

Chapter 7

Initiating behavioural change among street-involved youth: findings from a youth clinic in Accra

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Abstract

Street-involved youth, like most other young people, are particularly vulnerable to STDs including HIV because most know little about the disease and use condoms inconsistently. Biologically and socially, young people are more susceptible to STD infection than adults. Many choose self-medication resulting in untreated STDs, which make them susceptible to further infection including HIV. To cater specifically for the needs of these young people who feel cut off from the mainstream health care services, an office was set up at their area of operation to make certain medical and educational facilities more accessible to them. The broad objective of the program is to find a way of effecting AIDS-related behavioural change in the youth through health education, counselling, condom promotion and the treatment of STDs. Systematic and continuous information, including their biosocial characteristics, their migration history and some medical history, has been compiled since the second half of 1998. Results of their physical examinations and laboratory tests of collected samples are also compiled.

This chapter describes the psychosocial profile of street-involved youth in Accra and outlines the types, trends and patterns of STDs, including HIV, that affect them. The problems and prospects of this approach to initiating behavioural change in street-involved youth are discussed.

Available statistics in Ghana show that persons with HIV or AIDS are predominantly young, within the age group 20-39 years. The long incubation period of the virus means that some of them may have contracted the disease in their teens. Intervention programs aimed at the sexually active population, carried on over the years (see McCombie and Anarfi 1991), have all assumed that all young people have equal access to information and services. A 1992 study by Anarfi and Antwi (1995), however, revealed that a number of young people in Accra had no fixed accommodation and spent most of their time on the streets. Some of them were sexually active and multiple partnership was common. Some of them were involved in sex for survival and among those sexually active, a number had contracted STDs at least once. Although their general condition was stressful, as they struggled for food, shelter and protection and suffered from many diseases, they did not use mainstream establishments, including hospitals and clinics. When sick, they resorted to self-medication with the result that most of their ailments were not cured. Although they were aware of AIDS, they largely ignored preventive messages.

As a follow-up to the study, a drop-in centre was set up in one of the places where these young people congregate, in order to cater specifically to their needs. The objectives included offering them information as well as medical and educational facilities, and providing a place they would feel free to visit. The broad focus of the program has been to find a way of effecting AIDS-related behavioural change among the youth through health education, counselling, condom promotion and the treatment of STDs. It is hoped that through this program, a psychosocial profile of street-involved youth in Accra will be obtained. It is also intended to provide data on the types and trends of STDs, including HIV, among street-involved youth in Ghana.

The program started in July 1997 with a medical doctor and a public health nurse who are trained in STD management, and a social worker. It was initially housed in the office of a youth group called Ghana Youth Porters Association at the Agbobloshie market area in the centre of Accra. The offices of the Association were used because they agreed to collaborate with the program as partners. As part of the agreement the association used the centre to run a daily clinic for its members. The arrangement worked well for some time as young people who reported to the daily clinic with STD problems were referred to the program's team on their clinic day. In the second half of 1998 the program was relocated to the Kaneshie market area to the west of the city when there was a disagreement between the officers of the association and the resource persons over financial matters and the proper use of the centre. Since this time, every young person who attended the clinic has been required to complete a questionnaire, which covers their biosocial characteristics, their migration history and some medical history. They are then physically examined. Samples are taken from those who present symptoms that suggest the presence of STD; these samples are then taken to the country's leading medical laboratory for analysis.

This paper is based on records of the STD clinic for street youth in Accra since it was relocated in the second half of 1998. Since its inception, 120 young people have been screened at the clinic. However, this paper covers 91 clients whose records are complete.

Characteristics of the study population

The 91 clients consisted of 66 males and 25 females. Their ages ranged from 13 to 29 years with 47 per cent aged below 20 years: 41 per cent of males and 64 per cent of females (Table 1). Almost all of them were never married.

Table 1
Age distribution of respondents

Age group	Males		Females		Total	
	N	%	N	%	N	%
Below 15	2	3.0	1	4.0	3	3.3
15-19	25	37.9	15	60.0	40	44.0
20-24	31	47.0	6	24.0	37	40.7
25-29	8	12.1	3	12.0	11	12.0

Only three of the females and two of the males were married. Five of the females (20%) reported that they had children, with two having had two children each. Four indicated that their children were living with them. In terms of ethnic balance, 60 per cent were Akan, 16 per cent Ewe, 15 per cent were Mole-Dagbani and the rest were Ga-Adangbe (9%). They were mainly migrants who had moved into the city from other regions of Ghana. Only 22 (out of the 91 cases),

were born in Accra: 18 males and four females. Four of the respondents, three girls and one boy, were born in other African countries, Nigeria, Benin and Burkina Faso. Nearly 60 per cent of them came to Accra in the last five years (Table 2).

Table 2
Duration of stay in Accra

Duration (years)	Males		Females		Total	
	N	%	N	%	N	%
Up to 5	37	56.1	15	60.0	52	57.0
6-10	6	9.1	3	12.0	9	10.0
Over 10	12	34.8	7	28.0	30	33.0
Total	66	100.0	25	100.0	91	100.0

Migration history

Sixteen respondents, 12 males and four females, reported that they had ever lived outside Ghana. The countries they travelled to include Togo, Benin, Côte d'Ivoire, Nigeria, Burkina Faso, and Liberia. Two of the females were engaged in trading and one was an apprentice. The males were mainly involved in shoe shining and trading. One person said he was unemployed and two did not respond.

Within the country, 63 per cent of the respondents stated that apart from Accra, they had stayed in other towns in Ghana. This group comprised 45 males and 12 females. Thus the young people are a highly mobile group. The situation also seems to support the process of stepwise migration, which has been observed about earlier migrations in the country (Caldwell 1969; Nabila 1974). The duration of stay at the place they visited ranged between one month and 20 years.

Kumasi and Assin Fosu appeared to be the most popular towns the youth had visited before arriving in Accra. Kumasi is the capital of the Ashanti Region and the second largest city in Ghana; its central location allows all major roads to converge there. Assin Fosu is the capital of a district in the Central Region bearing the same name. It has experienced dramatic growth in population since the old road linking the Central Region to Kumasi was resurfaced in the mid-1990s.

Sexual experience and behaviour

A feature of street youth is the early initiation into sexual activity, which may occur as part of the survival strategy or part of the general process of growing up. In general, age at first sexual experience is low. Seventy-four out of the 91 respondents answered the question on age at first sexual intercourse; this ranged from 8 to 22 years. The females had their sexual debut earlier than the males, thus confirming findings of earlier studies (Anarfi and Awusabo-Asare 1993) (see Table 3). At the age of 18 years, 73 per cent of the youth studied were sexually active (63% of males and 96% of females).

Table 3
Distribution of the respondents according to age at first sexual intercourse

Age group in years	Males		Females		Total	
	N	%	N	%	N	%
Below 10	1	2.0	1	4.3	2	2.70
10-13	6	11.8	5	21.7	11	14.90
14-17	25	49.0	16	69.6	41	55.40
18-20	14	27.4	1	4.3	15	20.35
Above 20	5	9.8	-	-	5	6.60
Total	51	100.0	23	100.0	74	100.00

There was evidence that the respondents did not enter lasting sexual relationships. About 30 per cent of those who reported that they had sexual partners maintained the relationship for up to one month, 44 per cent maintained it for three months, and 59 per cent for six months. The females tend to be more enduring in their relationships than the males. While only 25 per cent of the males maintain a sexual relationship for more than six months, 74 per cent of females do so (Table 4).

Table 4
Duration of sexual relationships

Duration	Males	Females	Total
1 week	3	-	3
2 weeks	6	1	7
1 month	10	1	11
2-3 months	8	2	10
4-6 months	8	2	10
Above 6 months	12	17	29
Total	47	23	70

Not only did they change sexual partners very frequently, but their sexual episodes per week were also numerous. Their sexual activity per week ranged from one to fourteen episodes. About 31 per cent of them stated that they had sex once a week and another 29 per cent twice a week (Table 5). The remaining 40 per cent had sexual intercourse three or more times in a week.

Table 5
Respondents' sexual activity per week

Number of sexual episodes	Males		Females		Total	
	N	%	N	%	N	%
One	13	32.5	4	26.7	17	30.9
Two	10	25.0	6	40.0	16	29.1
Three	10	25.0	2	13.3	12	21.8
Four	3	7.5	1	6.7	4	7.3
Five or more	4	10.0	2	13.4	6	10.9
Total	40	100.0	15	100.0	55	100.0

The mean number of sexual acts per week for the male and female clients was almost the same, at 2.8 and 2.5 respectively. All the 12 female respondents who stated that they had stayed in other Ghanaian towns than Accra also indicated that they had sexual partners at these towns, compared to 16 out of the 45 males who had lived elsewhere in Ghana.

Regarding the number of sexual partners during the 12 months preceding the interview, 13 of the male respondents said that they had one partner each, ten indicated two partners each and another two had three partners. Eleven of them had three or more partners; some as many as ten. In general, males tend to exaggerate the number of sexual partners; nonetheless, the data point to a high level of partner exchange and sexual activity among them.

The female respondents stated that they received between two and ten thousand cedis (about US \$1 - \$4) from their boyfriends per visit. Although they did not say they were engaged in commercial sex, the report of regular payments was unusual since it is not a common practice for boyfriends to give money to their girlfriends after every visit. In fact, the difference between payments made to sex workers, and those made to regular girlfriends, is that the former are tied to the sexual act whereas the latter are not, but are supposed to occur in a relationship between two lovers, although girls expect and receive some rewards from their male partners (Ankomah and Ford 1993). Furthermore, our observations showed that some of the young women were involved in commercial sex.

Use of condoms

It might be assumed that people involved in such high levels of sexual activity would protect themselves against STDs. However, reported condom use among the group was very infrequent. Only one male stated that he used condoms always and another male used them often. Half of the males said they had never used condoms and another 25 either rarely used them or used them sometimes. Similarly, about a third of the 25 female respondents mentioned that their partners ever used condoms; the remainder had never used them.

The reasons they gave for seldom or never using condoms during sexual intercourse are shown in Table 6. The lack of knowledge and appreciation of the usefulness of condoms accounted for the high rate of non-use. These were followed by absence of pleasure among the males and the desire for pregnancy among the females. Other reasons include inability to meet the cost of condoms and haste.

Table 6
Reasons for non-use of condoms

Reason	Males	Females	Total
Not necessary	18	5	23
No idea / not effective	15	8	23
Wants pregnancy	-	5	5
Not affordable	2	-	2
Was in hurry	1	-	1
Does not enjoy its use	8	-	8
Total	44	18	56

Among the female respondents, 13 of the 25 stated that they had never recommended the use of condoms to their male partners. The remaining 12 reported that they had recommended

the use of condoms, but from Table 6 we see that their recommendations were outweighed by more powerful forces.

From the foregoing, it was evident that their life style could predispose them to contract STDs including HIV, because of the number of sexual partners, high frequency of partner change, high level of sexual activity, high spatial mobility and non-use of condoms.

Current symptoms and conditions

One of the activities of the clinic is the treatment of STDs. The respondents presented 13 different symptoms and conditions at the time of visit. These included vaginal discharge, genital ulcer, pain at ulcer, lower abdominal pain, dysuria, *pruritus vulvae*, pain during sexual intercourse, swollen testis, fever, diarrhoea and urethral discharge.

The females presented more symptoms than the males (see Table 7). Their medical history indicated that 23 of the males had ever had a sexually transmitted disease. Sixteen specifically mentioned genital ulcer and reported between one and four episodes of the infection; 19 mentioned urethral discharge. Three reported having HIV: one had had the disease for two months, one for a year, and the third for nine years.

Table 7
Symptoms and conditions of the patients

Symptom / Condition	Male		Female	
	N	%	N	%
Dysuria	21	31.8	3	12.0
Vaginal discharge	-	-	17	68.0
Genital ulcer	8	12.1	3	12.0
Pain at ulcer	4	6.1	3	12.0
Purulent discharge	4	6.1	-	-
Lower abdominal pain	-	-	14	56.0
Pruritus vulvae	-	-	7	28.0
Pain during intercourse	-	-	9	36.0
Inguinal bubo	-	-	1	4.0
Urethral discharge	16	24.2	-	-
Swollen testis/ vaginal bleeding	6	9.1	3	12.0
Fever	6	9.1	4	16.0
Diarrhoea	10	15.2	4	16.0
Loss of weight	10	15.2	4	16.0
Other	28	42.4	13	52.0

The females that had ever had a vaginal discharge reported between one and ten episodes among them. Those who reported genital ulcers had a range of two to nine episodes.

The young people did not report their reproductive health problems promptly to recognized health facilities, as there is a tendency among them to self-medicate. Some of the respondents took self-prescribed tablets and injections between the time they observed the symptoms and when they called at the clinic. Others underwent what they termed 'local treatment', which included herbal treatment, especially among the females. A previous study

revealed that the street-involved youth were a little apprehensive about mainstream health facilities and would not patronize them (Anarfi 1997). Some had endured conditions such as genital ulcers, swelling of testes and lower abdominal pains for 20 to 90 days. Some had conditions such as urethral and vaginal discharges, which cannot be concealed, for up to 50 days before they called at the health facility. Others whose situations received attention a few days after the symptoms had appeared only took advantage of the program's mobilization drive to report at the clinic.

Physical examination

The results of physical examination of the male patients showed that 55 (83.3% of the male respondents) were fully circumcised and four were partly circumcised. There was no disclosure on the remaining seven patients (Table 8). Four of the eight males who reported genital ulcer had their ulcers localized: three on the penile shaft and one on the glans penis. Two of the cases were purulent. Similarly, the genital ulcers of three females were confirmed, all of them located within the vagina.

Table 8
Results of physical examination

Condition	Males	Females
Vaginal discharge	-	16
Genital ulcers	4	3
Inguinal lymphadenopathy	3	2
Pelvic masses	-	1
Inflammation of vulva	-	4
Cervix discharge	-	1
Presence of pus	-	1
Bleeding from cervix	-	1
Urethral discharge	13	1
Other anomalies	6	1

The condition of 16 of the female patients who reported vaginal discharge was confirmed. Ten out of these cases were considered to be typical of candidiasis. Five of the respondents also suffered from inguinal lymphadenopathy.

Results of laboratory tests

Samples were taken for laboratory analysis of urine and blood serum from the males and vaginal swabs, cervical swabs and blood serum from the females. Results from 95 respondents are shown in Table 9: syphilis is the commonest STD among the street-involved youth followed by chlamydia. The complete absence of gonorrhoea is a little strange when compared to other studies based on reported cases (see Anarfi and Antwi 1995; Anarfi 1997). There is a tendency for people to refer to every genital disorder as gonorrhoea, because there are no local names for other sexually transmitted infections.

Table 9
Results from laboratory tests according to age

Age Group	Murex Chlamidia	RPR (syphilis)	HIVSPOT 1 & 2	Murex HIV 1&2	INNOLIA HIV1
Below 15	2	-	-	-	-
15-19	5	11	2	2	1
20-24	2	5	3	3	2
25-29	1	-	3	3	2
Total	10	16	7	7	5

Two different tests for HIV showed that there were seven cases of both HIV1 and HIV2. A confirmatory test (INNOLIA), however, showed five cases of HIV1 only. The table reveals that the street-involved youth who contract common STDs were a little younger than those who contract HIV. That seems to suggest that for some of the young people on the street, contracting HIV is, among other things, a function of time. Table 10 also shows that while there is an overwhelming dominance of males in the common STDs, females dominated in HIV, similar to the situation in the country.

Table 10
Sex distribution of laboratory results

	Males	Females	Both
Chlamydia	8	2	10
HIVSPOT 1 & 2	2	5	7
MUREX HIV 1&2	2	5	7
RPR (Syphilis)	14	2	16
INNOLIA	2	3	5
Total	28	17	45

Problems and prospects

The situation of the street-involved youth is complex and requires a multifaceted approach for any effective impact to be made. This calls for the involvement of a team of resource persons with varied backgrounds, as well as organizations, which offer different services. So far the program has benefited from the services of a medical doctor and a public health nurse with training in STD management since its inception. A social worker and a psychologist worked for the program only for a short period¹. That means that certain aims of the program cannot be achieved with the limited range of personnel.

A working relationship was forged with some organizations in the past but these have not lasted. For example the program collaborated with the Youth Development Foundation, a non-government organization which was engaged in health education for the street youth in Accra. The organization had a team of peer educators who went around to talk to young people on reproductive health matters, mobilizing patients for the program's clinic. The Foundation's project

¹ The latter went on maternity leave.

ran out of funding and had to close. Our program, therefore, devised its own means of encouraging people to visit the clinic, through a number of forums and the use of contact persons. Although this has been very effective in getting people to attend the clinic, it has stretched the program's limited budget.

Lack of support from the city administration has been particularly disturbing. To date the program has not been able to obtain its own accommodation. When the city administration was asked to allocate some of its offices which were lying idle at the inception of the program, they told us that although our aims were laudable, they needed the rooms to generate revenue. This was what compelled the program to be housed in the premises of the Ghana Youth Porters Association; this arrangement later ran into problems as explained above. Much precious time was wasted in finding another office and the contacts that had already been established for the smooth running of the program were lost.

Lack of co-operation from the young people has also been a big problem. They do not understand why anybody should persuade them to attend a clinic for free treatment, especially as this involved taking samples, including blood. Some, therefore, demand monetary rewards for attending the clinic; that has also been another drain on the program's budget.

The street youth have been pushed into the streets by forces beyond their control. A previous study described their environment as high-risk (Anarfi 1995). It has now been established that some of the young people in that environment have HIV. For some, their high-risk behaviour is part of survival strategies, which have implications for the success of the program as they create barriers to its smooth implementation. It is therefore absolutely necessary to get them out of the street if we are to effect any meaningful change in them. It is also necessary to equip them with alternative means of livelihood. This is beyond the scope of the program and it has not been easy to link them with organizations that offer training to young people.

One important objective of the program is to effect behavioural change in the street youth. This is necessary if we are to prevent the AIDS virus from crossing over from the environment of the street to the general population along the routes observed in a previous study (Anarfi and Antwi 1995). A major issue here has been how to measure behaviour change. A simple approach which the program planned to use was to collect baseline information on about 200 young people, follow them up for some time and compare later information collected with the previous information. This has not been possible because the street-involved youth are highly mobile and it has not been easy to retain them for follow-up over any meaningful length of time. However, there have been a few successful cases, which indicate that the program has prospects of having some positive effect. Two such cases are cited.

Case 1

Kofi was a 17-year-old boy whose father went blind and needed to be supported. This became a problem for the family, as his stepmother could not cater for them very well. Kofi therefore decided to move to Accra. After working in the street for some months he was introduced to drugs, and started having sexual relations with some of the street girls. He contracted an STD and reported at the clinic after several attempts at self-medication had failed. After he had been treated and counselled, and after a few follow-ups, he agreed to be taken back home. He was eventually taken home, to Kumasi, by one of the male nurses. The plan was to pay him regular visits to find out how he was adjusting to his home environment. However, because of financial

constraints, no visit was possible until after three months. When eventually we visited his place, he had left for Togo a week earlier because he could not get on with his stepmother.

Case 2

Amma is a girl of 19 years; she was sent to our clinic by one of the peer educators. She had sexually transmitted diseases and was also on drugs. After she had been counselled, she agreed to undergo detoxification treatment. The resource persons followed her up for a number of weeks and introduced her to a clinical psychologist at the Mental Hospital in Accra. She is still undergoing rehabilitation.

The two cases indicate the need for an integrated approach for any meaningful change to be made in the youth. That is lacking in the program at the moment. Nonetheless, some of the objectives with regard to STDs have been achieved: the types of STDs among the young people have now been established; it is now known that HIV is prevalent among them; we know some of their bio-social characteristics, which will help us to understand some of the issues related to STDs including HIV.

It may be concluded that the program has prospects if some of the barriers could be removed and the necessary collaborations could be achieved.

References

- Anarfi, J. K. 1997. Vulnerability to sexually transmitted disease: street children in Accra. Pp. 281-306 in *Vulnerability to HIV Infection and Effects of AIDS in Africa and Asia/India*, ed. J. P. M. Ntozi, J. K. Anarfi, J. C. Caldwell and S. Jain. Supplement to *Health Transition Review* 7. Canberra: Australian National University.
- Anarfi, J. K. and K. Awusabo-Asare. 1993. Experimental research on sexual networking in some selected areas of Ghana. Pp. 29-44 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell, G. Santow, I. O. Orubuloye, P. Caldwell and J. K. Anarfi. Supplement to *Health Transition Review* 3. Canberra: Australian National University.
- Anarfi, J. K. and P. Antwi. 1995. Street youth in Accra city: sexual networking in a high-risk environment and its implications for the spread of HIV/AIDS. Pp. 131-152 in *The Third World AIDS Epidemic*, ed. I. O. Orubuloye, J.C. Caldwell, Pat Caldwell and Shail Jain. Supplement to *Health Transition Review* 5. Canberra: Australian National University.
- Ankomah, A. and N. Ford. 1993. *Pre-marital Sexual Behaviour and Its Impact for HIV Prevention in Ghana*. Occasional Paper No. 22. Institute of Population Studies, University of Exeter.
- Caldwell, J. C. 1969. *African Rural-Urban Migration: The Movement to Ghana's Towns*. Canberra: Australian National University Press.
- McCombie, S. and J. K. Anarfi. 1991. Results from a survey of knowledge, attitudes and practices related to AIDS among young people in Ghana. Unpublished paper.
- Nabila, J. S. 1974. Migration of Frafra in Northern Ghana: a case study of cyclical labour migration in West Africa. Ph.D. dissertation, Michigan State University.