of sexual and reproductive health education through the mass media has gained prominence due to concerns about high fertility, low contraceptive prevalence rate and the spread of sexually transmitted diseases including HIV/AIDS (Bankole, 1994). The increasing availability of radio, television and the print media can be effectively used to influence people's behaviour. According to Bankole, the mass media can be a powerful tool not only for awareness creation about new technology but also for stimulating people's

desires for more information on sexual and reproductive health as well as facilitating their efforts to apply the information to their own behaviour. The radio, television and print media have also been used to reinforce key sexual and reproductive health messages. The programmes also focused on the reduction of misconceptions and fear of side effects of using family planning methods.

The spread of HIV/AIDS in Ghana and its attendant effects, the adoption of the 1994 Revised Population and 2000 Adolescent Reproductive Health Policies and the ICPD (PoA), have perhaps, intensified the need to provide comprehensive sexual and reproductive health education to the population, especially the youth. Several NGOs, public and private institutions have sprung up to offer such services. Public education and information dissemination on sexual and reproductive health issues was viewed as a vital tool for the control and spread of the disease and to ensure the total and complete development of the individual, then regarded as a key to the achievement of national and international goals and targets.

The expansion in the number and coverage of community radio stations (popularly known as FM Stations) and television have also facilitated the dissemination of information on sexual and reproductive health. Indeed, most of these stations have special educational programmes on sexual and reproductive health issues. For instance, Ghana Television (GTV) has “Mmaa Nkomo” and “Complete Woman” to educate their viewers on a wide range of issues such as abortions, family planning, STIs/STDs and gender based violence. Besides, a number of FM stations also specifically devote quality time for sexual and

reproductive health educations. Programmes such as “Wo ba ada anaa”, “odo ahomaso”, “aware so” and Happier Healthier Home (He Ha Ho) are few examples of sexual and reproductive health education programmes on the radio. The overall objective of these programmes is to provide quality information to the population to enable them make informed choices on their sexual and reproductive issues. Resource persons for such programmes include religious leaders, health care providers, legal practitioners, gender activist and traditional rulers.

Ghana is not the only country that is implementing educational programmes on sexual and reproductive health to empower her citizens to adopt healthy reproductive lifestyles. Other countries such as Burundi, Philippines and Guinea have adopted various strategies to disseminate information on sexual and reproductive health to the people. Some of the strategies include the use of posters, stickers, debates, training, workshops, advocacy and public lectures to educate the people on issues such as HIV/AIDS, sexual delinquency, prevention of female genital cutting and unplanned pregnancies (United Nations High Commission for Refugees [UNHCR], 2003). It should be noted that several of these programmes are not specifically targeted at people in the informal economy but are provided to reach the general population.

Evaluations of how such programmes have impacted on the sexual and reproductive behaviours of people who work in the informal economy such as dressmakers and hairdressers have not been comprehensively carried out.

Institutional support for sexual and reproductive health programmes

The 1994 Revised Population Policy of Ghana identified a number of institutions that will partner the National Population Council in the discharge of its duties. The institutions include government ministries, religious bodies and NGOs. There are quite a number of these NGOS, either international or local, spread throughout the country, which continue to provide sexual and reproductive health education and services.

The NGOs are regarded as legally constituted non for profit organisations which include voluntary citizens' groups formed and operated by private persons or organizations without government representation. They are organised on local, national or international levels to address issues in support of the public good. These organizations sometimes draw the attention of governments to the concerns of the people and encourage participation of civil society at the community level.

A pioneer organisation that focused its attention on the provision of education and services on sexual and reproductive health in Ghana is the PPAG which was established in 1967. It has expanded its scope from a narrow family planning focus to other sexual and reproductive health needs of the people most especially the youth aged 10-24 years (PPAG, 2008; Glover, Annabel, & Nerquaye-Tetteh, 1998). The Association, through its youth centres in the country has provided sexual and reproductive health related information, counselling, recreation and library services. A remarkable achievement of PPAG is its advocacy role which, in part, contributed to the adoption of the FLE programme

in 1984 as part of the syllabus of the formal educational system (Glover et al, 1998).

Between 2000 to 2005, Pathfinder International, Programme for Appropriate Technologies in Health (PATH) and the UNFPA partnered to implement the African Youth Alliance (AYA) project in Uganda, Ghana, Botswana and Tanzania. The project aimed to improve, scale up and institutionalised HIV/AIDS prevention and adolescent reproductive health programmes in the four countries.

In Ghana, for instance, the project was implemented in 20 districts within five regions to expand networks of peer-educators and non-traditional condom distributors such as dressmakers and hairdressers who mostly meet a large proportion of the youth in the context of their everyday lives. The project also involved the organisation of some outreach activities in schools, churches and communities as well as advocacy and behaviour change communication (BCC) with a specific focus on young people (Pathfinder International, 2008).

In collaboration with some agencies, charities and CBOs such as the Centre for the Development of People (CEDEP), Christian Health Association of Ghana, Ghana Education Service (GES) and the MOH (Reproductive Health Unit) the programme also focused on the provision of information and skills in sexual and reproductive health through role-plays, drama, facility-based youth-friendly services, mass media, debates and quizzes to both the out-of-school and in-school youth.

Undoubtedly, the provision of sexual and reproductive health education in Ghana has expanded both in content and coverage during the last two decades. There are other organisations that are providing the education and services to the people at the local level in most parts of the country. It should, however, be noted that these educational activities were initially directed at the aged population. The youth have only recently been placed at the centre of these activities. Adolescent sexual and reproductive health (ASRH) has now been the subject of concern for most policy formulators and programme implementers. A category of the youth that is likely to be vulnerable and susceptible to poor sexual and reproductive health practices are the ones who are out of school.

The following section contextualises sexual and reproductive health education in the informal economy of Ghana with emphasis on dressmakers and hairdressers.

The informal economy and reproductive health education

The dominance of the youth and children in Ghana's population has necessitated the introduction of some policies and programmes to ensure their development and maximum contribution to national development. The implementation of the 1994 Revised Population Policy, the 2000 Adolescent Reproductive Health Policy and the Free Compulsory Universal Basic Education (FCUBE) are some efforts by stakeholders to provide the youth and children with the needed skills, training, expertise and the enabling environment to build their capacity to make meaningful contributions to national development. However,

there are a large proportion of the people who are still ill-equipped and non-proficient in craft and skills to enter into the formal sector of the economy but engaged in activities in the segment of the economy widely described as informal economy (GSS, 2004; Okojie, 2003).

The informal economy is described as the range of economic units in both urban and rural areas which are largely owned and operated by individuals with little capital, labour, goods and services to generate income and employment (Adu-Amankwah, 1997). Becker (2004) refers to the informal economy as all the economic activities by workers and economic units that are, in law or in practice, not covered or insufficiently covered by formal arrangements. Indeed, the informal economy could be described as the non-structured economic sector that has emerged as a result of the formal economy's inability to absorb all the prospective job seekers.

The informal economy covers a variety of activities such as agriculture, fishing and fish processing, wholesale and retail food vending, chemical/drug sale, refuse collection, carpentry, portage, hairdressing/barbering and dressmaking (Adu-Amankwah, 1997; Becker, 2004; Chen, 2004).

The informal economy had been regarded as unnoticed, unprotected, mostly ignored, rarely supported, unregulated, sometimes unprofitable and confined to marginal activities (Adu-Amankwah, 1997; Becker, 2004). However, it has attracted a lot of attention worldwide in recent years due to the realisation that the sector has been expanding and offering job opportunities to many people, notably children, the youth and women who are essentially low-skilled and semi-

literate and the inability of the formal economy to absorb all the increasing job seekers and the high demand for low-cost goods and services from those employed in the formal economy (Becker, 2004; Chen 2004; Hormeku, 1998).

Another identifiable feature of the informal economy is the close interconnection between ownership and business. Many workers located in the sector are self-employed and utilize the labour from relatives, friends or apprentices who may either be casual or without contractual agreements but on mutual understanding (Susan, 1991). Other general features of the informal economy are ease of entry, reliance on indigenous resources, small scale operation, lower wages, unregulated markets and poor social security.

The informal economy is now a major partner of the formal economy in national development. Apart from providing sustainable services to the formal economy, it provides a means of livelihood for most people. However, there are a number of challenges that threaten the very survival of this economy including working in harsh, exploitative and unpredictable conditions; lack of job security; limited opportunity for advancement; non-existent or poor guarantees against income losses; limited infrastructure; inadequate labour legislation; seasonality of work; lack of substantial working capital or working with loans with high interest rates from money lenders (Jankulovska, 2002; Mukherjee, 2003; De Wit, 2007).

In addition, operators in the informal economy, especially the women, are sometimes ignored as far as public policy is concerned. Their activities are occasionally perceived as illegal. They oftentimes become victims of harassment by law-enforcement agents (Soetan, 2005).

In Ghana, substantial proportions of the youth who earn a living in the informal economy are located in the dressmaking and hairdressing sectors. Some of them have never been to school; others are drop outs while some are still in school but engaged in the activities either alone or with their parents/guardians to enable them acquire professional and income-generation skills.

The setting up of a dressmaking shop or hairdressing salon to commence operations involves the acquisition of space, a kiosk or an enclosed veranda; the acquisition of some basic equipment such as dryers, combs, towels, creams, rollers, blades and sewing machines; a certificate from either the Ghana Hairdressers and Beauticians Association (GHABA) or the Ghana National Tailors and Dressmakers Association (GNTDA) and, in some cases, a permit from the local council/district assembly.

The two associations seem well organised, with administrative structures at the national, regional and district levels. Detailed studies on their activities in Ghana are not enough; however, preliminary enquiries into their activities indicated that commencement of such businesses does not require much academic or professional qualification. The period of apprenticeship is also dependent on some factors such as the attitude of the supervisor and the preparedness of the apprentice to learn. An apprentice is likely to spend a minimum of two years on the average before he/she could graduate and qualify as a professional dressmaker or hairdresser.

The challenges in the dressmaking and hairdressing business in Ghana are not different from the other sectors of the informal economy. For instance, their

income levels are relatively low due to the increasingly high cost of some raw materials and services such as creams, electricity and rent in addition to the seemingly low charges for services rendered. There is also the problem of limited access to credit facilities to enable them establish and expand their business. In some cases, some of the apprentices do not have enough funds for their living expenses and therefore largely depend on their parents/guardians whose incomes are sometimes inadequate to meet their needs. They are thus forced to depend on other people such as friends including boyfriends (among the women), a neighbour or a benevolent person for survival.

The situation is even compounded for the apprentices who migrate from the rural areas to either settle alone in rented premises, lodge with a family member or friend. They sometimes misapply their independence (especially those on their own) to engage in higher risk behaviours such as indulgence in unprotected sexual intercourse. Little is known, empirically, about the extent to which dressmakers and hairdressers perceive themselves to be at risk of engaging in harmful practices particularly those that could affect their sexuality or reproduction.

Reproductive health seeks to ensure that people have the capability to reproduce and the freedom to decide if, when and how often to do so. It also ensures that both men and women have unrestricted access to quality information on family planning and other methods of fertility regulation as well as safeguard the rights of all couples and individuals to decide, freely and responsibly, the number, spacing and timing of their children (UN, 2007).

The Programme of Action (PoA) adopted at the end of the 1994 ICPD urged all countries to provide sexual and reproductive health care of family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood through the primary health-care system to all individuals of appropriate age by 2015. Finally, the PoA recommended that reproductive health-care programmes must meet the needs of men, women, adolescents, and children to encourage them to desire to be in good health and seek help when the need arises.

The Family Life Education programme was introduced in Ghana to teach young people about adult roles and expectations, marriage, child bearing, relationships, pregnancy and STI prevention (NPC, 1994). The programme is meant to complement the flow of information on sexual and reproductive health from peers, teachers, and the mass media. The programme, even though not examinable in schools, includes topics on human sexuality, consequences of unprotected sex, adolescent reproductive health services and some life skills in decision making, managing emotions and resisting peer pressure.

It should be noted that emphasis is sometimes placed on the sexual and reproductive health of the youth because early sexual maturation and later

marriage have increased the period of risk for early or non-marital pregnancy and exposure to sexually transmitted infections due to lack of knowledge and fear from seeking early treatment (Ghana Health Service [GHS], 2003). It is also at this stage in life in which reproductive health behaviour is formed and thus can influence fertility regulation during the entire life cycle of the individual.

A poor understanding of reproductive health issues at the youthful stage comes with grave consequences on the social, economic, and general well being of the individual and their families. Moreover, reproductive health care and education for the youth is imperative because the two groups are normally those who fall victims to violence and sexual exploitation. They lack the power and skills to refuse sexual intercourse and have a high level of desire to experiment sex and drugs with multiple, casual and riskier partners such as commercial sex workers and they often perform without any form of protection.

There are also some socio-cultural, biological, and demographic factors which continue to pose challenges in addressing the sexual and reproductive health needs of Ghana's young people. Examples of such challenges are early age at first marriage (19.1 years in 1998 and 19.6 years in 2003), low use of contraceptives (14% for modern methods) and increased indulgence in premarital sex and abortions (GSS & MI, 1999; GSS et al, 2004, PRB, 2007). There is therefore the need to ensure that the youth of Ghana (either in school or out of school) is provided with accurate information and services on sexual and reproductive health since they will bear the burden and consequences, if any, of problems created by the population in future. They are the ones who will decide

how fast the world adds the next billion to the population. They are also the ones whose decisions will determine whether the population will live in poverty, deprivation, equality or equity.

Ignoring these issues incurs a high cost in ill health, wasted life opportunities and social disruption. Information, education and communication (IE&C) and the provision of appropriate services are needed to assist beneficiaries make informed choices on their sexual and reproductive health.

In Ghana, sexual and reproductive health issues have been introduced into the formal school syllabus at all levels of education. Above all, conscious efforts are underway to develop the competencies, skills and knowledge of teachers and other stakeholders in sexual and reproductive health issues to provide both the school system and communities the support needed to promote population and family life education (Awusabo-Asare, 1999; United Nations Fund for Population Activities [UNFPA], 1991).

Except in some isolated instances, institutionalized programmes on sexual and reproductive health are not available to dressmakers and hairdressers in Ghana (Owusu, 2003). For instance, the GSMF, through its TOOLGUARD programme provides sexual and reproductive health programmes to equip dressmakers and hairdressers between the ages of 17-35 years with the necessary information on HIV/AIDS and fertility management issues to help them make informed and responsible choices regarding their sexual health.

With the assistance of the leadership of the two vocational associations, the GSMF recruited, trained and equipped some apprentices in some selected

towns in all the ten regions in Ghana to educate their colleague apprentices and other shop owners on healthy sexual and reproductive lifestyles (GSMF, 2007). The TOOLGUARD programme has recruited and trained about 460 dressmaking and hairdressing apprentices nationwide as peer educators and equipped them with toolkits to use in educating their colleagues.

Besides, some 300 salons and dressmaking shops have been branded and stocked with a variety of HIV/AIDS and other reproductive health literature, such as leaflets, mirror messages and other behaviour change materials to serve as resource centres to other users of the shops/salons.

There is also a Youth Advocacy Center at Gomoa Ankamu that was established by New Life Foundation where educational programmes on reproductive health and other contemporary issues exist specifically for Dressmakers with the aim of assisting in the reduction of the reported high incidence of teenage pregnancies in the area (New Life Foundation, n.d)

According to the Guardian News (2006), in Zimbabwe, a country noted for its very high HIV infection rate, more than 1,000 hairdressers have been trained to give advice to their clients about sexual matters and to sell male and female condoms. The salons in the country have been identified as favourable environments where women could freely communicate about HIV-related issues. The hairdressers offer sexual and reproductive health counselling as well as distribute female condoms to their clients as part of an innovative programme to reduce HIV infection through increased Voluntary Counselling and Testing (VCT) and the practice of safer sex .

It is not only in Zimbabwe where hairdressers have been playing a major role in promoting education on sexual and reproductive health. Other countries such as Kenya and Indonesia also provide some examples on how the capacities of dressmakers or hairdressers could be built and harnessed to contribute to the spread of appropriate information on sexual and reproductive health to people who work in the informal economy.

In Kenya, for instance, where economic contraction and HIV/AIDS infection have rendered some teenagers as household heads, a community-based group, Teenage Mothers and Girls Association of Kenya (TEMAK) assists some female dropouts— many of whom have HIV to learn tailoring, hairdressing, typing, or computer literacy. The apprenticeship programme is interspersed with sexual and reproductive health information and education, counselling, testing for HIV, treatment for skin infections, free condoms, and access to clinical services through referrals (Tarmann, 2008).

In Indonesia, a programme has been launched to train hairdressers in the country to promote discussion and educate people about HIV/AIDS. Seminars and other educational programmes have been organised to teach hairdressers how to educate others in their communities about HIV/AIDS and Indonesian hairdressers have been noted for spending more time interacting with their clients than HIV/AIDS educators and are well placed to educate their clients on sexual and reproductive health issues.

Togo also offers useful insights into how dressmakers have become targets of structured programmes on sexual and reproductive health. For instance, tailors

and dressmakers were trained as peer educators to sensitise the youth on HIV/AIDS and its related problems (Assih, 1998). As at 1997, Assih (1998) reported that about 881 supervisors and apprentices had benefited from the programme. The sewing shops became active outlets for the sale and distribution of condoms.

Research in the informal economy have focused on the general characteristics, contributions of the sector to economic development and how resources could be harnessed to reduce the challenges faced by operators in the informal economy.

Conceptual frameworks

The overall objective of the study was to assess the delivery of sexual and reproductive health education to dressmakers and hairdressers as well as their knowledge in sexual and reproductive health issues. The provision of education and services on sexual and reproductive health involves several stakeholders operating at different levels and in continuum.

The national social, cultural or political environment generally prevailing in the community or country must be conducive for the delivery of such services. In the same vein, the different communities (and families) where individuals live should be supportive in the provision of such services. Furthermore, the services have to be available and should address the needs of the individual concerned (Figure 2).

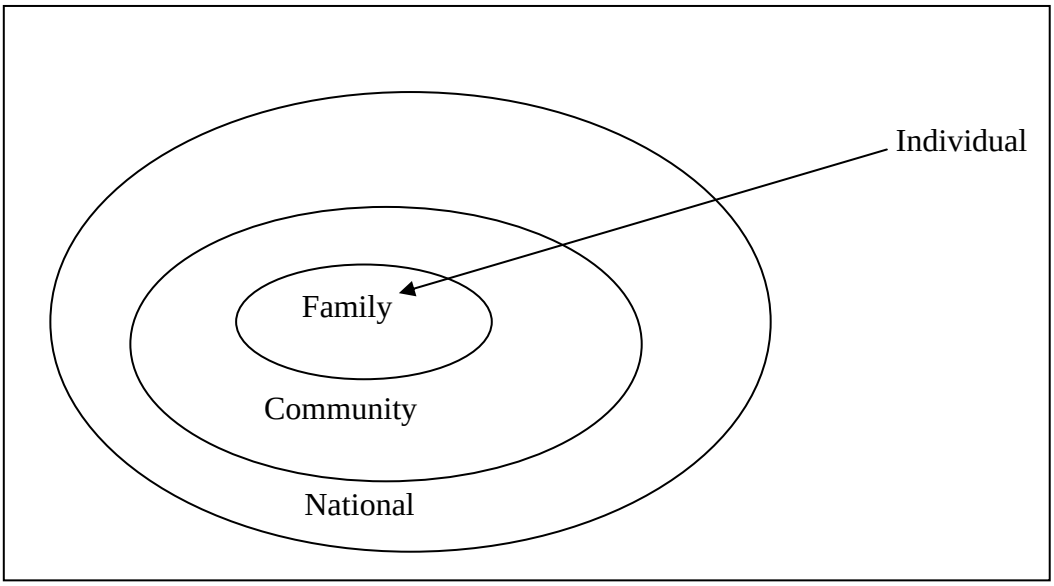

Figure 2: The Human Bio-Ecological Model

Source: Bronfenbrenner, 1979

The human bio-ecological model, originally developed by Bronfenbrenner in 1979, recognizes that while individuals ultimately make the decision to formally seek education on sexual and reproductive health, the decision is affected by other members of the family (e.g. parent or sexual partner) and, at the next level, by the community (e.g. work place and peers).

The weakness in this framework is its inability to assess the price that the individual, the community and the state might pay for failing to provide a targeted and structured programme on sexual and reproductive health to a section of the population engaged in activities in the informal economy. Again, it also fails to highlight the specific roles of the various institutions and programme implementers as well as the various modes of implementing sexual and reproductive health education. These weaknesses were addressed in the

assessment of sexual and reproductive health education model (Hardee, Feranil, Boezwinkle, & Clark, 2004) which was adapted for this study. Their model is presented in Figure 3.

Several factors influence the perception, knowledge and behaviour of an individual on sexual and reproductive issues. Ghana is a multi-ethnic society with substantial proportions of Christians, Muslims and practitioners of indigenous beliefs. Indeed, the 2000 Ghana Population and Housing Census identified Christianity as the dominant religion with a following of about 68.8% compared to 15.9% and 8.5% of the population expressing faith in Islam and traditional beliefs respectively.

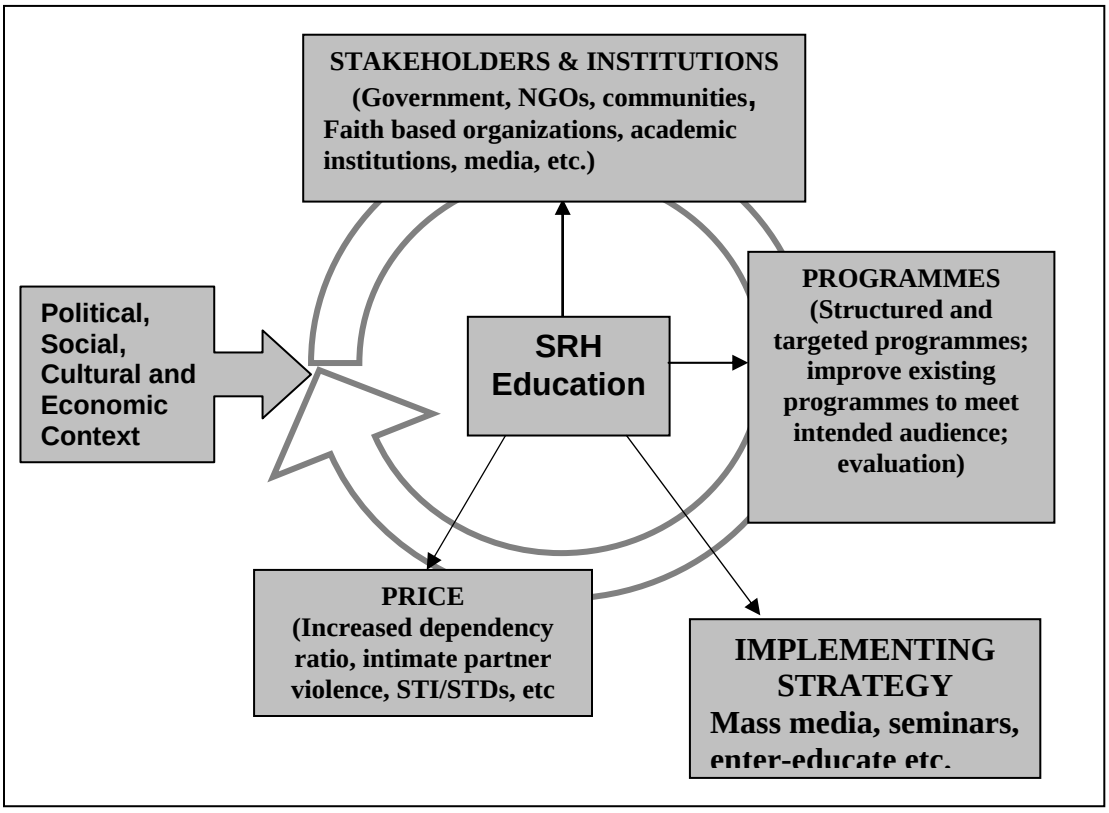

Figure 3: Assessment of sexual and reproductive health education model

Source: Adapted from Hardee et al, 2004

This diversity has significantly influenced the sexual and reproduction orientation of the population. For example, a person's religious affiliation sometimes determines the choice of sexual partner (s), his relationships with the opposite sex and his reproductive health care seeking behaviour. The Christian religion, for instance, frowns on pre and extra marital sexual activities of their members while the Islamic religion permits a man to marry up to four wives provided he could love all of them equally.

Economically, financial difficulties may influence a person to engage in negative sexual and reproductive activities such as prostitution, sexual promiscuity and illegal abortions. Social connectedness to family, adults and peers has been identified to have some influence on communication about sex-related matters (Henry & Fayorsey, 2002; Kumi-Kyeremeh, Awusabo-Asare, Biddlecom, & Tanle, 2007). The ramification of the religious, economic and social mix could include transmission of STD such as HIV/AIDS and a possible geometric growth of the population. The varying religious, economic and social context within which dressmakers and hairdressers operate may influence their attitudes to sexual and reproductive activities as well as their knowledge and depth of attention to sexual and reproductive health education programmes.

Sexual and reproductive problems such as higher maternal mortality, lower contraceptive prevalence rate, rising teenage pregnancy, stigma and discrimination against people living with HIV/AIDS, infant or child mortality and poor family planning practices are not peculiar to dressmakers and hairdressers. However, it appears that not much attention has been given to

providing sustained or structured educative programmes on sexual and reproductive health for people who earn their livelihood from informal economic activities.

It therefore becomes imperative on all individuals or groups who can affect or be affected by the sexual and reproductive activities of people who are directly involved in informal economic activities to act in concert to ensure that accurate information is made available to people to enable them make informed choices on their sexuality. The services of the public and private health practitioners, educational institutions, civil society organizations, faith-based organizations, the media and researchers would be beneficial in this direction.

Ghana intends to become a modernised and middle income country in the next few years. The implementation of some programmes such as the Millennium Challenge Project and the Ghana Poverty Reduction Strategy (GPRS) are all aimed at achieving this dream. The achievement of the above depends on the quality of Ghana's human resource. Failure to provide positive behavioural change programmes in sexual and reproductive health could lead to a human resource that is not well positioned to take productive decisions on STDs, abortions, contraception, personal hygiene, nutrition and family planning.

The long term implications would be an increase in the dependency ratio, intimate partner violence, sexual abuse, spending the limited income on ailing population or a loss of human resource to premature death. The existing sexual and reproductive health education programmes should be broadened to incorporate the peculiar needs of the population. They must also be accessible to

the section of the population that have not been previously targeted. New programmes must also be introduced to deal with the specific needs of the people who work in the informal economy including dressmakers and hairdressers.

It should be noted that the social, cultural and economic context within which dressmakers and hairdressers find themselves, the availability of institutions to provide comprehensive sexual and reproductive health policies and programmes within the prevailing social, cultural, economic or political context to the population as well as the consequences of poor or nonexistent sexual and reproductive health education programmes on the individual, community or nation are linked and interrelated. This will require that an integrated approach should be adopted in providing education on sexual and reproductive health to the people of Ghana including dressmakers and hairdressers.

The methodology, instruments and targeted respondents for this study were based on the content of the above frameworks.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter describes the various approaches that were followed to obtain data for the study and how the data obtained were analysed. It covers the research design, the targeted population, sources of data, sampling procedures and the sample size, the methods of data collection and analysis, pre-testing of the instruments, ethical issues and how they were addressed as well as challenges encountered in the field and how they were handled.

Study Design

This was an exploratory study undertaken to provide baseline information that will help define the exact problems to provide appropriate data collection methods and the various sources of data for future studies (Neumann, 2000). Even though an exploratory research is flexible, investigative and open, it may be time consuming, expensive and generally difficult to generalise the findings. Both qualitative and quantitative data collection approaches were employed in the data collection process and analysis in this study.

Target Population

The target population for the study consisted of dressmakers and hairdressers in the Assin South District. However, not all the targeted population was accessible during the period of the data collection due to their involvement in other economic activities such as farming or trading. The accessible population was therefore those dressmakers and hairdressers who were identified to be undertaking dressmaking or hairdressing activities during the data collection period. In addition, key informants from the Assin South District Assembly (ASDA), The Ghana Hairdressers and Beauticians Association (GHABA), The Ghana National Tailors and Dressmakers Association (GNTDA), the Assin South District Directorate of Health Services, and NGOs in the study area were targeted for the study.

Sources of data

Both primary and secondary information were sourced for the study. The primary data were generated from individual interview schedules, in-depth interviews (IDI) and focus group discussions (FGDs). The secondary information were gathered from published books, journals and articles such as the 1998 and 2003 Ghana Demographic and Health Surveys as well as the population policies of Ghana and the internet.

Reconnaissance survey

This was undertaken in October 2007 and June 2008. The rationale was to enable the gathering of all the stakeholders in the study area and to brief them on the objectives of the study and how they would assist in the data collection process prior to the commencement of the actual data collection. It was also meant to gather background information about the district and to identify all the likely challenges that would possibly emerge during the data collection period. Places visited during this phase of the study were the offices of the district assembly, the Business Advisory Centre (BAC) of the Rural Enterprises Project (REP), Assin South District Health Directorate (ASDHD) and some of the leaders of the two vocations in the study area.

This component of the survey was also intended to collate comprehensive data on dressmakers and hairdressers in the district for sampling purposes, however, it became evident during the survey that it will not be possible to compile a comprehensive list of the targeted respondents due to the fact that a substantial proportion of the dressmakers and hairdressers were engaged in other economic activities to supplement their dressmaking and hairdressing ventures and because of that may not be available during the period of the data collection.

The researcher then decided to sample respondents from dressmakers and hairdressers who will be physically present in the study sites during the period of the data collection.

Sampling procedure and Sample size

Feedback from the reconnaissance survey indicated that majority of the dressmaking and hairdressing activities in the study area are undertaken in the semi-urban and urban areas. The major semi-urban and urban settlements in the district were therefore purposively sampled as study sites. The district was divided into four zones (Figure 4) to ensure that the entire district was covered for the study.

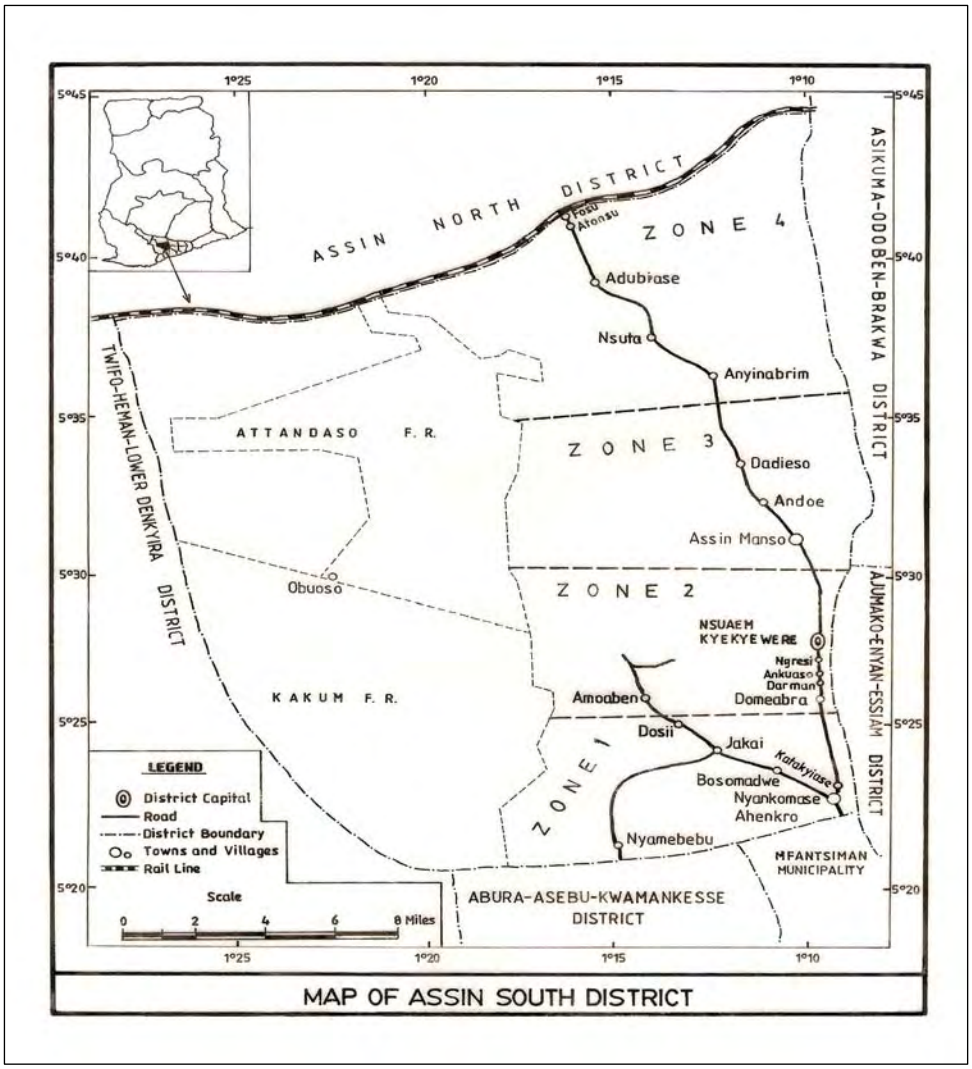

Figure 4: Map of Assin South District divided into four zones

Source: GIS, Remote Sensing and Cartography Laboratory, UCC

The five clustered settlements that host the administrative capital of the district were purposively categorised into one zone. This was because these settlements were attracting more dressmakers and hairdressers from other settlements due to the seemingly increase in the number of both informal sector workers and formal employees of the various ministries, departments and agencies (MDAs) in the district or the perceived increase in economic activities arising from the creation of the new district. Two major settlements from the remaining zones were also randomly selected using the lottery system. Table 1 provides the names of the sampled study sites from each zone.

Table 1: List of Study Sites by Zones

Zone	Name of study sites
One	Nyankomase Ahinkro and Katakyiase
Two	Assin Ngresi, Ankwaso, Darmang, Nsuem, Kyekyewere
Three	Assin Manso and Assin Andoe
Four	Assin Atonsu and Part of Assin Fosu

Source: Fieldwork, 2008

Since the exact number of dressmakers and hairdressers in the Assin South District was not available from the district assembly, the leadership of the associations and could not be compiled during the reconnaissance surveys, it was not possible to determine the sample size statistically. However, the study targeted 120 individual dressmakers and hairdressers spread across the district.

It was also difficult to easily locate the shops or salons of the intended respondents because some operated in their homes, kiosks, on verandas or as itinerant dressmakers and hairdressers. The snowballing technique (a non-probability sampling technique) which begins with one respondent, then, based on the information about the interrelationships from that respondent, identify other respondents, and then the process repeated again and again to sample the required respondents (Neumann, 2000) was employed to identify a shop or salon which then became the basis for sampling the respondents.

A maximum of five respondents were sampled from a shop or salon. This was considered representative enough because it emerged during the reconnaissance surveys that most of these shops or salons were manned by only the supervisor and a few apprentices. The supervisor and the chief apprentice were purposively sampled because they assumed leadership roles in the shops or salons and were expected to be knowledgeable enough in other areas of life including sexual and reproductive health education issues.

In addition, a maximum of three other apprentices, in shops or salons with other apprentices other than the supervisor and chief apprentice, were randomly sampled, thus making a maximum of five respondents from a shop or salon. The number per shop or salon was as a result of the need to gather data on sexual and reproductive health discussions at the workplaces of the respondents.

Twenty nine discussants that were not previously sampled as individual respondents were also purposively contacted and screened to participate in the focus group discussions (FGDs) which were used to gather detailed qualitative

data to complement the quantitative data from individual respondents.

Five key informants on sexual and reproductive health education in the Assin South District were also purposively sampled to provide insights on the overall sexual and reproductive health situation in the district with emphasis on dressmakers and hairdressers. The current Assin North District Director of Health Services in-charge of reproductive health responded for her counterpart in the Assin South District (ASD) because the latter had just taken over from the former. Table 2 shows the summary of the sampled respondents.

Table 2: Summary of sampled respondents

Category	Sampling procedure	Total
Individual Respondents		
• Dressmakers	Simple Random/Purposive	52
• Hairdressers	Simple Random/Purposive Sampling	67
Sub-Total		119
Focus Group Discussion		
• Dressmakers	Purposive Sampling	14
• Hairdressers	Purposive Sampling	15
Sub-Total		29
Key Informants	Purposive Sampling	5
Grand Total		153

Source: Fieldwork, 2008

Data collection instruments

A single data collection instrument was not sufficient to collect comprehensive data for a study of this nature. Both quantitative and qualitative data collection instruments were developed and used for the data collection.

The individual respondents responded to interview schedule (Appendix 1). IDI and FGD guides (Appendix 2 and 3 respectively) were also developed to collect data from the key informants and the focus group discussants respectively. Some of the questions were adapted from the 1998 and 2003 Ghana Demographic and Health Surveys. The instruments focused on the key issues proposed in the objectives and conceptual framework of the study.

Recruitment, Training and Pre-testing of instruments

Two post graduate students in the Department of Geography and Tourism with good knowledge in sexual and reproductive health education were recruited and trained on the objectives of the study, the content of the instruments, ethical matters, sampling and the data collection procedures to enable them assist in the data collection.

The draft instruments were pre-tested at OLA Community in the Cape Coast Metropolis from 4th -5th June, 2008. The choice of this community was informed by the fact that it had features similar to those in the study area. Lessons learned from the pre-testing were used to finalise the instruments and other logistical requirements for the study.

Data collection

Primary data collection commenced on 16th June 2008 in zone two and ended in zone 4 on 10th July, 2008. An average of one week was spent in each zone. Once a shop or salon was located using the snowballing procedure, permission was first sought from the supervisor or the senior apprentice in the shop for the data collection. The sampling procedure was implemented to sample the respondents. The objectives of the study and the consent form were explained to the sampled respondents before the instrument was administered.

All the focus group discussants were recruited and screened. Discussions were sometimes held at the shops or salons because the respondents were not willing to move away from their activity points. Once again, the consent of the discussants were sought and assured of their confidentiality before discussions commenced. Four FGDs, two each for dressmakers and hairdressers, were organised in the entire study area. One was organised in each zone.

The discussants objected to tape recording their responses so the assistants had to record the responses manually but as exactly as expressed by the discussants.

Introductory letters (Appendix 4) from the Head of Geography and Tourism Department, University of Cape Coast, were obtained and distributed to the key informants during the June reconnaissance survey. Appropriate schedules were then arrived at with each key informant for the interviews.

Editing, Coding, Data entry, Cleaning and Analysis

The data collected from the interview schedules were edited daily and immediately after the data had been collected to ensure accuracy and consistency of the responses. The edited individual interview schedules were fed into the computer and analysed using the Statistical Product for Service Solutions (SPSS version 12) software, which has facilities for descriptive and inferential statistics, cross tabulations and percentages. Since the study involved two vocational groups, viz, dressmakers and hairdressers, the cross tabulation software of the SPSS was used in the analysis.

Throughout the analysis "N" refers to the frequency or the number of individual respondents who provided responses to the question or issue being analysed. The Microsoft Office Excel Programme was used to generate the bar and pie charts. The responses to the open-ended questions in the individual interview schedules, the IDI and FGD were categorised and similar responses analysed manually.

Quality assurance of Data

The data generated were compared to some existing studies to determine their reliability and consistency. Examples of such studies considered were the Ghana Demographic and Health Surveys (GDHS), The 2000 Ghana Population and Housing Census (PHC) as well as other published and unpublished studies on the informal economy, sexual and reproductive health education.

Challenges from the field

The major challenge from the field was the lack of baseline data on the dressmakers and hairdressers in the study area. Perhaps, the unnoticed, mostly ignored, rarely supported and unregulated nature of the informal economy (Adu-Amankwaa, 1997; Becker, 2004) accounted for the lack of basic data on the activities of dressmakers and hairdressers in the study area.

Neither the district assembly nor other institutions such as the Rural Enterprises Project with some oversight supervision on the activities in the informal economy could provide appropriate data on the number, locations and programmes of dressmakers and hairdressers in the district. The impact of this challenge was the inability to statistically estimate the sample size for the study and the difficulty in identifying dressmaking and hairdressing salons in the study area. The difficulty was addressed with the application of the snowballing technique to locate dressmaking shops and hairdressing salons.

The seemingly unprofitable nature of businesses in the informal economy (Adu-Amankwaa, 1997; Becker, 2004) also posed some challenges during the data collection phase of the survey. Some of the dressmakers and hairdressers made financial demands after data had been collected. The limited budget for the study was sometimes stretched due to such demands though such demands did not affect the validity and reliability of responses.

Lastly, the sensitive nature of sex and sexuality also made some of the respondents uncomfortable at some stages of the data collection though they provided candid responses eventually.

CHAPTER FOUR

BASIC CHARACTERISTICS OF RESPONDENTS AND KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH

Introduction

People live in a wide range of social, economic, cultural and religious settings that have direct impact on their knowledge and practices on matters that relate to sexual and reproductive health (Hardee et al, 2004). This chapter presents the results of the socio-economic background of the dressmakers and hairdressers (who responded to the individual interview schedule) and their knowledge on sexual and reproductive health.

Socio-economic status is a term applied to the combined social and economic attributes of an individual or group of people often expressed in terms of education, occupation, marital status and household characteristics. Demographic variables of sex and age were also included in the study. To obtain this data, the respondents were asked questions on their age, marital status, educational and religious backgrounds since these variables directly or indirectly influence the sexual and reproductive behaviour of the respondents.

The second part of this chapter examines the respondent's knowledge on sexual and reproductive issues such as experiences in sexual intercourse, relationships with sexual partner(s), contraception and their sources of

information on sex and reproduction. Knowledge of sexual and reproductive issues is an important step toward gaining access to and using suitable methods in a timely and effective manner (GSS et al, 2004).

Sex distribution of respondents

Age and sex are important variables in analysing demographic trends (GSS et al, 2004). As indicated in Table 3, majority of the respondents in both vocations were females. While 69.2% of the dressmakers were females, all the hairdressers were females.

Table 3: Sex distribution of respondents

Sex	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Male	30.8	-	13.4	16
Female	69.2	100.0	86.6	103
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

N= Number of respondents

Age distribution of respondents

Table 4 provides the age distribution of all the dressmakers and hairdressers. In both vocations, majority (99.1%) of the respondents were aged between 15 and 35 years. About two-thirds (63%) of both dressmakers and

hairdressers were below 25 years with less than a tenth aged more than 35 years. The age distribution of the respondents indicates that a higher proportion of the respondents were young (15-24 years) and within their reproductive ages (15-49).

Table 4: Age distribution of respondents

Age	Dressmakers (%)	Hairdressers (%)	Total (%)	N
15-20	21.2	38.8	31.1	37
21-25	28.8	34.3	31.9	38
26-30	30.8	25.4	27.7	33
31-35	17.3	1.5	8.4	10
36 and above	1.9	-	0.9	1
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Educational attainment of respondents

Formal education is considered as the best process for improving access to information and broadening the horizon of people (GSS, 2005). Women's education, for instance, is considered as the single most influential investment that can be made in a developing world (Ashford, 2001). Education of girls is also closely related to improvements in family health and reduction in fertility rates (GSS et al, 2004). In almost every setting better-educated women are more likely not to marry too early, use contraception, source information on sexual and

reproductive health, bear fewer and raise healthier children (Ashford, 2001; GSS & MI, 1999; GSS et al, 2004). The educational attainment of the respondents is presented in Table 5 which indicates that nearly all the respondents attended school with 77.8% completing the Junior Secondary level.

Table 5: Educational attainment of respondents

Educational attainment	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Primary	9.8	19.7	15.4	19
JSS	80.4	75.8	77.8	92
SSS	5.9	3.0	4.2	5
Vocational	3.9	1.5	2.6	3
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

The high proportion (93.2%) of the dressmakers and hairdressers who completed only the basic education tends to corroborate the findings of the 2000 Population and Housing Census as well as the 2003 Ghana Demographic and Health Survey which identified large proportion of the population attaining only the basic education as their highest educational level. Such a finding was described as not encouraging since the positive effects of formal education do not begin to manifest themselves until after the basic level (GSS, 2005).

Again, the level of educational attainment of the respondents confirms the observation that the informal economy is fraught with mainly the youth and women who are essentially low-skilled and semi-literate (Ashford, 2001; Becker, 2004; Chen 2004; Hormeku, 1998; Soetan, 2005). Besides, the low level of education attained by the high proportion of dressmakers and hairdressers suggests that they have missed formal instruction on sexual and reproductive health education which they would have attained at the secondary and higher levels of education.

Religion

Several factors tend to influence the perception, knowledge and sexual and reproductive behaviour of an individual. Religion has been identified as a major social institution that has the potential to influence a person's behaviour in sex and reproduction (GSS et al, 2004; GSS & MI, 1999; Kumi-Kyeremeh et al, 2007).

The religious affiliations of the dressmakers and hairdressers as presented in Table 6 shows that Christianity is the dominant religion professed by 95% of respondents, with only 5% of them identifying with the Islamic religion. Indeed while 48.0% of the dressmakers and 38. 8% of the hairdressers claimed to be members of the Orthodox Christian faith which comprises the Presbyterian, Catholic and Methodist, 46.2% of dressmakers and 56.7% of hairdressers were of the Pentecostal or Charismatic faith. The religious background of the respondents is consistent with the 2000 Ghana Population and Housing census which

identified Christianity as the dominant religion (68.8%) followed by Islam (15.9 %) and traditional religion with 8.5 percent adherents.

Table 6: Religious affiliations of respondents

Religion	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Orthodox	48.0	38.8	42.9	49
Pentecostal/Charismatic	46.2	56.7	52.1	64
Islamic	5.8	4.5	5.0	6
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Relationship to Household head

The 2003 Ghana Demographic and Health Survey defined a household as a person or group of persons, related or unrelated, who live together in the same house or compound, share the same housekeeping chores and are catered for as one unit. In Ghana, the choice of household is determined by varied factors including marriage and occupation. The nature of a person's household determines the roles, duties and obligations of the individual or the group to the extent that the choice of a sexual partner could be affected by one's household structure (Nukunya, 1992).

Indeed, the size, nature and composition of the household in which dressmakers and hairdressers live as well as the sex of the household-head are

very essential in determining the sexual behaviour and knowledge of reproductive health of dressmakers or hairdressers. For instance, when the immediate past district director of health services in charge of reproductive and child health in the Assin- South district was asked what proportion of the dressmakers and hairdressers who live alone come from the nearby villages, her response was:

> *Most of the dressmaking and hairdressing apprentices' came from the nearby villages in the district to their current settlement to learn their vocation. They often times lack money for their upkeep so they either perch with somebody or take a boy/girl friend who will provide them with money in exchange for sex which most times lead to unplanned pregnancies. This household arrangement makes them one of the most vulnerable groups in the district.*

Some of the respondents migrated from nearby villages to their current settlement. With regard to person(s) the dressmakers and hairdressers were currently lodging with, the analysis in Table 7 shows that a higher percentage of the dressmakers (36.5%) lived alone; while a fairly high proportion (34.7%) lived with their parents. However, most of the hairdressers (41.7%) were living with their parents. Relatively higher proportions of hairdressers were reported to be living alone (26.9%) or staying with their spouses (22.4%). While none of the dressmakers lived with their boy/girl friends, 1.5% of the hairdressers cohabited with their boy/girlfriends.

Table 7: Relationship to Household head

Relationship	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Self	36.5	26.9	31.1	37
Spouse	19.2	22.4	21.0	25
Parent	34.7	41.7	38.7	46
Supervisor	1.9	0.0	0.8	1
Boy/Girlfriend	0.0	1.5	0.8	1
Other relative	7.7	7.5	7.6	9
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Status of Respondents in shops/salons

The status of respondents in their places of work is very important in determining the initiation, moderation and flow of communication on sexual and reproductive health. The supervisor is considered as the overall head in the shop or salon and wields a great influence in attracting apprentices and dictating the code of conduct of their apprentices. The educational, social, religious and other background characteristics of the supervisor greatly determine the type of issues and their content to be discussed at the shops or salons. As displayed in figure 5, 69.2% of the dressmakers and 43.3% of the hairdressers were supervisors while less than 10% were junior apprentices.

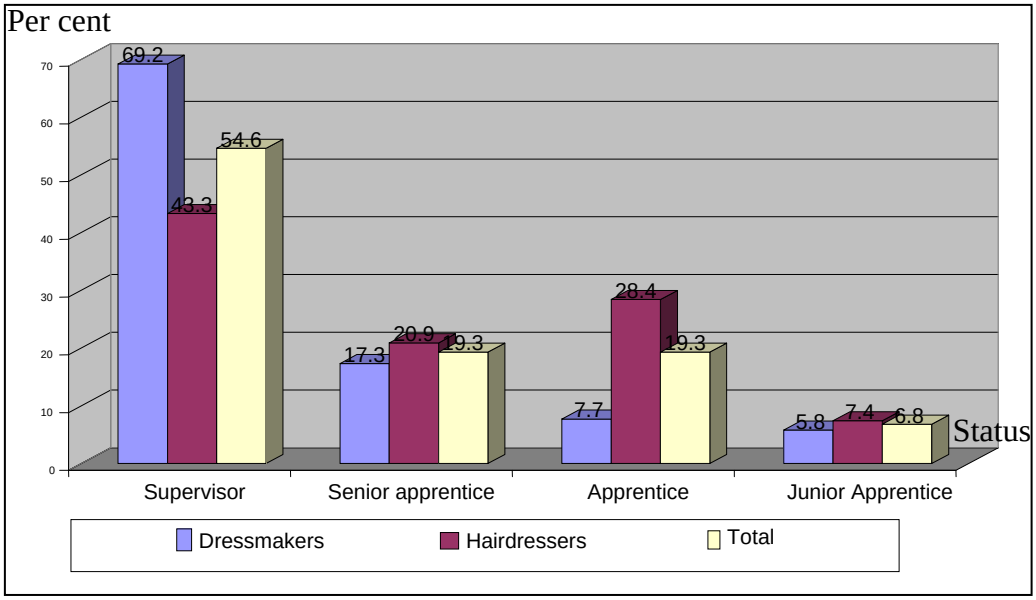

Figure 5: Status of respondents in shops or salons

Source: Fieldwork, 2008

It should be noted that dressmaking and hairdressing apprentices are not yet qualified dressmakers and hairdressers. For most part of the analysis in this study, responses from the supervisors and apprentices were amalgamated and analysed.

Apprenticeship fees

Another important economic factor that could influence the sexual and reproductive health behaviour of dressmakers and hairdressers is the mobilisation and payment of apprenticeship fees before an apprentice could be admitted by a supervisor to learn the vocation. There were no standard apprenticeship fees charged; however, the supervisors determined how much a prospective apprentice is charged and the increases thereof over time as shown in Table 8.

Table 8: Apprenticeship fees

Entrance fees	Dressmakers (%)	Hairdressers (%)	Total (%)	N
<GH¢ 10	23.1	11.9	16.8	20
GH¢ 10-50	44.2	46.3	45.4	54
GH¢ 51-100	21.2	35.8	29.4	35
GH¢ 101-150	3.8	4.5	4.2	5
None	7.7	1.5	4.2	5
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

A total of 45.4% of the respondents paid between GH¢10 and GH¢50 for their admission. Almost a third of the respondents had paid between GH¢51 and GH¢100 as fees to enable them enrol as dressmaking or hairdressing apprentice. Indeed, part of the amount was used to provide drinks for the senior apprentices to symbolise the formal acceptance of the new apprentice into the shop or salon.

Sources of Apprenticeship fees

Various sources constitute the avenues from where funds are raised to enable prospective dressmakers or hairdressers commence their apprenticeship. While parents remain the major financiers of their wards' education and training, other avenues were also exploited by the prospective apprentices to raise funds for

their admission and money for living expenses. One of such avenues was funds from boy or girlfriends which could have implications for sexual and reproductive health (Henry & Fayorsey, 2002). The various contributors of funds to enable prospective apprentices commence their apprenticeship are indicated in Table 9.

Table 9: Sources of Apprenticeship fees

Sources of entrance fees	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Self	4.1	3.0	3.5	4
Spouse	2.0	10.6	7.0	8
Parent	63.3	68.2	66.1	76
Boy/Girlfriend	2.0	3.0	2.6	3
Other relative (Uncle)	24.5	15.2	19.1	22
Free	4.1	0.0	1.7	2
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Majority of the dressmakers (63.3%) and hairdressers (68.2%) mentioned their parents as the main providers of their apprenticeship fees followed by relatively higher proportions of dressmakers (24.5%) and hairdressers (15.2%) who were sponsored by other relatives such as uncles. It is worthy of note that among both dressmakers and hairdressers lodging arrangements (Table 7) and sponsorship of apprenticeship (Table 8) were the main responsibility of parents.

Marital Status of respondents

Marriage is considered to be a primary indicator of exposure to the risk of pregnancy and pregnancy related issues such as abortion. The knowledge and attitude of a sexual partner towards sexual and reproductive issues have also been identified as some of the factors that could inhibit a person's desire to seek information or education on sexual and reproductive health. The distribution of the marital status of the respondents is presented in Table 10.

Of the total respondents more than two-thirds of the dressmakers (69.2%) and hairdressers (68.7%) have never been married, while 28.8% of dressmakers and 29.9%) of hairdressers were currently married. It is significant to note that even though about a third of the respondents (29.4%) were married some parents were still paying for their married children apprenticeship fees (Table 9).

Table 10: Marital Status of respondents

Marital status	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Never Married	69.2	68.7	69.9	82
Married	28.8	29.9	29.4	35
Divorced	2.0	0.0	0.8	1
Separated	0.0	1.4	0.8	1
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Age at first marriage

Marriage, in many societies and culture, signify the point in a woman's life to commence childbearing. Early experience of marriage or sexual intercourse not only affects the length of time a woman is exposed to pregnancy but also tends to lead to early childbearing and higher fertility (Hardee, Pine, & Wasson, 2004). Marriage at a young age would therefore imply early age at childbearing and a higher level of fertility for the society (GSS & MI, 1999) which has a great potential to affect the socio-economic development of the society. Table 11 shows a distribution of age at first marriage of three age groups.

Table 11: Age at first marriage

Age at first marriage	Dressmakers (%)	Hairdressers (%)	Total (%)	N
15-20	20.0	27.8	24.2	10
21-25	33.3	72.2	54.5	18
26-30	46.7	0.0	21.3	9
Total	100.0	100.0	100.0	37
N	17	20	37	

Source: Fieldwork, 2008

Most of the married hairdressers (72.2%) first married when they were aged between 21-25 years compared to only 33.3% of the dressmakers who first married at the same age cohort. Significantly, all the hairdressers who were married did so before they reached age 26 compared to nearly half (46.7%) of the

dressmakers who married at age 26 or beyond. Some 24.2% of the dressmakers and hairdressers either married as minors (before 18 years) or before they reached age 20. From the 2003 GDHS, the median age at first marriage was 19.6 years among females but 24.7 years among the males (GSS et al, 2004).

Age at first sexual intercourse

The age at first sexual intercourse is often used as the most reliable estimate of a woman's exposure to the risk of pregnancy since some women become sexually active before marriage (GSS & MI, 1999; GSS et al, 2004).

An assessment of first sexual experiences of different age groups of dressmakers and hairdressers as indicated in Table 12 showed that 70.8% of dressmakers and 79.1% of hairdressers have had sexual intercourse in their life time.

Majority (81.8%) of dressmakers experienced their first sexual intercourse when they were aged between 16 and 20 years. Similarly, majority (75.5%) of hairdressers had their first experience when they were of the same age group.

The dressmakers (70.8%) and hairdressers (79.1%) who have ever had penetrative sexual intercourse experienced it before or by age thirty. This seems consistent with the 1998 and 2003 Ghana Demographic and Health Surveys that virtually all women in Ghana initiate sexual intercourse by their mid-twenties.

Table12: Age at first sexual intercourse

Ever engaged in penetrative sex	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Yes	70.8	79.1	75.7	91
No	29.2	20.9	24.3	28
Total	100.0	100.0	100.0	119
N	52	67	119	
Age at first sexual intercourse				
Less than 15 years	3.0	9.4	7.0	7
16-20 years	81.8	75.5	77.9	70
21-25 years	6.1	15.1	11.6	11
26-30 years	9.1	0.0	3.5	3
Total	100.0	100.0	100.0	91
N	35	56	91	

Source: Fieldwork, 2008

Recent sexual activity

Dates of recent experiences of the dressmakers and hairdressers in sexual intercourse, as presented in Figure 6, ranged from one week to over one year.

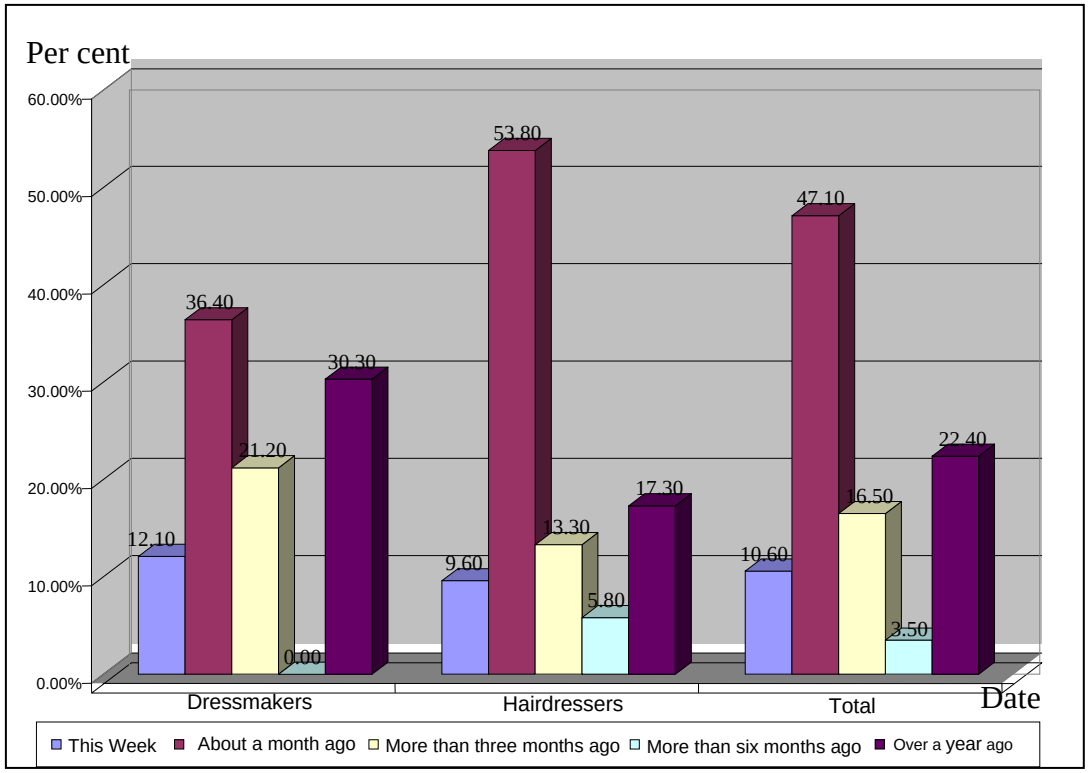

Figure 6: Date of last sexual intercourse

Source: Fieldwork, 2008

More than half of the hairdressers (53.8%) and a third of the dressmakers (36.4%) experienced sexual intercourse about a month to the date of the data collection. While 10.6% of the dressmakers and hairdressers with experiences in sexual intercourse engaged in the activity within the week of the data collection, some 22.4% experienced sexual intercourse more than a year to the date of the collection. A relatively fair proportion of the dressmakers and hairdressers (16.5%) had not experienced sexual intercourse for more than six months to the data collection period.

Relationship with sexual partner

Boy/Girl friend relationship dominated sexual partnerships of the respondents; with 60.0% of dressmakers and 61.5% of hairdressers having their last sexual intercourse on purely boy/girlfriend bases as against 39.4 % dressmakers and 32.7% hairdressers whose last sexual encounters were strictly spousal (Figure 7). This finding is inconsistent with respondents' marital status (Table 10). This perhaps could be explained that some respondents regard their sexual partners as their spouses although they might not be legally or culturally recognised as married couples.

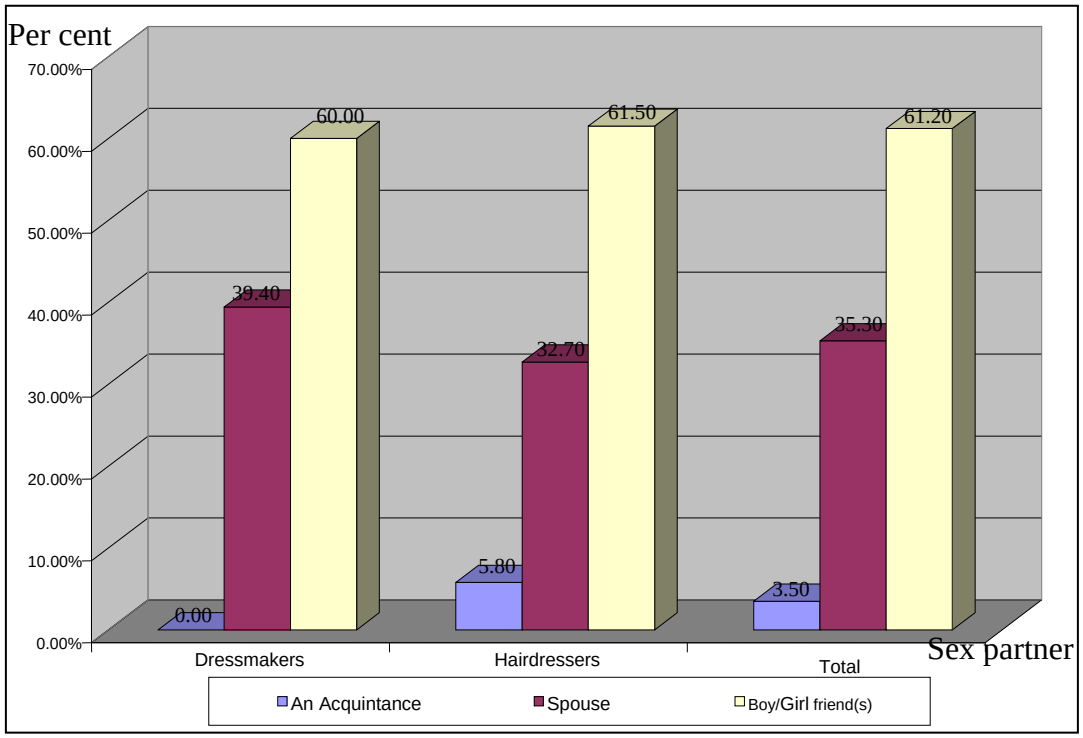

Figure 7: Relationship with sexual partner

Source: Fieldwork, 2008

The high incidence of boy/girlfriend sexual activity is poignant and provides issues for further analysis. Being mostly an unmarried group the dressmakers and hairdressers are exposed to widespread unhealthy sexual behaviour such as multiple sexual partnership, forced sex and non use of protective measures which can result in unplanned pregnancies and STDs.

Reasons for last sexual intercourse

Figure 8 shows that majority of the respondents (91.8%) voluntarily consented to the sexual intercourse; however, there were some reported cases of sexual intercourses that took place against the will of the respondents; as evidenced in 8.2% of the respondents who were forced into having sex with their partners though they were reluctant to provide further details.

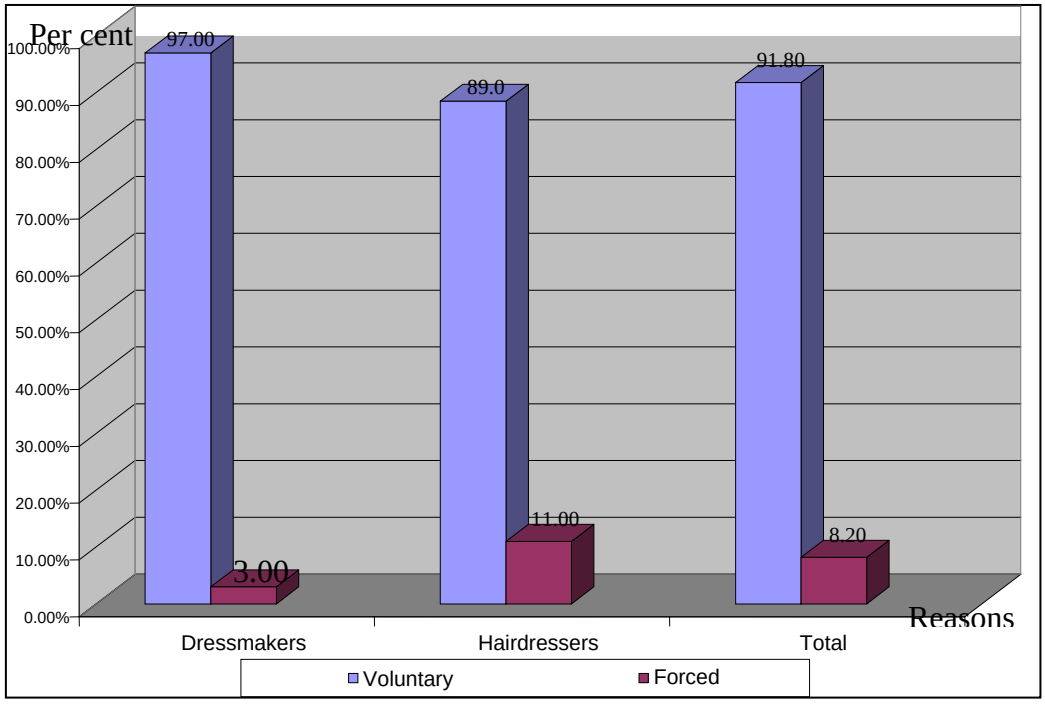

Figure 8: Reasons for last sexual intercourse

Source: Fieldwork, 2008

Females sometimes succumb to such pressures for fear of losing their sexual partners. It is also important to note that the respondents may not be too keen to report on these cases for fear of being drawn into bearing witness at a court of law if they are asked to give evidence (Gorgen, Yansane, Marx, & Millimounou, 1998; Kwankye, Nyarko, & Tagoe, 2007). It is also reported that in some countries such as the Dominican Republic, Cambodia, Egypt and Haiti, women suffer abuse silently and tend not to seek help or talk to others about the abuse mainly because they "think that the help will be of no use or they consider sexual violence as part of normal life" (Kishor & Kiersten, 2004:24-25).

Knowledge on some Sexual and Reproductive Health Issues

Several studies in Ghana have confirmed that knowledge on sexual and reproductive health issues is widespread (GSS & MI, 1999; GSS, 2005; GSS et al, 2004). An examination of the basic knowledge of the respondents on sexual and reproductive health including their source(s) of information on reproductive health is presented below.

Knowledge of contraception

Modern contraceptive methods of the Pill and Condoms were fairly widely known than traditional methods of the withdrawal and periodic abstinence. Table 13 shows that majority of both the dressmakers (94.2%) and hairdressers (92.5%) were aware of methods of contraception.

Table13: Knowledge of contraception

Contraception	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Awareness of method				
Yes	94.2	92.5	93.3	111
No	5.8	7.5	6.7	8
Total	100.0	100.0	100.0	119
N	52	67	119	
Use of modern method				
Pills	4.3	27.4	17.4	21
Condoms	34.0	24.2	28.4	39
Withdrawal	0.0	3.2	1.8	2
None	61.7	45.2	52.4	57
Total	100.0	100.0	100.0	119
N	52	67	119	
Benefits of method				
Prevention of pregnancy	89.5	100.0	96.2	58
Prevention of STI/STDs	10.5	0.0	3.8	4
Total	100.0	100.0	100.0	62
N	21	41	62	

Source: Fieldwork, 2008

More than half of the dressmakers (61.7%) and a high proportion of hairdressers (45.2%) had not used any of the methods of contraception during sexual intercourse even though majority of them were privy to the benefits of contraceptive use particularly for the prevention of unwanted pregnancy. The high knowledge base of the dressmakers and hairdressers (93.3%) relative to their low none usage rate (52.4%) of contraceptives corroborates the knowledge and usage gap that exists in Ghana (GSS et al, 2004).

Sources of information on reproductive health

Individual respondents were asked to indicate the most useful source of information on sexual and reproductive health available to them. Various sources from which the respondents acquired information on sexual and reproductive health issues as presented in Figure 9 shows the major sources of such information as friends (30%), radio/television (26%) doctors/nurses (19%) and parents (13%). These variety and authentic sources of information enable the respondents to make informed and intelligent decisions and choices on sexual and reproductive health issues.

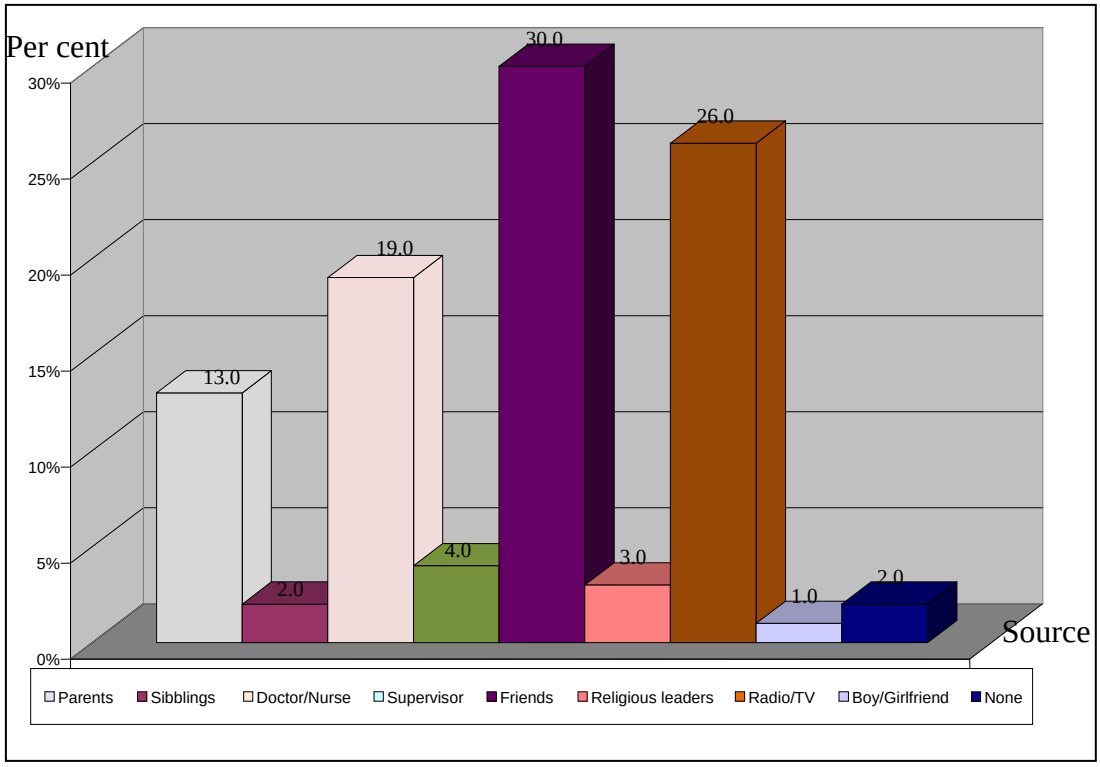

Figure 9: Sources of information on SRH

Source: Fieldwork, 2008

CHAPTER FIVE

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AND INSTITUTIONAL SUPPORT

Introduction

Education and communication play a crucial role in changing the behaviour of people in many ways. The enter-educate approach which involves the provision of education or information on sexual and reproductive health through entertainment media such as the radio and television soap operas and music has been widely adopted in providing sexual and reproductive health related education to a cross section of the people (Piotrow, Lawrence, Jose, & Ward, 1997). This chapter focuses on an assessment of education and communication patterns on sexual and reproductive health at the shops or salons of the respondents and the support received from institutions on sexual and reproductive health education.

Awareness of Sexual and Reproductive Health Education Programmes

The National Family Planning Programme, Social Marketing and the Family Life Education programmes aim at providing public education and information on sexual and reproductive health to the population. These programmes are major steps towards reducing the embarrassment associated with

public communication on sexual and reproductive health. These programmes are also designed to change the perception of people on modern family planning by presenting models of family planning as a positive behaviour with rewarding consequences (Piotrow et al, 1997).

Several sexual and reproductive health programmes are currently being implemented in Ghana to sensitise the population on the need to adopt healthy sexual and reproductive lifestyles. A prudent assessment of the respondent's awareness of and levels of interest in some of these programmes are presented in Table 14.

Mmaa Nkomo, an interactive programme on wide ranging issues of family planning, sexual and domestic violence aired on Ghana Television and TV-Africa seems to be the most popular. The popularity of this programme may be informed by the fact that the programme has been consistently aired almost every week for the past decade. Indeed, 48.1% of the dressmakers and 31.3% of the hairdressers were aware of this particular programme. This gives credence to the notion that continuity is a fundamental aspect of learning and that different sets of audience can be reached through a series of different materials, messages and campaigns (Piotrow et al, 1997).

Some 17.3% of the dressmakers and 20.9% of the hairdressers were more familiar with "Odo ahomaso" and "Wo ba ada anaa" respectively. However, 25.4% of hairdressers and 11.5% of dressmakers were not aware of any sexual and reproductive health programme. Sexual and reproductive health education goes beyond the programmes identified by the respondents.

Table 14: Sexual and reproductive health education programmes in Ghana

SRHE programme	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Nipa ne Abrabo	0.0	6.0	3.4	4
Aware so	3.8	10.4	7.6	9
Odo Ahomaso	17.3	3.0	9.2	11
Mmaa Nkomo	48.1	31.3	38.7	46
Wo ba ada anaa	9.6	20.9	16.0	19
He Ha Ho	7.7	0.0	3.4	4
Complete woman	0.0	3.0	1.7	2
Church programme	1.9	0.0	0.8	1
None	11.5	25.4	19.3	23
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

As could be observed from the table, nearly 20.0% of the respondents could not identify any sexual and reproductive health related programme. The programmes mentioned above constitute their understanding of sexual and reproductive health education programme.

Recent exposure to Sexual and Reproductive Health education programmes

Table 15 shows that only two hairdressers had listened to a sexual and reproductive health education programme on the day of data collection for the study. However, some of the dressmakers (32.6%) and hairdressers (32.7%) had listened to or viewed such programmes a month preceding the survey. An important observation made was that some respondents had difficulty in identifying the programmes which were for sexual or reproductive health education.

Table 15: Recent exposure to Sexual and Reproductive Health education programmes

Recent exposure to SRHE programme	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Today	0.0	4.0	2.1	2
A week ago	30.4	38.8	34.7	34
A month ago	32.6	32.7	32.6	31
Over six months ago	15.2	14.3	14.7	14
One year ago	10.9	8.2	9.5	9
Over one year ago	10.9	2.0	6.4	6
Total	100.0	100.0	100.0	96
N	46	50	96	

Source: Fieldwork, 2008

Topic for recent Sexual and Reproductive Health education

Even though multiple responses emerged in respondents' recollection of recent sexual and reproductive health topics which they discussed; observations in (Table 16) shows that as high as 31.6% of the respondents could not recall any topic discussed. While "Relationships" was the common topic among 39.1% of the dressmakers, sexuality was also a general topic cited by 19.6% of the dressmakers and 20.4% of the hairdressers. Issues on sexually transmitted diseases and personal hygiene were least mentioned even though the hairdressers seem more comfortable comparatively with issues on contraception.

Table 16: Topic for recent Sexual and Reproductive Health education

SRHE topic	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Contraception	4.3	20.4	12.6	12
Sexuality	19.6	20.4	20.0	19
Personal Hygiene	4.3	8.2	6.3	6
STI/STD	0.0	8.2	4.2	4
Relationship	39.1	12.2	25.3	25
No Recollection	32.7	30.6	31.6	30
Total	100.0	100.0	100.0	96
N	46	50	96	

Source: Fieldwork, 2008

Communication on Sexual and Reproductive Health at workplaces

Effective communication at workplaces is deemed vital in ensuring harmony, increased productivity and the building of strong relationships among co-workers. Responses shown in Table 17 indicate that while 18.4% of all the respondents were conversant with issues of sexual and reproductive health education and therefore hardly discussed them at workplaces; as high as 38.2% of them did not consider such issues as a priority for discussion. On the other hand, as high as 27.6% of the respondents were alone in their shops or salons and therefore missed the opportunity for such exposures.

Table 17: Communication on Sexual and Reproductive Health at workplaces

Reasons for no discussion	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Ignorance	7.3	14.2	10.5	8
Not a priority	36.6	40.0	38.2	29
Shyness	7.3	2.9	5.3	4
Alone at shop	34.1	20.0	27.6	21
Already know	14.7	22.9	18.4	14
Total	100.0	100.0	100.0	76
N	41	35	76	

Source: Fieldwork, 2008

In a focus group discussion with hairdressers, a 25 year old senior apprentice said:

> *We are more concerned with our work. We start work at 7:30am and close at 5:30pm. We spend all our day-time hours sewing or dressing hairs of our customers. We do not think about discussing sexual and reproductive health issues at the workplace .Besides, I will feel shy to participate in sexual or reproductive discussions. Our madam will not even allow us to talk about such issues here.*

In a similar discussion with the dressmakers, discussants were forthright with their supervisor's inability to educate them on sexual and reproductive health issues since such issues were deemed very vital to the growth and development of every individual. A 22 year dressmaker apprentice said:

> *Our mistress is very shy on sexual and reproductive health issues. She encourages us to concentrate on the vocation so that we can graduate in time. We do not discuss sexual and reproductive health issues to her hearing. She may think that we are spoilt girls. I wish we could discuss such issues in our shops but our mistress is indifferent.*

A 36 year old female executive member of the Ghana National Tailors and Dressmakers Association in the district confirmed the above assertion. According

to her, the association had not thought of encouraging the supervisors to discuss sexual and reproductive health issues with their apprentices, at least for now.

Role of supervisors in Sexual and Reproductive Health education

Table 18 presents the role of dressmaking and hairdressing supervisors in discussing sexual and reproductive health education issues in shops or salons.

Table 18: Role of supervisors in Sexual and Reproductive Health education

Role of supervisor	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Sits idle	16.7	0.0	5.0	2
Introduces topic	50.0	50.0	50.0	22
Suppresses discussion	0.0	21.4	15.0	6
Arranges the meeting	16.7	0.0	5.0	2
Facilitates the discussion	16.7	22.8	25.0	11
Total	100.0	100.0	100.0	43
N	18	25	43	

Source: Fieldwork, 2008

As shown in Table 18, 50% of the apprentices exposed to sexual and reproductive health education at their workplaces indicated that their supervisors introduced the topics for discussion. Indeed 25% indicated that some supervisors even facilitate the discussions while only few (15%) encountered supervisors who tended to suppress such discussions though such supervisors tended to encourage

their apprentices to abstain from casual sexual intercourse.

Access to mass media

The radio and television have been widely used to air exciting and entertaining programmes on sexual and reproductive health through which listeners' or viewers' emotions are engaged while informing them of new ideas and behaviour that could improve their behaviour (de Fossard, 1997).

Table 19 shows that 79% of respondents had access to radio in their houses as compared to 47% of them with access to radio in their workplaces. Less than ten percent of the respondents had access to television in both their houses and workplaces. This appears to be consistent with the 2003 Ghana Demographic and Health Survey which observed that access to the mass media, especially the broadcast media, is generally high in Ghana (GSS et al, 2004).

The respondents explained that they had access to these mass media by virtue of their position in the household but not through ownership of the sets; hence their access to programmes of their choice (either on radio or television) were minimal. The general observation in Table 19 is that the respondents had far better exposure to mass media at their homes than workplaces.

Table 19: Access to mass media

Access to mass media	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Home				
Radio	76.9	80.5	79.0	94
Television	7.6	10.5	9.2	11
None	15.5	9.0	11.8	14
Total	100.0	100.0	100.0	119
N	52	67	119	
Shop or salon				
Radio	38.2	51.5	47.0	56
Television	0.0	6.1	3.4	4
Newspapers	0.0	4.1	4.3	5
None	61.8	38.3	45.3	54
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008.

Explaining why the respondents do not have television sets in their workplaces (see Table 19), a 22 year old discussant during a focus group discussion with hairdressers said:

We do not have money to buy television and video recorders such as DVD or VCD player and install them in this salon. It

is rather prudent to have such equipments in the house. The income from our vocation is very meagre. Apart from the cost of purchasing these equipments, we must also consider the electricity bill that we will pay at the end of every month. I think it is not necessary to install a television in our salon.

Exposure to the print media was relatively low. Perhaps, the low academic qualification of most of the respondents explains their minimal patronage of the print media. Besides, the rural nature of the district also tends to account for the limited access to the print media. In any case none of the sexual and reproductive health education programmes carried in the print media seem to have been effective in providing knowledge and information to dressmakers and hairdressers in the study area to enable them make informed choices on their sexual and reproductive behaviour.

Sexual and reproductive health education through the mass media

It was observed that most of the respondents do not make deliberate effort to listen or view sexual and reproductive health education programmes from the mass media. Figure 9 shows that 63.8% of the respondents did not intentionally listen or view sexual and reproductive health education programmes through the mass media. It also emerged that the respondents who do not make deliberate efforts to educate themselves on sexual and reproductive health issues through the mass media preferred other programmes.

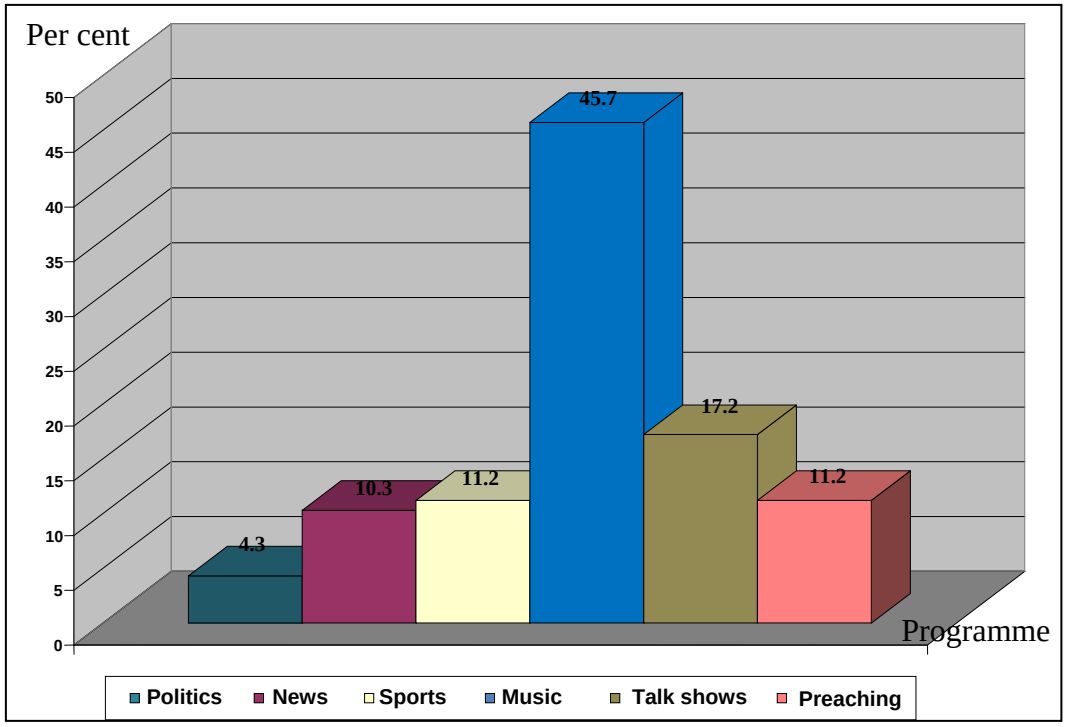

Figure 10: Favourite programme on radio

Source: Fieldwork, 2008

As indicated in Figure 10, 45.7% of the respondents preferred music played on radio than other programmes such as talk shows (17.2%) and sports (11.2%).

As could be observed from Table 20, 37.7% of the respondents were interested in movie and soap programmes on television. There was also a strong preference (25.4%) for musicals on television. Political discussions, sports analyses, religious sermons and sometimes news from various television networks also attracted varying levels of attention.

Table 20: Favourite programme on Television

Favourite TV programme	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Politics	2.1	1.5	1.8	2
News	19.0	9.0	13.2	15
Sports	26.0	6.0	14.0	16
Musicals	17.0	31.3	25.4	29
Talk shows	6.0	7.5	7	8
Movies	27.0	44.8	37.7	48
Preaching	2.0	0.0	0.9	1
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

Reasons for lack of interest in Sexual and Reproductive Health programmes

Respondents offered a number of reasons to justify their general dislike for sexual and reproductive health education programmes aired through the mass media. As indicated in Table 21, 31.4% of the dressmakers and 52.1% of the hairdressers expressed lack of interest in sexual and reproductive health education programmes in the mass media. Indeed, a dressmaker remarked that she would feel embarrassed listening to sexual and reproductive health education programmes on either the radio or television.

Table 21: Reasons for dislike for Sexual and Reproductive Health Education programmes on mass media

Reasons	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Inconvenient time	2.9	6.3	4.8	4
Asleep	14.3	8.3	10.8	9
No interest	31.4	52.1	43.4	32
Ignorance	28.6	18.8	22.9	17
Busy	22.8	14.5	18.1	14
Total	100.0	100.0	100.0	76
N	30	46	76	

Source: Fieldwork, 2008

Also, 10.8% of the respondents were of the view that most of the programmes were aired too late in the night when they would be asleep. For instance, counselling session on GTV is aired late in the night of Fridays as well as “odo ahomaso” which is aired from 10:00pm to 1:00am on Wednesdays and Saturdays on Adom FM in Tema. Again, a high proportion of the respondents (22.9%) were ignorant of the existence of such programmes on radio or television.

During a focus group discussion with hairdressers, some of the discussants expressed reservations about deliberately listening to such programmes. According to them, they do not want to show keen interest in such programmes to avoid being stigmatised as “spoilt girls” because already some members of the

public perceive dressmakers and hairdressers, especially the apprentices, as people with weak morals who engaged in unhealthy sexual and reproductive health practices such as having multiple sexual partners and aborting the foetus when pregnant. A 20 year old hairdresser remarked:

> *I will feel embarrassed to listen to issues on sex or reproductive health on the radio or television. Sexual and reproductive health topics normally upset me so I see no reason why I should sit down and listen to such programmes. I am happy such issues are not related to hairdressing neither are they precondition for my graduation. Some people have erroneously thought of hairdressers as husband snatchers. The fact of the matter is that our work ethics require us to dress neat to appeal to our customers. Some people think that we take boyfriends or exchange sex for money for our daily upkeep which is not true.*

Usefulness of Sexual and Reproductive Health Education programmes

Indications of how beneficial the programmes have been to those respondents who had listened to or received sexual and reproductive education programmes on radio or television are shown in Figure 11. Majority (95.3%) of the respondents said the programmes were beneficial. Indeed, 54.2% claimed the programmes were very useful in providing them with skills and information to enable them make informed decisions on sexual and reproductive health.

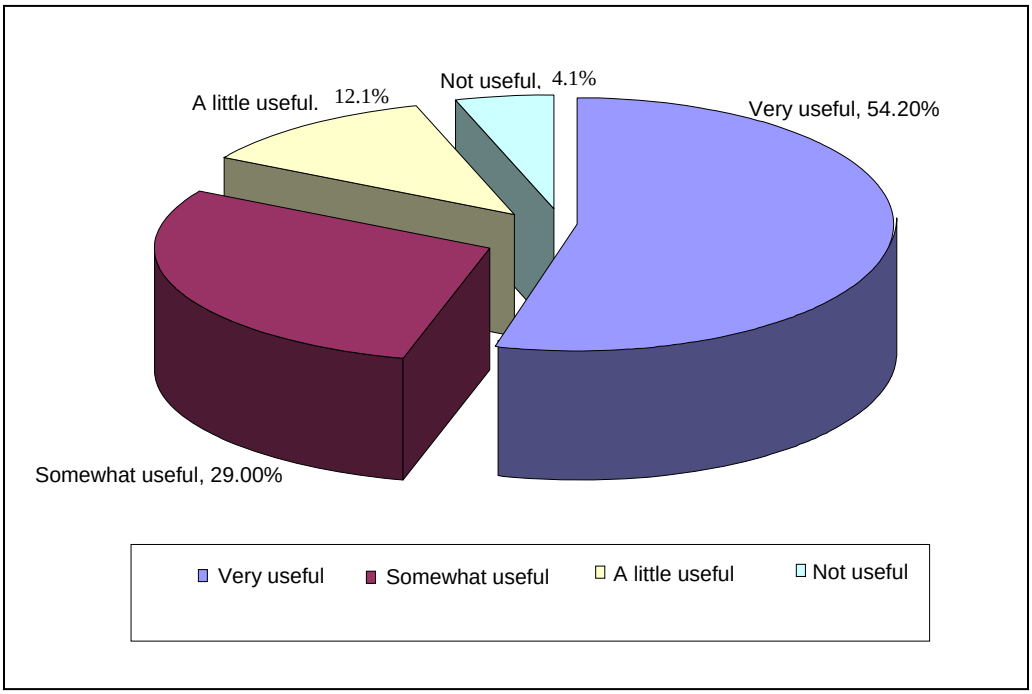

Figure 11: Usefulness of Sexual and Reproductive Health Education programmes

Source: Fieldwork, 2008

Overall attention to Sexual and Reproductive Health Education programmes

In order to ascertain the premium placed by dressmakers and hairdressers on sexual and reproductive health education, the respondents were asked to indicate their overall attention to such programmes. Figure 12 indicates that only 5.4% of the respondents paid serious attention to sexual and reproductive health education programmes, whilst 26.3% occasionally become interested in sexual and reproductive health education issues; with the remaining respondents paying little or no attention whatsoever to sexual and reproductive health education programmes. This phenomenon would require a targeted and structured programme(s) on sexual and reproductive health to meet the peculiar needs of

such people who work in the informal economy.

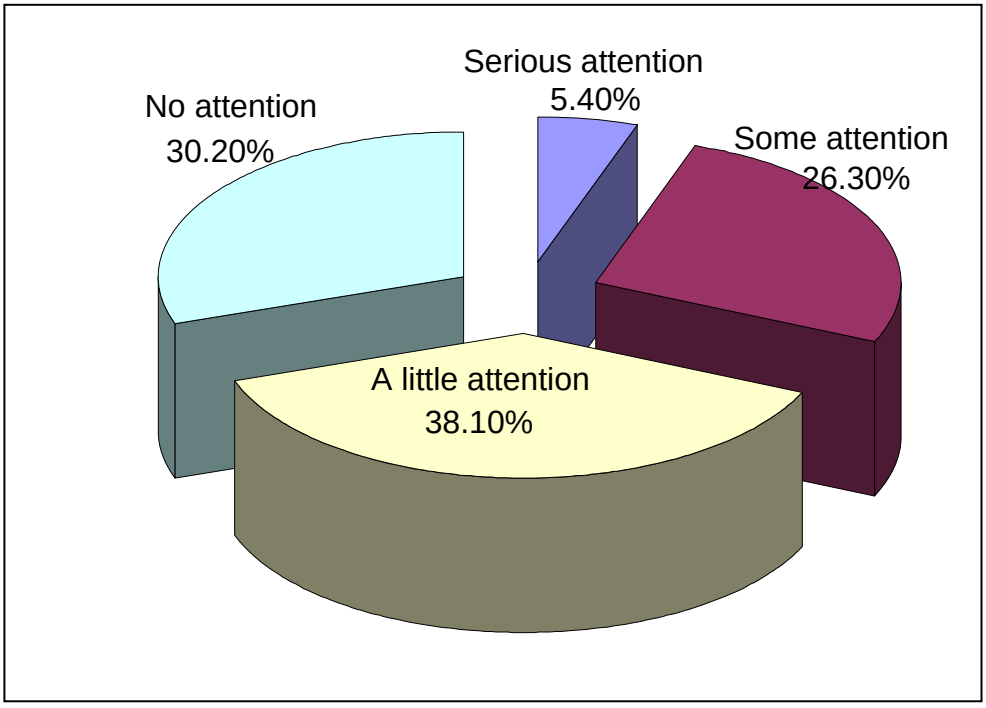

Figure 12: Overall attention to SRH education

Source: Fieldwork, 2008

Sexual and reproductive health education at workplaces

Some sexual and reproductive health education programmes have been implemented with dressmakers and hairdressers in Ghana as targets to empower them to adopt healthy sexual behaviours. Hence, dressmaking shops and hairdressing salons are sometimes the venues where young people congregate to discuss sexual and reproductive health issues (Essandoh, 2004). Reactions of the respondents to attempts to integrate sexual and reproductive health education issues into their training and for how long are presented in Table 22.

Table 22: Sexual and Reproductive Health education at workplaces

SRHE as part of training	Dressmakers (%)	Hairdressers (%)	Total (%)	N
Strongly agree	45.1	53.7	50.0	60
Agree	45.1	43.3	44.1	52
Disagree	9.8	1.5	0.8	1
Strongly disagree	0.0	1.5	0.8	1
Total	100.0	100.0	100.0	119
N	52	67	119	
Duration of SRHE programme				
Less than 10 minutes	6.5	1.5	3.6	5
10-30 minutes	47.8	55.4	52.3	62
One hour	45.7	40.0	42.3	50
More than one hour	0.0	3.1	1.8	2
Total	100.0	100.0	100.0	119
N	52	67	119	

Source: Fieldwork, 2008

As indicated in Table 22, a significant proportion (94.1%) of the respondents strongly agreed (50.0%) or agreed (44.1%) to the proposal to incorporate structured sexual and reproductive health education programmes into their training for periods of between 10 and 60 minutes. But the majority (52.3%) of the respondents favoured a ten to thirty minutes programme per week on sexual

and reproductive health education to be organised in their shops or salons.

Suggested areas of Sexual and Reproductive Health Education at workplaces

Various areas of sexual and reproductive health indicated by the respondents as their priority areas should programme planners and implementers decide to provide such education programmes for dressmakers and hairdressers in the district are shown in Figure 13.

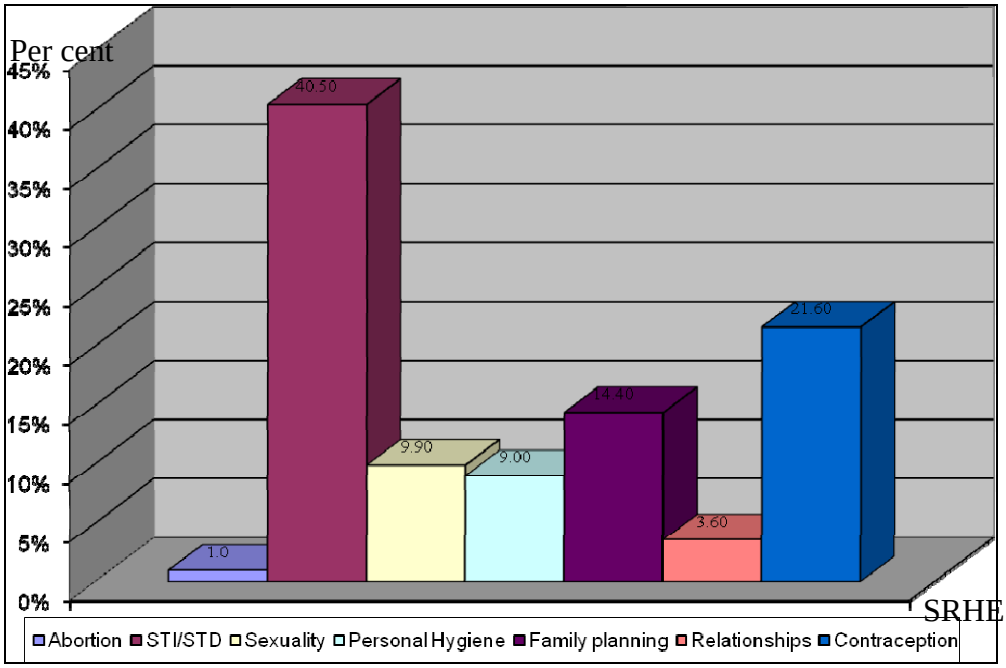

Figure 13: Suggested areas of Sexual and Reproductive Health Education at workplaces

Source: Fieldwork, 2008

The major priority areas were STI/STDs (40.5%) and contraception (21.6%) followed by family planning (14.40%). Other minor areas were sexuality and personal hygiene. These wide ranging sexual and reproductive health services

could be made available to other operators in the informal economy.

Institutional support

Multi-sectoral, multi-disciplinary and multi-dimensional approaches would be required to implement sexual and reproductive health education programmes to people who operate in the informal economy such as dressmakers and hairdressers. It would require the collective contribution of government, civil societies, NGOs and individuals to achieve the goals or targets for such programmes. Additionally, a determined and targeted effort would be needed from all the stakeholders before significant results could be achieved.

As already discussed in the conceptual framework (Figure 3), various institutions in Ghana such as the Ghana National Tailors and Dressmakers Association, The Ghana Hairdressers and Beauticians Association, Non-Governmental Organisation (NGOs), the District Assemblies and the Ministry of Health have, through various programmes, collaborated to provide sexual and reproductive health education to dressmakers and hairdressers as a means of empowering the beneficiaries to make informed choices. Hence the various support services offered by institutions to dressmakers and hairdressers in the study area were examined.

Responses from in-depth interviews of key informants from the Assin South District Assembly, Business Advisory Centre (BAC) of the Rural Enterprises Project, the leadership of the two vocational associations and the district health directorate suggest that not much had been done by the various

institutions to provide dressmakers and hairdressers in the study area with sexual and reproductive health education. For instance, an officer at the BAC remarked:

> *Even though my outfit provides capacity building services for the benefit of some artisans in the district, our focus is not on sexual and reproductive health.*

It was also established that the district secretariat of the two vocations, Ghana National Tailors and Dressmakers Association and the Ghana Hairdressers and Beauticians Association, were non-existent in the Assin Area, at least during the period of the study, to champion the course of their members. The existing groups were fragmented and organised on settlement basis without any proper coordination. A 36 year old "executive member" of the dressmakers association in one of the settlements said:

> *The supervisors in this settlement have formed an association to promote our welfare. We do not have problems in sexual and reproductive health because we are all married people. We used to discuss issues on marriage and personal hygiene during the formative years of the association but we have stopped for some time now due to lack of interest in such issues. Our apprentices also do not have any programme on sexual and reproductive health as well.*

The response of the leader of one of the hairdressing associations was not different from her dressmaking counterpart. According to this 38 year old hairdresser:

> *We conceived the idea of forming a group to regularise our activities and socialise our members about a year ago but at the moment the supervisors have to sort out some things first before we will allow the apprentices to join. Although there are major problems of teenage pregnancies, abortions and unhealthy relationships in this locality, we have not organised any educative programme on sexual and reproductive health to sensitise our members on some of the dangers. Currently the supervisors are trying to build the structures of our group so such programmes are not on our priority list. We will think about it in the future.*

The Adolescent Reproductive Health Policy of Ghana, for example, has explicitly mandated the Ministry of Health and the Ghana Health Service to provide youth-focused information and quality services such as counselling and family planning to young adults as well as to pioneer innovative interventions in sexual and reproductive health for the citizenry especially the youth. In response the significant contributions of the Ghana Health Service in the provision of information, education and communication as well as services on sexual and

reproductive health to dressmakers and hairdressers in the study area, the immediate past district director of health services in-charge of Reproductive and Child Health said:

> *No specific programme on sexual and reproductive health education has been organised for dressmakers or hairdressers in the district. We use the traditional methods of the media and durbar to target the general public if we want to carry out educative programmes in sexual and reproductive health. We have not, since the creation of the district, specifically targeted dressmakers and hairdressers to provide them with sexual and reproductive health education even though we perceive them to be at a higher risk of sexual and reproductive health related problems.*

Observations from the individual respondents tend to corroborate the various assertions reported above. For instance, majority of the focus group discussants were unanimous in their responses that none of the institutions mentioned above had ever organised an educational programme on sexual and reproductive health for them, however, the Adventist Development and Relief Agency (ADRA) was cited by few respondents in zone three for organising a one day workshop on HIV/AIDS for Dressmakers. The agency has since rounded up its activities in the district. As indicated in Table 23, none of the individual

respondents could recall any sexual and reproductive health education programme that had ever been organised by either the district assembly or the district's directorate of health services, contrary to the latter's mandate to provide budget lines for sexual and reproductive health programmes as proposed in the 2000 Adolescent Reproductive health Policy (NPC, 2000).

Table 23: Institutional support

Institutional support	Frequency	%
Contribution of ASDA		
No SRHE	86	72.2
Do not know	33	27.8
Total	119	100.0
Contribution of ASDHD		
No SRHE	88	74.8
Do not know	31	25.2
Total	119	100.0

Source: Fieldwork, 2008

Discussion

Education plays a major role in achieving the goals and aspirations of the individual and of the country. A large proportion of the population of Ghana is unable to attend school or complete the full cycle of education but engage in economic activities considered as informal.

Informal economy covers those activities with very small scale units,

producing and distributing goods and services and consisting largely of independent self-employed producers some of whom also employ family labour and/or a few hired workers or apprentices. They operate with very little capital or none at all and are characterized by low level of productivity, low and irregular incomes and highly unstable employment to those who work in them. This segment of the economy has become a major source of employment as well as an avenue for indigenous entrepreneurship.

Attempts have been made to strengthen Ghana's informal economy by both governmental and non-governmental organizations such as the creation of the National Board for Small Scale Industries (NBSSI) and the recent introduction of the new educational reforms which intend providing institutionalised apprenticeship training for the youth who could not further their education at the secondary level and beyond. The 1992 Constitution of Ghana recommended for the adoption of population policies that are consistent with the aspirations and development needs and objectives of the country. This has culminated in the revision of the 1969 population policy in 1994 and a further enactment of an adolescent reproductive health policy in 2000 to serve as frameworks to direct the country's agenda of building the capacities of her citizens for national development.

Sexual and reproductive health is one of the fundamental links in the process of developing a healthy society with the capability of propelling it into modernity. Education on sex and reproductive health should be consciously made available, accessible and affordable to every individual to enable him/her make

informed choices and decisions concerning his/her sexuality and reproduction which serves as basis of sustaining human existence.

Ghana is making frantic efforts to reduce maternal mortality, child morbidity/mortality, and rate of induced abortions and Sexually Transmitted Diseases (STDs) including HIV/AIDS through the implementation of a number of sexual and reproductive health programmes and services.

However, results from individual questionnaires, focus group discussions and in-depth interviews of dressmakers and hairdressers in the Assin-South district of the Central Region raised some major threats towards achieving good quality in human resources to drive the development programme of the country. For instance, some of the dressmakers and hairdressers delinked their vocation from sexual and reproductive health while a large proportion of the respondents (see Table 21) were either not interested in sexual and reproductive health education programmes or are ignorant about the existence of such programmes. These comments run contrary to what pertains in some developed countries such as Canada where attempts made by hairdressers have initiated empirical studies to assess the impact of hairdressing products on unborn babies (Chua-Gocheco, Bozzo, & Einarson, 2008).

Lack of coordinated and targeted programmes by government and private institutions in the district on sexual and reproductive health education for dressmakers and hairdressers who constitute a major component of the workers in the informal economy are indications that these groups within the country's population are at greater risk of engaging in negative sexual and reproductive

health practices (GSMF, 2003). It was therefore not surprising when the immediate past District Director of Health Services in charge of Reproductive Health in the Assin-District commented that:

> *Some of the dressmakers and hairdressers are victims of unsafe abortions, poor family planning and HIV/AIDS. The nature of their work is such that it will need a determined effort and resources to target them for education on sexual and reproductive health.*

While the various population and reproductive health policies in Ghana do not explicitly make provisions for dressmakers and hairdressers, it was also observed that no definitive policies or programmes exist in the study area to mandate the immediate superiors of dressmaking and hairdressing apprentices to actively engage their subordinates in sexual and reproductive health issues at their workplaces. It has already been explained in Table 18, that some of the supervisors either sit idle or deliberately suppress any communication on sexual and reproductive health in their shops or salons due to lack of urgency in such issues while those who tend to facilitate such discussions only concentrate on advising their apprentices to abstain from casual sexual intercourse.

This phenomenon, if allowed to continue would pose enormous challenges to the overall development programmes of Ghana to the extent that it might compel the country to mobilise resources to combat a looming increase in sexual and reproductive health related problems such as teenage pregnancies, unsafe

abortions, STI/STDs and inadequate information to a section of the population. This, according to the conceptual framework developed for this study (Figure 3) is the price a country is likely to pay for failing to tackle sexual and reproductive health related problems head on.

While majority of both dressmakers and hairdressers who participated in the study were within their reproductive age range of 15-49; most of them had never married or are either divorced or separated from their spouses. Indeed only a third of them were married and living with their spouses. In any case a high proportion of them had ongoing experience in penetrative sexual intercourse (see Tables 4, 12 and Figure 7) with some of them being engaged in the practice as early as age 15. Some of the non-married respondents were even engaged in sexual intercourse with casual sexual partners such as boy/girlfriends (see Figure 7) and therefore exposed to widespread unhealthy sexual situations such as multiple sexual partnership, non-use of protective measures, unwanted pregnancies, increased induced abortions and, in some cases, broken homes when the relationship does not end in marriage.

These anticipated problems are likely to be compounded as a result of the lack of targeted sexual and reproductive health education programmes and services by government agencies, civil society and NGOs designed specifically for dressmakers and hairdressers in the study area.

Friends and the mass media, particularly radio/television were some of the sources of sexual reproductive health information to the respondents (Figure 8). The resource persons who provide sexual and reproductive health education

through the mass media are professionals with varied backgrounds who provided in-depth and authentic information on a wide range of sexual and reproductive health related issues; however, more than two thirds of the dressmakers and hairdressers did not deliberately listen to or viewed sexual and reproductive health education programmes through the mass media (Figure 13) but rather preferred musicals and movies. Such over reliance on friends as their main sources of such information created the impression that the blind was leading the blind in the dissemination of sexual and reproductive health information.

Enough attention and resources should be channelled to the informal economy to build the capacities of the people in sexual and reproductive health issues. Indeed, majority of the respondents have expressed their willingness to accept any decision of incorporating sexual and reproductive health education into their training and vocation (see Table 23). This should culminate in all stakeholders involved in the human resource development of our country lending strong support to provide equal opportunities for the people in the informal economy to enable them contribute meaningfully to the overall development of the nation.

A significant proportion of the country's labour force is working in the informal economy. This force is mostly marginalised or excluded and falls outside the country's framework of laws and regulations. The line between formal and informal economies is increasingly becoming blurred thus refuting claims that the informal economy would be progressively absorbed by the formal economy through economic growth. Currently, the informal economy is expanding rapidly

in Ghana; providing employment to a large proportion of the youth. The formal economy, in most instances, depends on the services of the informal economy to exist and expand. It therefore becomes imperative that the informal economy in Ghana as well as the human resources in this important segment of our economy be provided with knowledge and skills, not only to assist them improve production, but to be able to make informed decisions and choices on sexual and reproductive issues since the continuity of the human race does not only depend on quantity but also quality of the people.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter deals with the summary of how the study was conducted, the conclusions drawn from the findings within the context of the objectives of the study and recommendations.

Summary

This exploratory investigation was undertaken to identify the sexual and reproductive health education programmes that are being implemented for dressmakers and hairdressers in the Assin South District of the Central Region of Ghana. It also aimed at determining the various sources of information on sexual and reproductive health available to dressmakers and hairdressers and to carry out an assessment of communication pattern(s) on reproductive health among the dressmakers and hairdressers at their workplaces. The assessment of sexual and reproductive health education model by Hardee et al (2004) was adapted for the study.

The study area was divided into four zones to ensure that the entire district was covered for the study. Three data collection instruments comprising an

individual interview schedule, focus group discussion guide and an in-depth interview guide were designed to gather primary data for the study. The snowballing technique was adopted to locate the shops, salons or activity points of dressmakers and hairdressers after which the purposive and the simple random sampling techniques were employed to sample the respondents. The application of the above sampling techniques produced one hundred and fifty three (153) respondents comprising one hundred and nineteen (119) individual respondents, five (5) key informants and twenty nine focus group discussants.

The individual respondents provided data through the individual interview schedules while the key informants and focus group discussants responded to items in the in-depth interview and focus group discussion guides respectively. The individual interview schedules were analysed using the SPSS software. Responses from the in-depth interviews and focus group discussions were hand recorded, categorised and analysed. Data was presented using tables, frequencies and charts.

Conclusions

Meeting the sexual and reproductive health needs of Ghanaians is one of the key challenges confronting policy makers and implementers in the country. Providing antidotes to these challenges require new insights into the overall effectiveness of existing policies and programmes on sexual and reproductive health and how operators in the informal economy of the country have access to and use of sexual and reproductive health information.

Observations from the study indicate that the traditional methods of sexual and reproductive health education through the mass media have not yielded the needed behavioural changes among dressmakers and hairdressers in the study area. In fact a host of events, activities and interest such as musicals and movies have clouded their attention to such programmes.

Supervisors in the various shops and salons were not keen on discussing sexual and reproductive health related issues with their subordinates. Rather, peers who are their immediate contact persons have become the important sources of such information. The unstructured sexual and reproductive health education programme(s) specifically designed for dressmakers and hairdressers and other workers in the informal economy could undermine the quest for harnessing the full potential of every Ghanaian for national development.

Recommendations

The following recommendations are based on the findings of this study.

- It is recommended that dressmaking and hairdressing supervisors in the various shops or salons could be periodically trained in sexual and reproductive health issues by reproductive health training institutions or organisations to engage their subordinates in formal discussions on sexual and reproductive health issues. They could also serve as initial resource persons to their subordinates who would require basic services in sexual and reproductive health. The overwhelming desire of the dressmakers and hairdressers to have sexual and reproductive health education issues

incorporated into their activities would require knowledgeable and competent supervisors to facilitate such discussions.

- It is also recommended that dissemination meetings should be organised for the supervisors, the Assin South District Assembly, health care providers and NGOs by the researcher to facilitate the process of developing workable strategies that would strengthen sexual and reproductive health education in the informal economy.
- The Ghana Hairdressers and Beauticians Association (GHABA) and the Ghana National Tailors and Dressmakers Association (GNTDA branches in the district had not been inaugurated during the period of the study. It is recommended that the national and regional secretariat of the two vocational associations should hasten the process of inaugurating their respective branch associations in the Assin South District to enable them liaise with other stakeholders to implement sexual and reproductive health education programmes for their members.
- The one year apprenticeship and skill training programme proposed in the current educational reforms should incorporate sexual and reproductive health education issues to empower apprentices with knowledge and skills in sex and reproductive issues.
- There is evidence that a gap exists in knowledge and practice of contraceptives in Ghana (GSS, 2004). The analysis of the results in this study was not different as well. Even though some programmes have been implemented, for instance, to encourage Ghanaians to practice safe sex

- It was evident that the respondents preferred musical programmes on radio and movies on televisions. It is recommended that the Behavioural Change Communication programmes must adopt the concept of enter-educate more vigorously as a means of disseminating educational information on sexual and reproductive health to dressmakers and hairdressers.
- A national survey on sexual and reproductive health education in the informal economy should be conducted by research institutions to guide policy formulation, programme planning and implementation.

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APPENDICES

APPENDIX 1

INDIVIDUAL INTERVIEW SCHEDULE

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AMONG DRESSMAKERS AND HAIRDRESSERS IN THE ASSIN SOUTH DISTRICT

SHOP/SALON IDENTIFICATION

Zone…….....

Community…….....

Name of Shop/Salon…….....

Name of Supervisor …….....

Name of Respondent (First name only) …….....

INTERVIEWER VISITS

	1	2	3	Final Visit
Date				Day
Interviewer's Name				Month
Time interview start				Year
Time interview end				*Result

*** RESULT CODES

01 Completed

02 No supervisor in Shop/Salon

03 Shop/Salon locked during entire period of data collection

04 Refused

Informed Consent

"Hello. My name is _____ and a student from the Department of Geography and Tourism, University of Cape Coast. I am collecting data from dressmakers and hairdressers in the Assin-District for a research study on reproductive health education and how it impact on their activities. You have been sampled to participate in this study by providing responses to the questions that I will ask you. The findings of this study would be used to complement the existing knowledge on reproductive health education in the country. If you agree to be interviewed, you will be asked questions about your knowledge and experience with reproductive health education and how reproductive health education impacts on your training. I will entreat you to provide responses to all the questions that will be asked, however, if a question makes you feel uncomfortable, you may choose not to answer it. The survey usually takes between 30 and 45 minutes to complete depending on your approach to answering questions. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Do you agree to participate in this study?" YES [ ] NO [ ]

I certify that I have read this statement to the respondent, that s/he fully understood its meaning and that she/he agreed to participate in the study.

…… ----------

Interviewer's signature **Respondent signature/Initials**

SECTION A: BACKGROUND DATA

Let's begin with some background data about you, your household and shop.

SKIP

1. Type of Activity **CIRCLE ONE ONLY**	Dressmaker……...….1 Hairdresser…….2	
2. Number of apprentices.	None……..1 1-5 …….2 6-10 ……..3 11 and above …….4	
3.Sex of respondent	Male……...…1 Female……...2	
4. What is your status in this shop? **CIRCLE ONE ONLY**	Master ……..….1 Senior Apprentice…….2 Apprentice……3 Junior Apprentice……..…...4	

5. Age of respondent	15-20……..…1 21-25……..2 26-30……..…3 31-35……..4 36-40……..….5 41-45……..6 46-50……..…7 51 and above……..….8	
6. How many years have you spent as an apprentice and /or as a master?	Less than 6 months……..…..…..…1 1-2 years……..…...……2 3-4 years……..…...……3 5-6 years……4 7 years and above…….……..5	
7. Have you ever attended school?	Yes……..1 No……...2	=> **8** => **9**
8. If yes, what is the highest level of schooling you completed? **CIRCLE ONE ONLY**	Primary……...……1 J.S.S……..…….2 S.S.S……...3 Vocational……..……..…4 Polytechnic……..……...5 University……..…6 Other (specify) _____7	

9. Would you like to attend school or continue schooling?	Yes……..…1 No……..…2	=> **10** => **11**
10. If Yes, what is the highest level of schooling would you like to complete?	Primary…….....1 J.S.S……....…2 S.S.S……...3 Vocational……..4 Polytechnic…….……5 University……..6 Other (specify) _____7	
11. What language do you use most often in your daily life? **CIRCLE ALL MENTIONED**	English ……..1 Fanti……...2 Twi…….3 Ewe……4 Hausa…….5 Ga……..6 Other (specify) _____7	

12. What is your marital status? **CIRCLE ONE ONLY**	Never married ……..……..1 Married ……..2 Divorced ……....3 Separated……....4 Widowed/Widower……....5	=> **14** => **13** => **13** => **13** => **13**
13. If you have ever married, how old were you at your first marriage?	15-20 years……1 21-25…….……2 26-30 years……..…3 31 years and above……4	
14. What is your religion? **CIRCLE ONE ONLY**	None…….…..…1 Orthodox…….……...2 Islamic ……..….3 Pentecostal/Charismatic ……....4 Traditional…….…5 Other (specify) _____6	

15. What is your relationship to your head of household? **CIRCLE ONE ONLY**	Self……..……1 Wife/Husband…….2 Son/daughter …….…….3 Parent……..….4 'Master'…….5 Boy/girlfriend ……...6 Friend…….……...7 Non- related……..….8 Religious leader……..…9 Other (specify) _____10	
16. What is your ethnic group? **CIRCLE ONE ONLY**	Ga……..…….1 Akan ……..……2 Ewe……..…..3 Hausa…….4 Other (specify) _____5	
17. Have you lived in this settlement since birth?	Yes……..……1 No……..……2	=> **20** => **18**
18. If No, how many years have you lived in this settlement? **CIRCLE ONE ONLY**	Less than 6 months……...…..1 1-2 years……..…2 3-4 years…….3 5 years and above…….……..…4	

19. Why did you come to live in this settlement? **CIRCLE ALL MENTIONED**	To learn hairdressing/dressmaking…….1 To live with parents/guardians……...2 To join a spouse or other partner……...3 Other (specify) _____ 4	
20. How likely is it that you could be evicted from your current dwelling? **CIRCLE ONE ONLY**	Don't know…….1 Very likely……..……...2 Somewhat likely…….3 Not at all…….4	=> **21** => **21** => **21** => **22**
21. If evicted, who are you likely to stay with to complete your apprenticeship? **CIRCLE ONE ONLY**	Will rent a place by myself…….....1 Wife/Husband……..…...2 Son/daughter …….....3 Parent…….…....4 'Master'…….…….5 Boy/girlfriend ……6 Friend…….7 Non- related……8 Religious leader……..9 Other (specify) _____10	
22. Do you have other occupations of your own?	Yes…….……1 No…….…….….2	=> **23** => **24**

23. If Yes, what is the occupation? **CIRCLE ALL MENTIONED**	Carpenter ……..……..1 Electrician……..…..2 Teacher …….…….3 Dressmaker…….……4 Hairdresser…….…….5 Baker…….……6 Agricultural worker……....7 Other (specify) _____8	
24. Do you have the following items in your household? **CIRCLE ALL MENTIONED**	Radio……..….1 Mobile phone……..…2 TV……..3 Computer……4 None……...5	
25. How much did you pay to be enrolled into this apprenticeship? **CIRCLE ALL MENTIONED**	Less than GH¢ 10.00……..……1 GH¢10.00- GH¢50…….……2 GH¢ 51.00- GH¢100.00…….……3 GH¢ 101.00- GH¢ GH¢150……...…4 GH¢ 151and above…….5	

26. Who provided the money/ items? **CIRCLE ALL MENTIONED**	Self……..…….1 Wife/Husband…….……2 Son/daughter …….…….3 Parent……..…4 'Master'…….….5 Boy/girlfriend ……....6 Friend……..…7 Non- related…….…..8 Religious leader……..…9 Other (specify) _____10	
27. Is/Are there anything(s) that could hinder you from learning this apprenticeship?	Yes ……....1 No…….…..2	=> **28** => **29**
28. If yes, what could hinder you? **(CIRCLE ALL MENTIONED**	Financial difficulties ……....……1 My master is not good on the job……..…2 I come to work hungry……...3 Sexual partner wants me to stop……...4 Other (specify) _____ 5	

29. Did you have to stop the apprenticeship for some reasons?	Yes……..……1 No……..2	=> **30** => **31**
30. If yes, why? **RECORD** **RESPONSE** **VERBATIM**	…… …… ……	

Section B: Knowledge on Sexual and Reproductive Health

31. Have you ever had sexual intercourse?	Yes……...1 No……..……..2	=> **32** => **41**
32. If yes, how old were you when you first had sexual intercourse?	[____][____]	
33. When was the last time you had sex?	Month [_____] Year [_____]	

34. Who did you have the sex with the last time you had sex? **CIRCLE ONE ONLY**	A relative……. 1 An acquaintance……..2 Prostitute……..3 Spouse…….4 Boy/Girlfriend…….5 Other (specify) _____6	
35. Why did you have the sexual intercourse with him or her? **CIRCLE ONE ONLY**	Just wanted to have sex ……1 I was forced to have sex……2 I exchange sex for money…….…..3 Other (specify) _____4	
36. Have you ever contracted a Sexually Transmitted Disease?	Yes…….……...…1 No…….……2	=> **37** => **41**

37. If yes, what was the disease? **CIRCLE ALL MENTIONED**	Syphilis……1 Gonorrhoea……2 Chlamydia……3 HIV/AIDS……4 Candidacies……5 Genital herpes……6 Genital warts……7 Other (specify) _____8	
38. Did you seek treatment?	Yes……1 No……2	=> **39** => **40**
39. If yes, from where did you seek the treatment? **CIRCLE ALL MENTIONED**	Friend……1 Doctor/Nurse……2 Master……3 Drug store/Pharmacy……4 Traditional Healer……5 Sexual partner……6 Religious leader……7 Other (specify) _____8	

40. If No, why did you not seek treatment? **(Write explanation Verbatim**	…… …… ……	
41. Do you know of any contraceptive method (s)?	Yes……...1 No……...……..…2	=> **42** => **45**
42. If yes, what are some of the contraceptive methods? **(CIRCLE ALL MENTIONED)**	Pills…….…..……1 Condoms…….....2 Norplant…….....3 Sterilization…….....4 Rhythm...…….....5 Injectable…….....6 Vasectomy……...……...…7 IUD…….....8 Other (specify) _____9	

43. Which of the methods have you ever used? **CIRCLE ALL MENTIONED**	Pills……...……..1 Condoms…….…..…..2 Norplant……...…...3 Sterilization……...…..4 Rhythm……5 Injectable…….....6 Vasectomy…...……...……7 IUD……..8 None…….……. .9 Other (specify) _____10	=> **45**
44. Why did you use that method of contraception? **CIRCLE ALL MENTIONED**	To prevent pregnancy……...…….1 To prevent STI/STD……..2 It is readily available and accessible..3 It has no side effects…….……4 My health worker prescribed it for me..5 Other (specify) _____ 6	

45. Where do you receive the MOST useful information on Reproductive Health? **CIRCLE ONE ONLY**	Parents……1 Brothers/sisters/cousins……..2 Doctor/Nurses…….3 Master…….4 Friend……..5 Radio...…….....6 Books……..7 Religious leaders…….8 TV……...9 Newspapers/magazines…….10 Traditional Healer…….11 Drug store/Pharmacy Shop……..12 Other (specify) _____ 13	

46. Who will you first consult if you have reproductive health problems? **CIRCLE ONE ONLY**	Parents……1 Brothers/sisters/cousins……..2 Doctor/Nurses…….3 Master…….…….4 Friend…….……..5 Radio…….....6 Books……..7 Religious leaders…….8 TV……...9 Newspapers/magazines…….10 Traditional Healer…….11 Drug store/Pharmacy Shop……12 Other (specify) _____ 13	

Section C: Sexual and Reproductive health education and Communication patterns at shops

47. What reproductive health education programmes do you know?	None……..……..1 Programme…….2	=> **53** => **48**
48. When was the last time you listened to the programme(s)? **CIRCLE ONE ONLY**	Today……..……...….1 A week ago…….2 A month ago……...3 Over six months ago…….....4 A year ago…….……...5 Over a year ago…….....6	
49. What was the topic for discussion? **CIRCLE ALL MENTIONED**	Contraception ……..……..1 Sexuality…….2 Personal Hygiene…….....3 STI/STD…….4 Mortality…….5 Relationships……..6 Other (specify) _____7	
50. Do you discuss the content of such programmes with your colleagues at work?	Yes……..1 No…….……2	=> **51** =>**52**

51. If yes, what role does your master or apprentice play in such discussions? **CIRCLE ALL MENTIONED**	Sits idle……..……..1 Introduces the topic…….……..2 Suppresses discussions…….....3 Provides discussion materials……4 Arranges the meeting…….....5 Facilitates discussions……6 Provide Resource Persons…….....7 Other (specify) _____ 8	
52. If NO, Why? **WRITE RESPONSE VERBATIM**	…… …… ……	
53. Do you have the following equipment(s) in your shop?	Radio…….……1 Television……...2 DVD/VCD/VHS……3 Electricity……..4 A telephone/cell phone……..5 Newspapers/magazines…….6 None……...7	

54. How often do you listen to the radio? **CIRCLE ONE ONLY**	Almost every day……1 At least once a week……...2 Less than once a week……3 Not at all……4	 => **60**
55. What is your favourite radio station in Ghana? **CIRCLE ONE ONLY**	ATL FM …….1 Peace FM……2 Adom FM…….....3 Yes FM…….....4 Eagle FM……5 Radio Central……..6 Other (specify) _____7	
56. What is your favourite programme on the radio? **CIRCLE ONE ONLY**	Politics……1 News……...2 Sports…….....3 Music…….....4 Talk shows ……5 Other (specify) _____6	

57. Do you intentionally pay attention to Reproductive Health education programmes on the radio?	Yes……..1 No……..2	=> **58** => **59**
58. If yes, what reproductive health education programme (s) do you listen to on the radio? **RECORD PROGRAMME AND STATION**	Radio Programme:…… Radio Station: ……	
59. If No, Why? **RECORD RESPONSE VIRBATIM**	…… …… ……	
60. How often do you view the Television? **CIRCLE ONE ONLY**	Almost every day……..…...1 At least once a week……..…..2 Less than once a week……3 Not at all…….4	=> **66**

61. What is your favourite Television station in Ghana? **CIRCLE ONE ONLY**	GTV …….....1 METRO TV……...2 TV 3…….…….....3 TV AFRICA…….....4 COASTAL TV……5 Other (specify) _____7	
62. What is your favourite programme on the Television? **CIRCLE ONE ONLY**	Politics……1 News……..2 Sports…….....3 Music…….....4 Talk shows ……5 Other (specify) _____6	
63. Do you intentionally pay attention to Reproductive Health education programmes on the Television?	Yes……..1 No……..2	=> **64** => **65**

64. If yes, what reproductive health education programme(s) do you view from the Television? **(Record programme and station)**	TV Programme:…… TV Station: ……	
65. If No, Why? **RECORD RESPONSE VIRBATIM**	…… …… ……	
66. How often do you read newspaper(s) or magazine(s)? **CIRCLE ONE ONLY**	Almost every day……...1 At least once a week……..2 Less than once a week……3 Not at all……4	=> **72**
67. What is your favourite newspaper(s) or magazine(s) in Ghana? **CIRCLE ONE ONLY**	Daily Graphic……..……1 Mirror……2 P&P…….……...3 Daily Guide…….....4 Ebony……5 Other (specify) _____6	

68. What is your favourite column in the newspaper(s) or magazine(s)? **CIRCLE ONE ONLY**	Politics……1 News……..2 Sports…….....3 Music…….....4 Talk shows …….5 Other (specify) _____6	
69. Do you intentionally pay attention to Reproductive Health education programmes in the newspaper(s) or magazine(s)?	Yes……..1 No……..2	=> **70** => **71**
70. If yes, what reproductive health education column(s) do you read in the newspaper(s) or magazine(s)?	Column:……. Paper/magazine……..	
71. If No, Why? **RECORD RESPONSE VIRBATIM**	…… …… ……	

72. How much attention do you pay to information about reproductive health from the Television/Radio/Newspapers/Magazines? **CIRCLE ONE ONLY**	A lot ……...……1 Some……..……..…2 A little…….3 Not at all……4	=> **74**
73. Overall, how useful was the reproductive health information you got from the Television/Radio/Newspapers/Magazines?	Very useful…….1 Somewhat useful……2 A little useful……..3 Not at all useful……..4	
74. Does your master or apprentice routinely ask/teach you about topics in reproductive health?	Yes……..1 No……..2	=> **75** => **76**

75. If yes, what are some of the topics? **CIRCLE ALL MENTIONED**	Contraception ……1 Sexuality……..…2 Personal Hygiene……3 STI/STD…….4 Mortality…….5 Relationships……..6 Other (specify) _____ 7	
76. If No, why not?	S/he is ignorant about the issues…….1 S/he is shy to talk about the issues…..…2 It is not our priority…….…...3 It is not condition for graduation……4 Other (specify) _____5	
77. Have you ever had your training interrupted due to Reproductive Health issue(s)?	Yes……..1 No……..2	=> **78** => **82**
78. If yes, how many days/weeks/months/years was your training interrupted? **CHOOSE ONE ONLY**	Less than a week……..……...1 About a month……..……..2 More than three months……..3 Above six months……...…4	

79. What was the Reproductive Health issue(s) that interrupted your training? **CIRCLE ALL MENTIONED**	Contraception……..……..….1 Family planning……..……2 Sexuality…….……3 STI/STD……..……..4 Personal Hygiene …….……..5 Mortality…….……6 Relationships……..7 Abortions……8 Other (specify) _____9	
80. What was the initial reaction of your master when she/he heard the news? **CIRCLE ONE ONLY**	Sacked me from the shop……..1 Empathized with me…….……..2 She/he was not bothered … ……...3 Provided financial assistance ……....4 Provided material assistance……..5 Other (specify) _____6	
81. What did you lose during the period that you were absent? **RECORD RESPONSE VERBATIM**	....	

82. Do you agree that reproductive health education programmes should be included in your training? **CIRCLE ONE ONLY**	Strongly agree……1 Agree……..…….2 Disagree……..3 Strongly disagree ……...4	=> **83** => **83** => **86** => **86**
83. If strongly agree or agree, what would be your priority area(s)? **CIRCLE ALL MENTIONED**	Contraception……..……..….1 Family planning……..……2 Sexuality……..……3 STI/STD……..……..4 Personal Hygiene …….……..5 Mortality…….……6 Relationships……..7 Abortions……8 Other (specify) _____9	
84. What should be the duration for such an educative programme? **CIRCLE ONE ONLY**	Less than 10 minutes……..1 10-30 minutes ……2 One hour…….....3 Over one hour …….....4 Other (specify) _____ 9	

85. Which period of the day do you propose for such an education? **CIRCLE ONE ONLY**	Morning……1 Afternoon…….……2 Evening ……3 Any period ……4 Other (specify) _____5	
86. Do you have a private health expert that you consult on reproductive health education issues?	Yes……..1 No…….....2	=> **87** => **89**
87. If yes, what kind of health expert do you see most often? **CIRCLE ONE ONLY**	Doctor……1 Nurse……..2 Spiritual healer……...……3 Traditional Healer……...4 Other (specify) _____ 5	
88. During the past 12 months, how many times did you receive care for yourself from this expert? **CIRCLE ONE ONLY**	None ……..……1 Once …….……2 Twice…….……3 Thrice…….....4 More than five times……..5	

89. In general, what would you say about your knowledge on reproductive health issues?	Excellent……..1 Very good……2 Good…….....3 Fair…….4 Poor……5 Very Poor……6	
90. Are you currently a member of the National Health Insurance Scheme?	Yes……..1 No……..2	=> **92** => **91**
91. If No, will you consider joining the scheme in the future?	Yes……..……1 No……...2 I do not know…….……3	

Section D: Institutional support for sexual and reproductive health education in the Assin South District

92. Did you attend the last meeting of GHBA/ TDMAG?	Yes……..1 No……...2	=> **94** => **93**
93. If No, why did you not attend the meeting? **CIRCLE ALL MENTIONED**	I intentionally decided not to attend……...1 Did not hear of the time and venue……2 I do not qualify to attend……3 The meeting was irrelevant to me……..4 The agenda was not attractive……5 I am not a member of the association……6 No money for transport……..7 Other (specify) _____8	
94. When was the last time the association organized an educative programme on reproductive health for their members? **CIRCLE ONE ONLY**	None……...1 This week……...2 Last month……..3 Six months ago……...4 Somewhere last year…….....5 More than two years ago……6	=> **99**

95. If ever organised, how often? **CIRCLE ONE ONLY**	Once a week……...……1 Once a month ……...….2 Once a quarter ……...3 Twice a year……...4 Once a year……5 Do not know ……..6 Other (specify) _____ 7	
96. What topic(s) was/were discussed during the last programme? **CIRCLE ALL MENTIONED**	Contraception……..……..….1 Family planning……..……...2 Sexuality…….……..3 STI/STD……..……4 Personal Hygiene …….……5 Mortality…….……6 Relationships……..7 Abortions……8 Other (specify) _____9	
97. How did you rate the programme? **CIRCLE ONE ONLY**	Very relevant……1 Relevant……2 Irrelevant…….…….3 Very irrelevant…….…….4	

98. Who was/were the resource persons? **CIRCLE ALL MENTIONED**	Executives……..…….1 Doctor/Nurse…….…....2 Peer educator…….……3 Religious leader……4 Traditional healer……..5 Do not know…….6 Other (specify) _____7	
99. What is the specific contribution of the ASDA to the provision of RH education to Dressmakers and Hairdressers in this District? **CIRCLE ALL MENTIONED**	None……..…….……1 Do not know……..……2 Organise workshops…….……..…3 Provide resource persons…….…….4 Provide funds for programmes…….5 Other (specify) _____6	=> **102** => **102** => **100** => **100** => **100**

100. What is your assessment of the ASDA contribution to the provision of RH education to Dressmakers and Hairdressers? **CIRCLE ONE ONLY**	Very good……...1 Good …….2 Poor……3 Very poor……...4	=> **102** => **102** => **101** => **101**
101. If poor or very poor, what do you expect the ASDA to do for Dressmakers and Hairdressers in the provision of RH education? **CIRCLE ALL MENTIONED**	Provide funds for such programmes ……1 Provide resource persons…….……2 Provide R/H materials free of charge…….…..3 Provide R/H materials at a cost……....4 Other (specify) _____5	

102. What is the contribution of the DHA in the provision of RH education to Dressmakers and Hairdressers? **CIRCLE ALL MENTIONED**	None……..…….……1 Do not know……..……2 Organise workshops…….……..…3 Provide resource persons…….…….4 Provide funds for programmes…….5 Other (specify) _____6	=> **105** => **105** => **103** => **103** => **103**
103. What is your assessment of the DHA contribution to the provision of RH education to Dressmakers and Hairdressers? **CIRCLE ONE ONLY**	Very good……...1 Good …….2 Poor……3 Very poor……...4	=> **105** => **105** => **104** => **104**

104. If poor or very poor, what do you expect the DHA to do for Dressmakers and Hairdressers in the provision of RH education? **CIRCLE ALL MENTIONED**	Provide funds for such programmes ……...1 Provide resource persons……2 Provide R/H materials free of charge.……..3 Provide R/H materials at a cost……..4 Other (specify) _____ 5	
105. What is the contribution of NGO (s) in the provision of RH education to Dressmakers and Hairdressers in this district? **CIRCLE ALL MENTIONED**	None……..……..……1 Do not know……..……2 Organise workshops…….……..…3 Provide resource persons…….……4 Provide funds for programmes…….5 Other (specify) _____6	=> **End** => **End**

106. What is your assessment of NGO (s) contribution to the provision of RH education to Dressmakers and Hairdressers in this district? **CIRCLE ONE ONLY**	Very good……...1 Good …….2 Poor……3 Very poor……...4	=> **End** => **End** => **107** => **107**
107. If poor or very poor, what do you expect the NGO(s) to do for Dressmakers and Hairdressers in the provision of RH education? **CIRCLE ALL MENTIONED**	Provide funds for such programmes ……...1 Provide resource persons……2 Provide R/H materials free of charge.…….3 Provide R/H materials at a cost……..4 Other (specify) _____ 5	

END OF THE INTERVIEW

These are all the questions that I have for you. If you want other information about this study or have some questions you can locate me at the Department of Geography and Tourism, UCC. Thank you very much for your cooperation.

Do you mind if my supervisor returns to make sure I did my work correctly?

Yes [ ] No [ ]

Record time interview ended…….....

INTERVIEWER'S comments:

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APPENDIX 2

IN-DEPTH INTERVIEW GUIDE (IDI) FOR KEY INFORMANTS

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AMONG DRESSMAKERS AND HAIRDRESSERS IN THE ASSIN SOUTH DISTRICT

Date and time interview commenced…….

Introduction

Thank you for accepting to be part of this study. My name is ……..and come from the Department of Geography and Tourism, University of Cape Coast. I am conducting a research on sexual and reproductive health education among dressmakers and hairdressers in the Assin-South District of the Central region. The purpose of this interview is to solicit your views on sexual and reproductive health education situation in the district and how it affects dressmakers and hairdressers. Your confidentiality is assured.

Before we begin, I would like to get some brief background data about you.

Section A: **Background Data on Respondent**

1. Name: (First Name Only).
2. Sex of respondent.
3. Age of respondent.
4. What is your status in this institution/association?

5. How long have you been working in this capacity?
6. Religion (example Christianity).
7. Highest Educational level reached (example J.H.S.).

(Check data for accuracy and continue to section B)

Section B: General Information about Facility

Let us continue with some background data on the nature of your institution/association.

8. Name of institution/association
9. Year institution/association was established or formed.
10. Location of institution/association (Record town/village)
11. Why was institution/association established or formed? (Probe for all reasons)
12. What are the major features of your clients or members? (Probe for age, educational level, economic activities)
13. How many clients or members (on average) are under your care?

(Summarize section and continue to Section C)

Section C: Provision of Reproductive Health Education programmes/services

14. What is/are the major sexual and reproductive health related problem (s) in this district?
15. What sexual and reproductive health education programmes/services does your institution or association provide? (Probe for all programmes/services).

16. Describe how the programme(s)/services is/are organized or provided.
17. Are dressmakers/hairdressers at risk of sexual and reproductive health issues?
18. If yes, what puts them at risk?
19. Are you satisfied with their level of knowledge on sexual and reproductive health issues?
20. If No, why are you not satisfied?
21. What is/are the specific contribution (s) of your institution or association to the provision of sexual and reproductive health education to hairdressers/dressmakers in this district?
22. Do you have specific written guidelines on sexual and reproductive health education issues for dressmakers/hairdressers? If yes, can I get a copy?
23. Do you charge for the programmes or services rendered? (Probe for cost and the fate of those who cannot pay).

(Summarize section and continue from Section D)

Section D: The Way Forward

24. What sexual and reproductive health education programmes/services can your institution or association offer to hairdressers/dressmakers in this district?
25. How should such a programme be organised? (Probe for time, venue, nature and facilitators?

26. What do you think will hinder the success of such programmes and how can they be overcome?

(Summarize section and conclude the interview)

END OF THE INTERVIEW

These are all the questions that I have for you. Thank you very much for your cooperation. Do you mind if my supervisor returns to make sure I did my work correctly?

Yes [ ] No [ ]

Record time interview ended……

INTERVIEWER'S comments:

……

…….....

APPENDIX 3

FOCUS GROUP DISCUSSION (FGD) GUIDE

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AMONG DRESSMAKERS AND HAIRDRESSERS IN THE ASSIN SOUTH DISTRICT

Introduction

Thank you for agreeing to be part of this discussion. My name is ……..from the Department of Geography and Tourism, University of Cape Coast. I am here with…… from the same department. We are conducting a research on sexual and reproductive health education among dressmakers and hairdressers in the Assin-South District of the Central region. The purpose of this discussion is to find out more about your opinions, knowledge and understanding of the sexual and reproductive health education issues in the district and how they relate to your vocation.

The discussion will solicit data on the nature of your work, your sources of information on sexual and reproductive health as well as how such issues are discussed in your workplaces. Everybody is encouraged to express his or her opinion during the discussion. Everything you say during the discussion will be treated as confidential.

Record Date and time discussion commenced.

Before we begin, we would like to get some brief background data of all discussants.

Section A: **Demographic and background data of Discussants**

1. First Name.
2. Age.
3. Sex.
4. Religion (example Christianity).
5. Highest Educational level reached (example J.H.S.).
6. Vocation (Dressmaker/Hairdresser).

(Check data for accuracy and continue to section B)

Section B: Data on vocation

7. How many years have you worked as a dressmaker or hairdresser?
8. What motivated you to become a dressmaker or hairdresser?
9. What influenced your decision on the choice of your supervisor?
10. Describe a typical day's schedule of a dressmaker/ hairdresser. (Probe for activities in the morning, afternoon and evening)
11. On the average, how many dressmakers or hairdressers work in a shop or salon?

(Summarize the section and continue to section C)

Section C: Knowledge on sexual and reproductive health education

12. What do you consider to be the major problem(s) facing dressmakers and dressmakers in this district at the moment?
13. What do you consider to be the major health problem(s) facing dressmakers and dressmakers in this district at the moment?
14. Do you have explicit guidelines/rules/regulations on sexual and reproductive health in your shops or salons? (If yes, probe for its rationale, objectives, implementation strategy and request a copy, if available).
15. Is there relationship between your vocation and unhealthy sexual behaviour?

(Summarize section and continue to Section D)

Section D: sexual and reproductive Health Information and Education

16. Have you ever had complications with pregnancy, abortion, STI/STD or any related sexual and reproductive health issue?
17. If yes, describe the scenario. (Can allow a maximum of three discussants to share their experiences).
18. Who did you consult for assistance and why that person?
19. Do you have specific periods in everyday/week or month devoted for the study of sexual and reproductive health issues at your work places?
20. If yes, when and how is the programme organised? (Probe for topics discussed, the delivery strategy and leader(s) of the programme).
21. If No, why not?

22. Do you think information on sexual and reproductive health education already available in this district enough?
23. If No, what do you think is lacking?

(Summarize section and continue from Section E)

Section E: Role of stakeholders in sexual and reproductive health education

24. Who normally initiate discussions on sexual and reproductive health issues in your shops or salons?
25. What specific role(s) does your supervisor play in educating you on sexual and reproductive health issues at your work places?
26. Describe the specific roles of the following organizations/institutions in the provision of sexual and reproductive health education to dressmakers and hairdressers in this district:
    a. The Assin South District Health Directorate
    b. Non-Governmental Organizations
    c. The Assin-South District Assembly
    d. The Ghana Hairdressers and Beauticians Association
    e. The Tailors and Dressmakers Association of Ghana

(Summarize section and conclude the discussion)

END OF THE INTERVIEW

This is all the questions that I have for you. Thank you very much for your cooperation.

Do you mind if my supervisor returns to make sure I did my work correctly?

Yes [ ] No [ ]

Record time interview ended.

INTERVIEWER'S comments:

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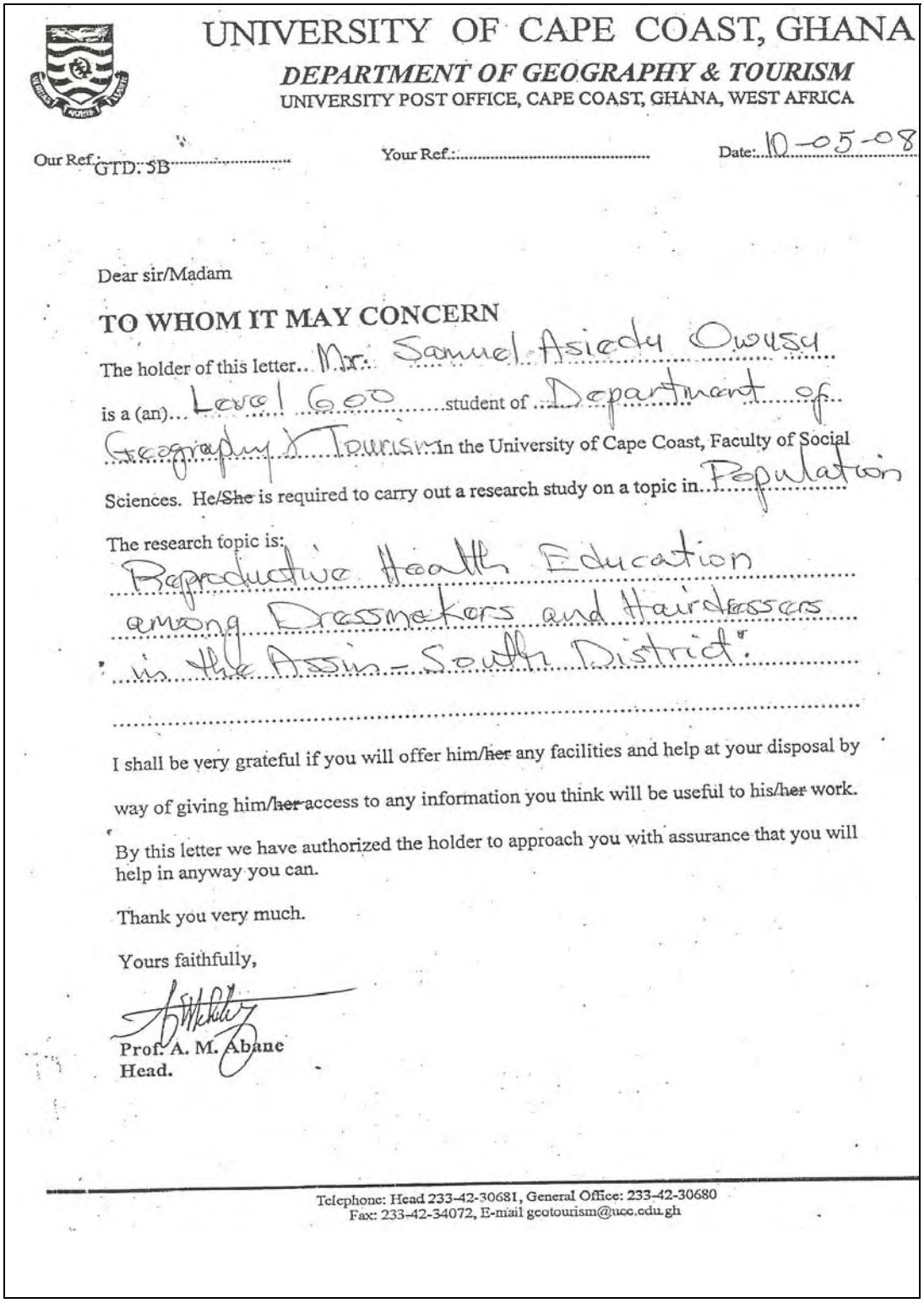
APPENDIX 4: INTRODUCTORY LETTER



UNIVERSITY OF CAPE COAST, GHANA

DEPARTMENT OF GEOGRAPHY & TOURISM

UNIVERSITY POST OFFICE, CAPE COAST, GHANA, WEST AFRICA

Our Ref.: GTD: 5B Your Ref.: Date: 10-05-08

Dear sir/Madam

TO WHOM IT MAY CONCERN

The holder of this letter.. Mr. Samuel Asiedu Owusu

is a (an)... Level 600 student of ...Department of... Geography & Tourism in the University of Cape Coast, Faculty of Social Sciences. He/~~She~~ is required to carry out a research study on a topic in..Population

The research topic is:

Reproductive Health Education among Dressmakers and Hairdressers in the Assin-South District.

I shall be very grateful if you will offer him/~~her~~ any facilities and help at your disposal by way of giving him/~~her~~ access to any information you think will be useful to his/~~her~~ work.

By this letter we have authorized the holder to approach you with assurance that you will help in anyway you can.

Thank you very much.

Yours faithfully,

Prof. A. M. Abane
Head.

Telephone: Head 233-42-30681, General Office: 233-42-30680
Fax: 233-42-34072, E-mail geotourism@ucc.edu.gh