FORMATIVE STUDY ON PARENTING PRACTICES

stakeholders’ understanding of raising children (girls and boys aged 0-19 years)

Technical report

Presented to UNICEF Ghana

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Authors:
Ruth Essuman, Joshua Amo-Adjei (PhD)

Contact Person and Technical Lead:
Ruth Essuman
ruth.essuman@kantar.com
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<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ACT-PRSK-</td>
<td>ACT Against Violence, Parents Raising Safe Kids</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CFSC</td>
<td>Communication for Social Change</td>
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<td>CHWs</td>
<td>Community Health Workers</td>
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<tr>
<td>COREQ</td>
<td>Consolidated Criteria for Reporting Qualitative Research</td>
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<tr>
<td>CwSN</td>
<td>Child with Special Need</td>
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<tr>
<td>C4D</td>
<td>Communication for Development</td>
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<tr>
<td>DAs</td>
<td>District Assemblies</td>
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<tr>
<td>DEOs</td>
<td>District Education Officers</td>
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<tr>
<td>DOVVSU</td>
<td>Domestic Violence and Victim Support Unit</td>
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>FGDs</td>
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<td>GES</td>
<td>Ghana Education Service</td>
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<td>GHS</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>In-depth Interviews</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>KIIIs</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>NGOs</td>
<td>Non-Governmental Organisation</td>
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<td>NPA</td>
<td>National Plan of Action</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PTA</td>
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<td>SBCC</td>
<td>Social Behaviour Change Communication</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>SEM</td>
<td>Socio-Ecological Model</td>
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<tr>
<td>SMC</td>
<td>School Management Committee</td>
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<tr>
<td>SRHR</td>
<td>Sexual Reproductive Health Right</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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We are grateful for valuable inputs and guidance from the members of the Steering Committee set up for the study review, comprising representatives of the department of Children, Community Development, Social Welfare, Health Promotion Division (GHS), Ghana Education Service. Dr Patrick Aboagye, Director, Family Health Division, Ghana Health Service, Chaired the Steering Committee and we are grateful for his keen interest and guidance.

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The team members from different organizations who were engaged throughout are listed below:

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3.1 Introduction

Children’s first agent of socialization is the family setting with mothers and fathers contributing substantially to formative experiences of children. In doing this, parents may receive support services from other stakeholders – often described as secondary in diverse ways. Put together, the diversity of individuals as well as experiences that they contribute play considerable role in shaping how children turn out as adults. Discourses in current global development agendas places strong premium on giving children the relevant foundation. The foundational needs here are delivered in educational, health and nutrition, rights, protection, safety and responsibilities of children, discipline and responsive care avenues for children. As the Government of Ghana, together with its development partners, works to achieve the Sustainable Development Goals (SDGs), which is underpinned by inclusivity, critical evidence is needed to support interventions. This formative study explored primary stakeholders’ perspectives on parenting, focusing extensively on early childhood education and stimulation, health and nutrition, discipline and responsive care, child protection and safety and children with special needs.

3.2 Methods

The study relied on triangulation of qualitative methods (in-depth interviews (IDIs), focus group discussions (FGDs), and key informant interviews (KII)) in cross-sectional approach. Using critical case sampling, the study was conducted in eight (8) districts in six (6) regions. Two districts each were sampled from two UNICEF convergence working regions – Northern and Upper West, one each from two low convergence regions (Volta and Ashanti) and one other from Greater Accra (host of national capital) and a coastal district from Central region.

Individual participants were sampled from among parents (with children 0-19 years), adolescent mothers with children 0-4 years, parents with children with special needs, adolescents (10-19 years) and grandparents informed by maximum variation or heterogeneous purposive sampling. Using expert purposive sampling technique, district level heads of Social Welfare Department, Ghana Health Service, Ghana Education Service, Police Service (Domestic Violence and Victim Support Unit – DOVVSU), and community leaders/gatekeepers e.g. religious leaders (Christian, Islam, African Traditional Religion etc.) and traditional leaders were interviewed. We also conducted mapping of ECD initiatives in ministries of Health, Education and Social Welfare, Community Development, Department of Children and implementing and funding agencies such as USAID/ Jhpiego, and JICA.
A structured study tools were used for IDIs, FGDs and KII. Tools were pre-tested in Accra, a cosmopolitan area that has diverse population characteristic of the Ghanaian population. Twenty fieldworkers were trained for 5 days and data collection lasted for fourteen days. The Ghana Health Service Ethics Review Committee approved the study protocol. All the transcribed text was edited in Microsoft Word. Following this, the data was exported into NVivo version 12 (QSR International) for coding and analysis. The analysis followed the Consolidated Criteria for Reporting Qualitative Research (COREQ). The results should, however, be interpreted in the light of the wholly qualitative approach which precludes generalizations. Quantifiable inferences cannot be drawn from the findings. However, the findings provide a general sense of typical views about parenting among the primary and secondary stakeholders.

### 3.3 Summary of findings

#### Understanding of parents and caregivers and care among children with special needs

For most parents, particularly mothers, parenting CwSNs could be extremely stressful, causing some disruptions to their usual life courses (e.g. terminating full time work) as well as strained social and marital relationships (threats of divorce due to child disabilities. The implication is that parents are either not utilizing existing services (e.g. special schools) for children with special needs or service providers (e.g. social welfare) are not fully reaching out to parents with CwSNs. Parents with CwSN thought that they were doing well in providing suitable academic environment for children through home tuition, regular care-seeking activities (some, to the extent of seeking alternative traditional care), and general routine parenting activities such as feeding, bathing and playing with CwSN. Community perceptions about children with special needs were couched in sympathy, indifference and abnormality.

#### Notions of care, safety and protection of children and adolescents

Whereas parents are aware of the long-term benefits of early stimulation activities such as storytelling, they rarely did tell their children stories except for grandparents who were story tellers and source of validation for children about stories told in school. Funeral related activities such as wake-keeping, poverty, fishing, begging, Internet fraud (Sakawa), transactional sex (among girls) and vehicular movements were the frequent concerns of parents about the safety of children. Sexual abuses perpetuated by family members could be handled a little bit leniently or as often said, it will be resolved at home, less harshly with teachers (first point of call is the head teacher) but more harshly with strangers.

#### Care, feeding, physical, cognitive, social, emotional needs and safety of adolescents

Adolescents appear to show disconnect between their worldview of ideal mothers and fathers. Two words sum adolescents’ expectations of ideal mother or father – affectionate for mothers and provider for fathers. However, mixed adolescents’ notions were, it swayed more towards dissatisfaction of fathers and mothers they observe in their communities. Not surprisingly, adolescents repeatedly mentioned emotional support as one of their major needs. Community leaders accept the traditional roles of fathers and mothers – the former as provider and the later as homemaker. However, community leaders concede that many fathers were failing on provider roles, putting more stress on mothers.

#### Stakeholders’ understanding of gender and caregiving

Parents – mothers and fathers were gender neutral in relation to what aspirations they had for children. The popular view was that both boys and girls have equal capacities/abilities in achieving whatever they set out to do with proper guidance and nurturing. Cognizant of these, either parents
were supporting the academic work (providing school supplies and paying fees) of their children or praying for them to achieve their potentials. Positively, the accounts of teachers show that both boys and girls are treated equally in class work, school compound activities (e.g. cleaning) and assessment. Teachers’ frequently mixed boys and girls in classwork activities.

**Views about discipline at home**

All parents interviewed showed considerable consciousness about the positive role of correction and discipline in reinforcing positive values in children. However, the tools of exerting positive values varied among parents. Corporal punishment (beating), gifts, withdrawal of privileges, and counselling/advising were used at one time or another. However, fathers preferred talking to children out of negative behaviours while mothers seemed more inclined towards beating and withdrawing privileges including food. Adolescents’ preference for discipline and correction was guidance and counselling than shouting, scolding, and withdrawal of privileges, which, unfortunately, were common methods of parents in their communities.

**Use of interventions to support parenting**

Accounts of all categories of mothers showed high utilization of government and non-governmental interventions to support parenting. Among these services investigated included birth registration, child growth monitoring services, knowledge of child immunization requirements, and patronage of formal health services in managing child health problems was prevalent among adolescent mothers. Mothers recalled that knowledge on these services were acquired mainly during ANC visits. However, adolescent mothers utilized these services at lower scale due to stigmatization, discrimination, disrespect and abuse by service providers.

On education, the narratives show that parents view ECD education programmes highly. However, teachers were either poorly equipped to deal with ECD education pedagogy or lacked the relevant materials relevant for stimulation of children.

**Media use, community views about parenting and parental aspirations for children**

WhatsApp and Facebook are common modern media platforms adolescents relied on for information, and connect with friends and in some few instances, for job and educational opportunities. With adolescents spending more time on these platforms, parents were rightly worried. Adolescents will benefit immensely from education programmes on responsible use of social media.

Many community leaders felt that the parenting landscape in this generation is changing in terms of how parents exacted punishment and disciplinary interventions. The predominantly corporal punishment is effacing amidst increasing emphasis on child rights but less emphasis on responsibility of children. These were attributed to the increasing involvement of NGOs communal living.

Parents aspirations for their children centred on supporting them to achieve their educational and career goals. A remarkable finding from the data is that while some parents seemed to have an “ideal” career and professional aspirations for their children, they generally conceded and accepted children’s agency in choosing what they felt capable of doing. They are supporting children achieve these aspirations by providing for their basic needs and with prayer.

**Knowledge of service providers on care, feeding, physical, cognitive needs among children**

Community Health Workers (CHWs) generally felt capable of dealing with some of the basic issues earmarked for primary health care providers. However, most felt incompetent in dealing with adolescent health concerns, of which they would require further on-the-job training interventions.
Although some teachers had CwSNs in their classes, most had no pre-service or on-the-job experience in teaching and managing children with special needs. They usually identified such children through casual observations. Teachers will require in-service interventions in honing their skills in dealing with special needs children to advance the quest for inclusive education.

### 3.4 Conclusions and Recommendations

Parents and caregivers seemed to understand the needs of all children on health, nutrition (e.g. exclusive breastfeeding), benefits of ECD, parent-adolescent relationships, including those with special needs but also stressed in parenting children with special needs due to certain prevailing myths and misconceptions and absence of supportive services for parents about CwSN.

Parents and teachers exhibited no gender biases and discrimination in aspirations for children and allocation of responsibilities to children – both at home and school. All participant groups agreed to the benefits of discipline, but the methods differed across groups; rewards - gifts and praises are common across participant groups; mothers were more inclined to use corporal punishment than fathers who seemed to abhor the extremes of corporal punishment and would rather talk to children. Adolescents prefer affectionate counselling and guidance of parents and teachers and other adults to shouting, scolding, and beating.

Service providers – especially health care workers have appreciable capacities in addressing ECD needs of children. However, the output of CHWs will be enhanced with further capacity development activities, especially on adolescent health. For health leaders at district levels, key ECD care delivery gaps are related to the spread and distribution of health personnel as well as infrastructure. The narratives of teachers demonstrate limited capacities in identifying and screening children with special needs and have barely any specialised skills in teaching pupils with special needs.

**Key recommendations** to health services providers is strengthening early screening programmes for detecting disabilities and deformities, capacity strengthening of providers on adolescent sexual and reproductive health services, reorienting providers on respectful engagement with mothers particularly adolescents.

For education stakeholders, it is important to strengthen capacities for ECD education teachers. Community leaders will also require capacity building initiatives on addressing parenting needs of parents in the communities. The on-going engagements of community leaders on second chances for adolescent mothers need sustaining; we found evidence/traces of support of teachers and other stakeholders.

Child safety concerns remain, and the issues are similar across all study communities – for instance, sexual abuse, child labour, cultural risks (funeral wake-keeping) and Internet fraud were common. These will require multi-sectoral approach among social protection agencies (e.g. social welfare, police/DOVSU and community development).
4.1 Introduction

The early years of life are critical stages for a child’s growth and development. Any positive improvements caused by positive parenting interventions during this period have short-term and long-term constructive implications. For instance, poor breastfeeding and complementary feeding practices are among the prime proximate causes of malnutrition in the first two years of life, and in turn increases the risk of infectious diseases, poor mental and motor development and obesity and metabolic diseases later in the life course\(^1\). Again, orientation of parents and parenting practices may mirror children’s intellectual, emotional and behavioural development\(^3\).

The clarion call in the recently commissioned Sustainable Development Goals (SDGs), leaving no one behind, provides a compelling reason to re-energize efforts to scale-up early childhood development (ECD) interventions. Indeed, it is recognized that early childhood interventions and programmes are central to the achievement of the SDGs as it propels children to develop the critical intellectual skills, creativity, and well-being required to become healthy and productive adults\(^4\). Further asserting the crucial role of ECD, in a recent study on childhood development in developing countries, it was reported that about 219 million children less than 5 years were unlikely to achieve their developmental potential and that could lead to a shortfall of 19.8% in adult income per annum.

Childhood development is conceptualized as a maturational and interactive process, resulting in an ordered progression of perceptual, motor, cognitive, language, socio-emotional, and self-regulation skills\(^5\). Health, nutrition, security and safety, responsive caregiving, and early learning influence children’s developmental competencies for academic, behavioural, socio-emotional, and economic achievements. These interact and jointly strengthen the overall development of children as foundations for nurturing care.

Nurturing care refers to a stable environment created by parents and other caregivers that ensures children’s good health and nutrition, protects them from threats, and gives young children opportunities for early learning, through interactions that are emotionally supportive and responsive\(^6\). The way mothers, fathers, and other caregivers’ nurture and support children in the early years are a strong currency for healthy child development, with lifelong and intergenerational benefits for health, productivity and social cohesion. This requires multi-sectorial interventions, cutting across nutrition, education, health, social

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welfare and child protection and at multiple levels. The Government of Ghana and its development partners have, over the years, pursued different strategies that will enhance and improve ECD. More recently, the Ghana Health Service/Ministry of Health, following the WHO, launched the Nurturing Care Framework for Early Childhood Development. This is expected to yield results in good health, adequate nutrition, opportunities for early learning, security and safety, and responsive care giving for Ghanaian children. In support of the important work of UNICEF towards child development in Ghana and other related contexts, this formative study on stakeholders (parents, teachers, social workers, etc.) understanding of raising girls and boys aged 0-18 years is geared towards generating evidence that may support on-going and/or new initiatives on child care and ECD.

4.2 Research problem

Child and family researchers have long recognized parenting as making an important contribution to child development. The manifestations of parenting practices are seen across the life course in terms of health, educational, economic, and psychosocial outcomes. In Ghana and many other developing country settings, evidence on parenting is budding, compared to the impressive body of evidence accumulated in Western developed countries. Emerging evidence show that the parenting styles noted in Ghana and other similar collectivist contexts may not follow those found in the West. The implication is that interventions on parenting practices based on some of the established models may not work in the Ghanaian situation. This formative study will fulfil the need for context-specific evidence on parenting practices from multiple players, which may be applied to, and inform programmes and interventions.

4.3 Objectives of the formative study

The objectives of the study are as follows:

- At the family level, understand what both parents (including parents who take care of non-biological children, primary care providers) think and do with regards to caring for and raising children.
- At the extended family and neighbourhood level, understand how children are cared for and the role of the extended family and community in raising children.
- What is the knowledge of frontline/social workers, caregivers of residential homes for children and teachers – on early childhood development and parenting.
- At the system level, what are the real and potential sources of support to parents, caregivers and duty-bearers with responsibilities towards children?

4.4 Justification for the study/Theory of Change

An important step towards building sustainable change on social and behavioural practices is strongly linked to generating and nesting contextual evidence to inform solutions. Our proposition is that the delivery of interventions and programmes to improve parenting and child nurturing can be catalysed through strong evidence that is applied to rallying networks and partnerships, building leadership, inform advocacy and currently, however, little evidence exists on the context of parenting and nurturing care in Ghana. This work begins the task of building background evidence on the subject matter. As Head

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(2009)* astutely asserts, in the absence of facts, policy-making, activism, practice and advocacy will rely on intuition, ideology or conventional wisdom – or at best, theory alone.

In countries, including developing ones, which have used evidence to guide policy-making, positive changes have been recorded. Evidence generated in this study will be used to engage respective government officials in relevant ministries, departments and agencies as well as non-governmental institutions as well as parents on better parenting practices and norms.

In context, goals of this study are strongly aligned to the theory of change underlying UNICEF’s Strategic Plan 2018. Evidence generation, policy dialogue and advocacy are crosscutting themes underlying nutrition, education, water, sanitation and hygiene, child protection, HIV/AIDS and social inclusion. This can be found in Table 1 in Appendix.
5.1 Parenting styles

Two critical questions have driven phenomenal amount of studies and discourses on parenting. One, what are the modal patterns of child rearing and two, what are the developmental consequences of the different child rearing practices. Efforts to find satisfactory responses to these questions led to duality of positions taken by child behaviourist and Freudian theory. To behaviourists, modelling reinforcement children is a key driver of their developmental dispositions. The Freudian theorist on the other hand emphasised on the biological outlooks, which stood in conflict with parental and societal requirements or expectations10.

A persuasive model that has informed parenting discussions is Baumrind’s11 tripartite typology of parenting – authoritative, authoritarian and permissive. Late on, Maccoby and Martin12 added a third strand, neglectful, with empirical confirmation from Lamborn et al13. Although the assumptions underlying these models are discrete, they are all measured through warmth (responsiveness – the extent of being involved and concerned with their activities, listening and being supportive to children) and demandingness (control – expectations of behaviour) and autonomy granting (allowing free expression of children at home). Low responsiveness, high demandingness and low levels of autonomy granting characterise authoritarian parenting. In authoritative parenting, marked responsiveness, high demandingness and autonomy granting are the main features. Among permissive parents, there is considerable responsiveness coupled with autonomy granting and little demandingness. Neglectful parents are disengaged, displaying little responsiveness and demandingness and autonomy granting14.

5.2 Early childhood development

With recent advances in neuro-scientific research outputs, ECD has emerged to be one of the top priority areas of the WHO and UNICEF. It is considered a critical window of hope and opportunity for maximizing health and education outcomes throughout the life course. ECD is defined as “encompassing physical, socio emotional, cognitive and motor development from the prenatal period up to 8 years of age”15.

Providing children with the right kind of ECD environment is considered the best start in life. The first three years are noted to be the most critical. There is evidence to show that it is at this point that the brain’s neural pathways that support communication, understanding, social development and emotional wellbeing grow. The right context of ECD positively predicts schooling and school achievements. One study showed that even after controlling for wealth, maternal education, sex of the child and age, early cognitive development was a strong predictor of later school outcomes.

Some of the specific activities’ parents are engaged to advance ECD include eating nutritious food during pregnancy, staying away from drugs and alcohol, breastfeeding or iron-fortified baby formula, creating safe spaces for them to play, talking and reading to children and singing and dancing with children. Other activities include providing opportunities for children to play outside, encouraging children to explore through their senses and comforting children when upset. Whereas these activities are not exhaustive, our design will explore these indicators and others that emerge in the iterative process of the study.

5.3 Child care practices – feeding and nutrition

Nutritional behaviours obtained during infancy find their way through to adulthood and variations in nutrition during childhood are important indicators of nutrition value in adults. Child nutritional conduct is influenced partly by individual factors (e.g. food preferences, sociocultural factors (e.g. peer norms, parent attitudes/beliefs) and environmental factors (e.g. food type and availability). Parents are extremely significant in shaping their child’s nutrition by providing the child with the capability and chance to make healthy or unhealthy varieties through the careful use of food parenting practices. It is little wonder that the ECD Framework of the UNICEF places the individual parent as the foundation to early child nurturing and stimulation efforts.

Evidence indicates that parents play considerable role in children’s food setting in terms of ‘when’, ‘what’, and ‘how much’ of food provided, whereas children should be permitted to decide ‘how much’ food to be eaten (portions) made available to them. Given that feeding and nutritional practices can have lifetime effects on cognitive and health outcomes, effective parental understanding of child nutrition is necessary to alleviating risk.

5.4 Cognitive development

It is well known that brain development and cognitive maturation occur simultaneously during childhood and adolescence. The development of the prefrontal cortex is thought to play an important role in the maturation of higher cognitive abilities. Mature cognition is categorized by

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17 Filmer D, Pritchett LH. Estimating wealth effects without expenditure data—or tears: an application to educational enrolments in states of India. Demography 2001; 38:115–32.
18 Catholic Relief Service. Early Childhood Development—Basic Concepts in training for early childhood caregivers and teachers.
the ability to filter and suppress irrelevant information and actions (sensorimotor processes), in favor of relevant ones (i.e. cognitive control)\textsuperscript{28}. A child’s capacity to filter information and suppress inappropriate actions in favor of appropriate ones continues to develop across the first two decades of life, with susceptibility to interference from competing sources lessening with maturity\textsuperscript{29}. In deed the first 1000 days are considered the most critical in children’s cognitive development. This period spans roughly from conception to the first two years of life. The most critical of all interventions during this period is the quality of nutrition – especially adequacy provision of iron\textsuperscript{30}. Adequate iron content in foods giving to children at this point is known to increase myelin production neurotransmitter synthesis, and neuronal energy production. These enhance the ability of the brain to process at higher speeds and contribute to shaping affect and emotion and learning and memory\textsuperscript{31}. Unfortunately, many children in resource poor countries continue to suffer from iron deficiencies which compromise on their growth process. In Ghana for instance, evidence from the recent GDHS showed that just around 60\% of children consumed iron-rich food 24hrs before the survey\textsuperscript{32}.

According to Pianta\textsuperscript{33} the developmental significance of parent-child relationships fosters children’s cognitive development. This, according to Pianta, could be linked to the affordance value in such relationships. That is, the extent to which adults bring to the relationship resources to support a child’s intellectual development that would not be available.

5.5 Social and emotional development of children

Social development comprises social relationships that provide material and interpersonal resources that are valuable to individuals, such as counselling, access to information and services, sharing of tasks and responsibilities and skill acquisition\textsuperscript{34}. The emotional understanding and companionship needed throughout this period is critical to child development. Right from infancy, children depend on the emotional support of their parents and develop safe connections to others based on the compassion and dependability and help of parents and other adults\textsuperscript{35}. Children who are nurtured adequately on social and emotional development grow to be self-confident and assertive which prepares them competently for schooling and school performance. In a recent randomised controlled trial, Synder et al\textsuperscript{36} found that social and emotional development interventions for children significantly prepared and improved student behaviour and character, influenced school-level achievement, attendance and disciplinary outcomes. Parental dysfunction can make children vulnerable to feelings of failure, inferiority complex, especially when they are young, which can have a long-lasting effect on their social and emotional development. Children may develop insecure and disorganized connections if they do not get the assistance required from parents and adults\textsuperscript{37}. In a recent comparative study between Ghana and China, the authors found that there was greater resilience among children who had stronger emotional support from their parents\textsuperscript{38}.

\textsuperscript{28} Ibid
\textsuperscript{30} Cusick, S., & Georgieff, M. K. (2014). The first 1,000 days of life: the brain’s window of opportunity.
\textsuperscript{31} Ibid.
\textsuperscript{32} Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014. Rockville, Maryland, USA: GSS, GHS, and ICF International
5.6 Parenting and gender

Boys/men and girls/women behave differently in many parts of the world and these differences are linked to situations, cultures, and historical events\(^{39}\). There is also a longstanding notion that differences in behaviours of boys and girls can be attributed to parenting and nurturing styles of parents towards boys and girls\(^{40}\). Biosocial theory is an important exposition to understanding gendered parenting of boys and girls. According to this perspective, gender differences in social behaviour is explained by gender division of roles, positioning women as homemakers and men as economic providers\(^{41}\). Consequently, a belief system and expectancies arise (gender stereotype) is eventually created, causing differential treatment of boys/men and girls/women. For instance, some evidence points to parental control of girls characterised by kindness, consideration, empathy, and interpersonal closeness. For boys, parental control is branded in power, assertiveness, aggressiveness and dominance\(^{42}\). In a meta-analysis, Lytton and Romney\(^{43}\) found that boys were more likely to be corrected through physical punishment than girls and similar findings are reported in observational studies.

Another perspective, gender schema, posits that not all parents conform to societal expectations of behaviours for boys and girls. This view holds that parents pursue gender-differentiated controlling and autonomy based on their own gender role stereotyping\(^{44}\). Such parental notions may be transmitted to their children, which may be cyclical and continue for many generations\(^{45}\).

In terms of household roles, parents may assign boys and girls responsibilities that are considered masculine or feminine\(^{46}\). Similarly, in terms of opportunities for human development/skills acquisition, evidence from developing countries show high preference for educating boys over girls when family resources are incapable of caring for both. Also, girls may be prevented from schooling on the basis that the modesty expected of girls may be eroded as they gain higher formal education\(^{47}\). Stereotypical views about boys and girls is a significant contributor to sex selective abortion in certain parts of Asia, namely, India\(^{48}\), Pakistan\(^{49}\) and China\(^{50}\).

Over time, however, these gender differences in parental norms and attitudes towards caring for boys and girls are diminishing modern and egalitarian societies. This is becoming more prevalent among urban, educated and affluent households where minimal differences exist for boys and girls; boys and girls are receiving similar investments in education, performing similar roles in households etc\(^{51}\). This changing pattern has been demonstrated in a recent systematic review of observational studies\(^{52}\).

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5.7 Child protection and safety, including violence

Violence and abuse against children can have long-lasting distressing effects, which may manifest on psychological, somatic, and social well-being of children into adulthood. The World Health Organization estimates that one in four adults were abused as children and around 12% of children have been sexually abused in the past year. There are many risk factors that expose children to abuse and violence. Pieces of research show that children under four years or adolescents, being unwanted child, having special needs or showing abnormal features are significantly exposed to abuse.

At the parental/caregiver level, poor nurturing, difficulty in bonding with new-born, being victims of abuse in childhood, drug and alcohol use, financial difficulties, poor understanding of child development and unrealistic expectations are key factors.

There are also certain kinds of relationships that expose children to violence and abuse. These include family breakdown or violence between family members, isolation and or lack of social support systems, waning support of extended family and mental or developmental problems of family members.

Certain community level norms and characteristics also make children susceptible to abuse and violence. Such norms could include gender, and social inequalities, poor housing infrastructure, unemployment, proximity to drugs and alcohol, weak policy and regulatory systems, norms and practices that directly or indirectly adore violence, gerontocracy norms or tendencies to disrespect and diminish adult/parent-child relationships. These triggers of violence against children are quite prevalent in Ghana where old people are “never wrong” when it has to do with children. For instance, in the traditional settings for dispute resolution, when an adult is found guilty in a dispute with a child, the verdict is not publicly pronounced in order not embarrass the adult. Such social norms may perpetuate a culture of impunity of violence and abuse against children. Protecting children and enhancing their safety requires multi-sectoral interventions such that parents, extended family members and other relations as well as community institutions are concurrently targeted with positive parenting values and practices. For instance, the ACT Against Violence Parents Raising Safe Kids program (ACT-PRSK) project of the American Psychological Association showed that reduced incidence of spanking and hitting of children with objects on the one hand and improved knowledge, behaviours and beliefs on violence against children on the other hand.

Relying on evidence from Ghana, Imoh underscored the popular appeal of corporal punishment to children among a section of the population. For instance, in the school setting, Agbenyega found that corporal punishment is perceived as a moral, effective learning and spiritual imperatives among some educators in Ghanaian schools. Evidence of this nature signal that remains undone in achieving the ideals of the Conventions on the Rights of the Child of the UN, to which Ghana is a signatory.

5.8 Parenting and caring for children with special needs

Parents who give birth to a child with disability are faced with their child’s identity constantly and must make modifications in their caregiving and in their anticipations. Parents of children with disability may experience exceptional stressors. Children with developmental disabilities may
frequently display more problematic behaviours than their naturally developing peers. Dozens of research findings demonstrate that some parents who have children with special needs have negative notions and feelings about themselves as well as their children⁵⁸. Such parents may show pessimism, hostility and shame⁵⁹. For others, it is denial, blame, guilt, grief, withdrawal, and rejection, helplessness, anger, anxiety, shock, disbelief, depression and self-blame. These negative feelings relate to parents overall parenting styles and the prognosis of disability event in the child⁶⁰.

However, not all parents of children with developmental disabilities view their parenting as stressful. For instance, Hastings et al⁶¹ found that parents’ perceived children with special needs as source of personal growth and maturity increased family closeness and strength as some positive experiences of parenting children with special needs. On either side – positive or negative experiences, the availability of financial resources, quality of networks and marital quality are among some of the critical factors that shape parents’ overall notions and experiences parenting children with special needs⁶₂. On marital quality for instance, in patriarchal societies, women may be blamed for giving birth to children with special needs. They could be blamed as witches or causing the disability of their children though sexual infidelity.

The larger social context where such parents live may also complicate the range of experiences particularly in settings where children with special needs are sometimes ostracized. In fact, there is a rich body of research in some parts of Ghana that have explored this subject. For instance, some of these children are labelled as spirit children and in some instances, killed at birth⁶⁵.⁶⁶

In the context of this, the Ghana’s Disability Act 715 was timely to address some of the micro and macro difficulties that persons with disabilities face. Among other things, it re-echoed the constitutional right of all children to education, proper care and access to public spaces. It also imposed on the ministries of health, education and department of social welfare the responsibility of setting up screening services to enhance early detection, prevention and management of disability in children.

Children with special may also be subjected to abuse, stigmatization and discrimination in different ways. These manifest in children being assaulted without provocation, locked up in rooms to avoid being seen by other people, or in extreme instances, killed eventually. Such acts of violence against children with special needs are documented in Ghana⁶⁷ and other similar settings.

5.9 Determinants of parenting and child care practices

The plethora of studies on factors that determine parenting styles and practices put the key issues under three thematic areas – child characteristics,
parent characteristics, and social context including community norms and national legal and policy frameworks. Of the child characteristics, it has been observed that hard-to-manage; negatively emotional and demanding children may develop behaviour problems, which in turn could evoke hostile-intrusive and detached-uninvolved parenting from their caregivers. For example, among adolescents, Pike et al. noted that very aggressive ones tend to receive an equal measure of aggressive and hostile parenting. Studies along this line affirm the role of children’s temperament on parenting they experience, although not suggesting causality.

Several characteristics of parents have been reported to determine the kinds of parenting children receive. One of the foremost established is intergenerational transmission of parenting. This view contends that both positive and negative parenting may be transmitted through generational connections, either from mothers or fathers. Evidence also points to the psychological attributes and disposition of parents. The so-called main personality characteristics – extraversion, agreeableness, conscientiousness and flexibility to experience contribute to parenting practices through the emotion’s parents emit. Thus, parents may explain the behaviours of children based on their own perceptions. Again, the amount of resources – social and economic that is available to parents also influences parenting attitudes. For instance, maternal/paternal education has strong effects of feeding practices, illness management.

The nature of parenting children have is also a function of the larger social context they and their parents live. The first of the social spaces is the quality of marital relationship between parents. Community and social notions about parenting, the nature of relationships that must exist between parents and children, norms about punishment and rewards, perceptions about ideal or bad parent all have bearings on the kind of parenting children obtain. In some collectivist’s cultures for instance, authoritarian parenting seems more acceptable and normal.

5.10 National and international frameworks for child care and protection

Creating the right spaces and environment for children to grow and develop was popularised at the international level in 1990 through the acceptance of Convention on the Rights of the Child. This was stimulated through UN General Assembly resolution 44/25 of 20th November 1989. Ghana signed on to it on January 1990 and ratified it in February the same year. Among others, the Convention outlined critical strategic areas of interest, namely non-discrimination; protection of child rights; parental guidance; survival and development; registration, name, identity and care; separation from parents; respect for the views of the child, freedom of expression; freedom of association and right to privacy. Some others are parental responsibilities and state assistance, protection from all forms of violence, support and care for children with special needs.
right to adoption, social security, right to education, leisure, play and culture, protection from child labour, drug abuse and sexual exploitation. As part of efforts to fulfil these benchmarks, the Government of Ghana developed a 10-year national action programme titled The Child Cannot Wait. This was the first step towards legal reforms consistent with the Convention. This process resulted in the Children’s Act (Act 560) in June 1998. The Act, which is built into the key principles of the Convention, prioritizes the welfare of the child on all matters that concern children. The Act goes further to set up certain fundamental requirements to actualize the rationale for the law. These are: establishment of social welfare offices in all districts for the implementation of the Act; that parents and other persons legally liable to maintain a child are under a duty to supply the necessities of life, health, education and reasonable shelter; establishment of child rights committees and residential homes to advocate for rights of children and cater for needs of children outside of their homes and the establishment of family tribunal with a panel to consider and deliberate on all cases involving children.

At the national level, a plethora of laws and policies targeting child welfare exists. The Domestic Violence Law, Act 732 provided another significant impetus to protect women and children from domestic abuses. Hitherto, violence and abuse occurring in domestic settings were largely considered ‘family matters’ against which the state was not required or supposed to intervene. However, with surging cases of reported abuse of abuse women and children with fathers/husbands as the main perpetrators, the state, rightly so, intervened through the promulgation of Act 732 in 2007. Specifically, the Act addresses all forms of abuse that can occur in the home environment – physical, emotional, sexual, economic and psychological abuses. It further sets up and bestows more powers to certain state institutions such as the Police and the Social Welfare department to make appropriate interventions when the welfare of children is at stake.

Other legal documents that seek to enhance children’s experiences with parenting and safe spaces for proper growth and development include the Intestate Succession Act, 1985 (PNDCL111); the Human Trafficking Act, 2005. Some policies that are aimed at translating some of these laws into actionable programmes include National Plan of Action (NPA) on Child Labour and the Worst Forms of Child Labour, 2009-2015; the National Plan of Action (NPA) on Orphans and Vulnerable Children (OVC), 2010-2015; the Early Childhood Care and Development Policy, 2004; the National Domestic Violence Policy and the Plan of Action, Hazardous Child Labour Framework; Gender and Children’s Policy Standards, Child and Family Welfare Policy, 2014 and more recently, the National Nurturing Care Framework for Early Childhood Development, 2018.

Despite the existing of these legal frameworks for safeguarding the rights and welfare of children in Ghana, there are outstanding miles to cover; for instance, institutions set up to protect children are under resourced in human and financial terms. Community-level structures set-up to protect children is informal and therefore weak in adequately protecting children.22

5.11 Conceptual framework guiding the study

This work is situated in the Socio-Ecological Framework of UNICEF. Originally propounded by Bronfenbrenner in 1992 and named as ecological systems theory, the framework situates individual behaviour in a web of systems that have reverse “causal effect” on the individual. That is the individual influences and at the same time shaped by multiple actors in time and space. It is anchored on assumption that individual behaviours are connected to and formed within interactive social and physical environments. The SEM framework is organized into five hierarchical levels – individual, inter-personal, community, or-

ganization and policy/enabling environment. The broad nature of the model makes it an appealing framework for understanding social and behavioural norms as well as guiding interventions to cause social change. The pictorial view of the model appears in Figure 1.

**Individual level**

At the core of the model is individual characteristics such as age, gender, education, economic status, expectations, values which are foundational to knowledge, attitudes, behaviour, self-efficacy among others. These individual characters have consistently shown significant association/relationship with behaviours around health, nutrition, educational attainment and outcomes. It further posits that a reciprocal relationship between individuals and their environments (social and physical). For instance, in parenting, evidence shows that children of educated parents are likely to do well in school, get more nutritious diets and develop speech skills earlier. Similarly, child survival rates are higher in the children of educated women than those with no or little education and birth defects are less common in fathers with better education.

**Interpersonal**

The interpersonal relationships comprise of formal and informal social networks and support systems that shapes the attitudes and behaviours of individuals. In respect of childcare, the emerging evidence shows that social networks shape childcare in both positive and negative ways. For instance, a recent research in a slum area in Nairobi showed that single mothers extensively relied on kin support for child nurturing. Other studies have also reported mixed findings on the benefits of grandmothers to childcare. Pandey et al. (2018) reported that combining community resources with grandmothers raising grandchildren enhanced family resiliency, social support and self-efficacy. The presence of grandmothers has also been shown to improve nutrition interventions. On the other hand, grandmothers can become barriers to child health care seeking behaviours of mothers.

The next level of the framework is community. The locus here is concerned with dealings or affairs among and between organizations and informational networks that exist in communities such as religious groupings/associations, hometown unions/associations, community and religious leaders etc. In childcare and nurturing, some of these community networks and associations are increasingly becoming a large pool of resource and support for childcare, especially for working mothers. This is reported to be more common among immigrant communities. Also, at the community level, including the school environment and care homes, better childcare practices can be constrained, particularly for children with special needs. Community level enablers

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and constraints (e.g., stigma and discrimination because of gender and ability) to parenting— for children with special needs and those without will be explored and examined in detail.

At the organizational level, individual behaviours, attitudes and practices may be influenced or affected by organizational/institutional rules—be they health, educational and social protection/safety. These institutional arrangements may promote or discourage utilization of very critical resources for childcare and nurturing. For example, irregular opening of child welfare clinics may discourage parents/mothers from utilizing such services. Also, another layer of organizational lever that concerns child nurturing and parenting is institutionalized homes. While they fill important gaps in caring and nurturing orphans and vulnerable children (OVCs), children parented in institutionalised homes may experience maltreatment, limited parental attachment, which is critical for emotional and psychosocial development of children. Views of care home operators—of and non-state actors, institutional/organizational support opportunities for parenting and childcare are some of the areas that we will explore.

Finally, policies and programmes that are offered at the national and sub-national levels as well as effective allocation of resources have impact on parent’s use of targeted services and programmes. Similarly, the policies and instruments states have at their disposal to intervene in childcare and protection can have diverse impacts on parenting practices. In more developed welfare states for instance, parents who consistently show poor parenting features such as physical or sexual violence, inadequate feeding among others may have their children taking to care homes. Anecdotal evidence indicates that such interventions may put fear into parents as poor parenting could lead to children taken into care homes. Whereas these interventions are uncommon in the larger context of this study, knowledge, perceptions, beliefs and attitudes state-governed child protection programmes will be explored in this study. At the governance it will be helpful to explore and appreciate the policy architectures, finances and coordination geared towards improving quality and access to early childhood development and education.

In sum, the first and second objectives can be positioned at the individual (parents & children), interpersonal and community levels while objectives three and four fit into the organizational and policy strata. However, since human behaviour is extensively complex, we don’t expect a uni-directional flow of events; each level is dependent on the other. For instance, public policy on childcare structures are generally informed by contexts, which includes individual values aggregated at the community level and beyond. Guided by this framework, we outline the practical steps that will be positioned to identify and generate data for this study.

6 METHODOLOGY

6.1 Study design

This is a qualitative cross-sectional study. It was intended to explore the context – social, economic, cultural and political context of parenting in selected districts. Given the exploratory nature of the study, we triangulated a cocktail of qualitative techniques, among which were in-depth interviews (IDIs), focus group discussions (FGDs), key informant interviews (KII), Photovoice, and observations. The IDIs were geared towards understanding individual level concerns and experiences of parenting. The FGDs explored group/community level norms; practices and attitudes towards parenting while the KIIs aimed at understanding institutional cultures and systems that support parenting. Through the observations, we delved into, and gain deeper insights into individual parents’ daily/routine pathways on parenting.

6.2 Sampling of study sites

Using critical case sampling, the study was conducted in eight (8) districts in six (6) regions. Critical case sampling rests on the assumption the sampled study population and groups are more likely to give and meets certain indicators. In this study, the following parameters were used as the basis for selecting districts.

First, we sampled two districts each from two high UNICEF convergence working regions. Regions are described as high convergence if they have 15 interventions in five of the six-programme/Themematic areas. Incidentally, these programmatic areas are at the base of ECD in both theory and practice. These are Communication for Development (C4D), Education, WASH, Social Protection, Health and Nutrition. Northern and Upper West met this criterion. Within these two regions, Tolon and Kpandai; Wa West and Lambussie Karni in the Northern and Upper West regions respectively qualified for inclusion. Two other districts from low convergence regions were selected. Low convergence districts, have three, or fewer interventions in the six thematic areas and have no ECD, concentrated activities. These were Kwabere East and North Tongu was sampled from Volta and Ashanti regions respectfully.

We further sampled two districts from Greater Accra and Central. Greater Accra is the host region of the national capital and has a high concentration of government and non-governmental early child development outfits. For instance, it is the host to the foremost institutional care facility in the country - Osu Children’s home. Subsequently, the area demarcated as Greater Accra Metropolis was selected. In terms of child health indicators, it reports some of the best in the country; the highest (47%) proportion of children who received meals comprised of four or more food groups as well as meal frequency were reported in the region.

The choice of Central Region was premised on the assumption that it has some of poorest child health outcomes; for instance, it has the second highest prevalence of height-for-age (8.6%),
weight-for-height (7.7%) and weight-for-height (14%). The region also reported the second highest proportion of adolescents (21%) who had started children and at the time of the 2014 DHS, the region had the highest percentage of adolescents (7%) who were pregnant. These indicators make the regions suitable for inclusion in a study on parenting. In the Central Region, we purposively selected the Komenda-Edna-Eguafo-Abirem district – which has the highest teenage pregnancy rate in the region, it is a major coastal fishing district and reflects the typical Ghanaian coastal community. Regarding the communities, we selected one urban and one rural community in each district, given a total of 16 communities. District capitals were automatically selected for the urban sites in each district and one rural town was randomly selected. These are displayed in Table 2.

6.3 Sample size and sampling strategy

The total numbers of individuals sampled for the study was 440, broken down in Table 1. In arriving at the proposed numbers, we were mindful of numbers that are not too large to affect depth and at the same not too small to affect information redundancy required of exploratory qualitative studies. The use of sample size over information redundancy is due to the concurrent deployment of moderators across the study sites and the use of multiple interviewers’ present challenges to determining saturation during the data collection period. The sampling was done systematically to increase the chance of getting the various targets within communities with less biasness. For each community, the moderators used a structured screening guide, which was completed for households that were systematically selected. The details of household members including children and all dependants as well as the parameters to determine the wealth status of the households were gathered. The completed interviews were synced instantly as data was captured using tablets and various targets meeting the criteria were selected and shared with moderators to be interviewed. This process made the sampling protocol very consistent and enhanced the achievement of the huge quota we set out to do. Again, households with children with special needs that were not within our sampled households were identified purposively with the aid of community members.

6.4 Sampling of parents

Parents who had children in the following age groups were interviewed: 0-6 years; 0-6 years of children with special needs; 7-9 years; 10-14 (early adolescents) and 15-18 years (late adolescents) were selected. No one set of parents was interviewed for different age cohorts of children. Also, whereas similar set of questions was asked, we deliberately ensured that questions were relevant to the age to which parents had been pinned. That is maximum variation or heterogeneous purposive sampling informed the sampling of parents. This helped capturing parents of different characteristics such is residence (urban-rural), wealth status and ethnicity. Others were parents with children with special needs /learning challenges, maternal/paternal age, marital status, couple residential arrangements (co-residence and other forms), religious affiliation, education, and occupation among others.

6.5 Sampling of children and adolescents

Adolescents were recruited from households different from where parents were recruited. The reason not to recruit parent-child dyads is to avoid a situation where participants may discuss interview questions and possible responses after

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9 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014. Rockville, Maryland, USA: GSS, GHS, and ICF International
the survey and to ensure adolescent feel comfortable to discuss their views on parenting practices without fear.

Two sub-groups of adolescents were recruited for the FGDs; 10-14 years, and 15-19 years. These distinctions allowed for ease of FGD facilitation and encourage reasonable participation of all participants. Participants were recruited from households. We sought parental consent and child assent for each participating adolescent less than 18 years. Emancipated minors, however, provided individual consent. Other parental/household characteristics such as wealth and education will be considered in selecting samples. The sample allocation to each participant category is shown in Table 3.

6.6 Sampling of grandparents and other targets

Using the listed household data, we selected all other targets such as the grandparents and foster parents, through purposive maximum variation (e.g. ethnicity, education, age of grandparent, age of children etc.).

6.7 Sampling and recruitment of stakeholders

Using expert purposive sampling technique, district level heads of Social Welfare Department, Ghana Health Service, Ghana Education Service, Police Service (Domestic Violence and Victim Support Unit – DOVVSU), and community leaders/gatekeepers e.g. religious leaders (Christian, Islam, African Traditional Religion etc.) and traditional leaders were interviewed. Of the different units/categories, we relied on national, regional and district administrative structures for entry.

6.8 Mapping of current government and development initiatives around ECD

The first process in mapping of ECD initiatives started with a consultative meeting with government institutions e.g. Ministry of Health, Education and Gender and Social Protection among others. During this meeting we solicited for the different interventions currently or recently completed on ECD such as – health, nutrition, education etc. We then arranged follow-up meetings with each of the participants for further meetings where we used a checklist to identify all the relevant on-going interventions.

6.9 Instrumentation

Structured toolkits were used IDIs, FGDs and KII. We also developed a checklist for observations and photovoice. All data collection tools were translated into the predominant Ghanaian languages spoken in the study districts/communities.

6.10 Pre-test

We conducted pre-testing of the instruments in Medina in Accra, which has a diverse population that reflects the major ethnicities of Ghanaian population. Through this, we were able to simulate and adjust the tools for the final study.

6.11 Recruitment and training of enumerators

Twenty fieldworkers collected the data for the study. Fieldworkers had to meet basic criteria such as: minimum of tertiary school qualification and should have participated in not less two related assignments to be recruited. Also, they had to be highly proficient in major languages spoken in the study districts in addition to English.
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Twenty fieldworkers collected the data for the study. Fieldworkers had to meet basic criteria such as: minimum of tertiary school qualification and should have participated in not less two related assignments to be recruited. Also, they had to be highly proficient in major languages spoken in the study districts in addition to English.

6.12 Trustworthiness measures

A major concern to qualitative researchers and users of the evidence arising from the same is credibility of text data. Cognizant of these, we followed the following steps to ensure the credibility of the data. First, samples of the transcripts were subjected to member checking. We also included reflexivity as a requirement for field report each fieldworker produced. This is a process of self-reflection as a researcher, detailing personal biases, preferences and preconceptions about the topic under study as well as any relationships between interviewers and participants, which might affect the answers to questions.

6.13 Risk analysis and mitigation

Childcare issues, including violence victimization are a sensitive terrain and may evoke memories of past experiences. For instance, researchers may be exposed to narratives on violence victimization accounts, which portend legal risk to participants. Similarly, people may resist observations around childcare practices such as feeding, which may be viewed as intrusive. Again, routine practices and behaviours may be altered under observation. The following practical measures were therefore taking to minimize these risks on data quality and increase success rates.

First, regarding legal risks to participants, there is no exact consensus on how to resolve such complications. However, there is recognition that the trust of research participants must be maintained unless there is serious criminal activity involved. In this instance, the likelihood of such high criminal activities occurring is minimal. No such observations were made based on the field reports.

Another risk we made efforts to abate was coercion or “buying” their participation through gifts. During the training, we emphasised on non-coercion and also exposed trainees to UNICEF and universal research protocols. Children also face the risk of being abused physical or sexually. The criminality of such acts and attendant legal sanctions were thoroughly discussed with research assistants.

6.14 Ethical consideration

The following measures were taken to ensure that the study adhered to protection of research participants.

Respondents
First, all interviewers were trained on research ethics as part of the training for the fieldwork. Also, we sought and obtained verbal and written consent of participants and interviews were conducted in secured places where privacy and confidentiality were maintained. No identifying information of respondents are retained in the data presented in the report.

Data protection
To ensure data security, all data files were protected with a password and shared only among core study team members. Emancipated minors – adolescents who were below 18 years but had assumed ‘adult’ responsibilities, in this case, of being mothers, gave personal consent.

Institutional ethical approval
The Ghana Health Service Ethics Review Committee approved the study protocol.
6.15 Data collection

All IDIs and FGDs were conducted face-to-face. The data collection started in April to 15th June, 2019. We did not record any major issues although recruitment of specific targets such as parents with disability was quite difficult. Noted some research fatigue and incidences of unfulfilled promises in the past by other agencies to help CWSNs. We conducted observations of child-care practices such as feeding among mothers and with their permission took photographs of routine practices.

6.16 Documentary/desktop review

The documentary review was guided by the main objectives and research questions that are explored in this study. Research papers/articles or project reports were sourced from Pubmed. Among illustrative keywords that guided the review were “parenting”, “parenting styles”, “early childhood development” “care/child care”, “feeding”, “physical needs of children”, “social needs of children”, “emotional needs of children”, “child safety”, “child violence” and “GHANA” were searched. Ghana was a common search term in all the entries.

6.17 Transcription

Transcription of interviews was done concurrently to data collection. The added advantage of approach was that we were able to review and feedback appropriately into subsequent interviews. This approach also helped to reduce the turnaround time to deliver the transcripts for report writing.

6.18 Qualitative data management software

All the transcribed text was edited in Microsoft Word. Following this, the data was exported into NVivo version 12 (QSR International) for coding and analysis.

6.19 Data analysis

Reporting of qualitative findings follows the Consolidated Criteria for Reporting Qualitative Research92 (COREQ). Quality/trustworthiness is pursued through thick descriptions and peer review. Both deductive and inductive techniques were applied to analysing the text data. The deductive approach was frame around the major themes or research objectives and questions (parent nodes). For the next stage, we used inductive techniques to identify child and grandchild notes through immersive, detailed, and repeated reading of the text. Based on these, we developed a coding framework, which guided the coding of text into the NVivo software. The codes were then reviewed by a senior research scientist with Kantar, who checked for inconsistencies and re-aligned codes where necessary. Thematised accounts of participants are presented under sections and supported by relevant extracts. The overall analytical approach leaned more towards descriptive given that many participant groups were interviewed. The analysis was mainly done for each target group. However, within group or closely related participants are compared where necessary.

First, this report relies wholly on qualitative techniques. The use of purposive sampling for instance negates generalizations. The presentation is extensively narratives, which helped us capture daily lives and experiences of participants. Although some graphs and charts are provided, they only indicate frequently used and relevant concepts applicable to each theme.

Again, most of the mothers targeted for photo-voice did not have logistics such as smartphones. This limited our ability to make full use of photo-voice processes. However, we relied on fieldworkers to take photographs of key events of mothers to complement the narratives.

The list of target groups was long, which gives a larger coverage of several stakeholders, but this also limited the depth of exploration on all indicators and for each target population.
8 MAPPING OF ECD INTERVENTIONS AND PROGRAMMING

To contextualize the study in the macro space of implementation of ECD programmes and policies, we conducted a mapping exercise to identify the various existing interventions being implemented by both governmental and non-governmental agencies. Specifically, the mapping exercise sought to:

- Identify the different interventions across the various sectors involved in ECD and adolescent programmes;
- Identify donors, agencies and service providers of ECD at the national, regional and district levels; and
- Ascertain the main capacities of these agencies in relation to ECD and adolescent programmes, their experience and the scale of their programmes.

8.1 Approach

The methodology adopted for the mapping exercise comprised a literature review, consultations and dialogue with key actors in the early childhood development and adolescent sector (Social Welfare, Department of Children, Community Development, Ministry of Education, Ghana Education Service, Ghana Health Service etc.) and interviews with Development Partners. It involved secondary data on early childhood (ECD) and adolescent in Ghana. Consultations were also held with key actors in the ECD and adolescent sector from the government sector, international partners such as JICA, USAID and UNICEF. The Departments that provided reports on ECD activities, children and social welfare interventions were Department of Community Development, Social Welfare, Ministry of Education/Ghana Education Service (MoE/GES and DOVSU etc.) to identify key policies and the scale of their activities in the ECD and adolescent sector. These consultations were further to consolidate the compilation of secondary data as well as initiate the process of primary data collection on ECD activities nationwide.

8.2 Key learnings

8.2.1 Policy Implementation and enforcement

The government of Ghana acknowledges the need for Early Childhood Care and Development policy and other policies such as inclusive education and child welfare policies as well as implementation plans or guidelines which promote the development of the Ghanaian child from age 0 to 19 years. These policies provide adequate guidelines for financing the policies and child development in health, education and child protection etc. These various policies have institutional arrangements that show the various ministries and departments’ roles and responsibilities in the development of the child. There are however, some issues that need clarity to ensure consistency in the implementation of the policies. For instance, the 2004 Early Childhood Care and Development Policy places Day Care Centres (0-3-year olds) under Ministry of Employment and Labour Rela-
tions (previously Ministry of Manpower Development and Employment with the initiative implemented by the Department of Social Welfare. On the contrary, the Child and Family Welfare Policy place the supervision of the Department of Social Welfare under the Ministry of Local Government and Rural Development, which shows some level of inconsistency in policy direction on ECD. Enforcement of these policies is faced with some challenges as demonstrated throughout the mapping engagement – budgetary allocations and financing of policy initiatives on childcare has been minimalist in nature, which is inconsistent with the policy.

Policy financing is heavily donor driven. There are also challenges with some of the agencies complying with the policy guidelines because of weak monitoring systems in place. There will be the need to bring together the various disjointed roles in the various ministries and departments that have connections to ECD, with attention on monitoring the cross-government policy; regulation and funding of ECD related initiatives of the various ministries and department to ensure alignment and efficiency. The ECD initiatives require that the various agencies/departments receive the necessary financial resources on consistent basis to ensure that the initiatives are fully implemented to address the needs of the child. Lack of resources can have a detrimental effect on the potential outcome ECD initiatives. Fortunately, the Department of Children, under the Ministry of Gender has initiated the evaluation and review of the ECCD Policy process to address multi-faceted implementation challenges in the future.

8.2.2 Spread and coverage of program

Multifaceted initiatives have been implemented on Early Childhood Care and Development in health, education, child protection etc. as part of implementing national policy on childcare and development. Table 4 shows the locations of the various initiatives across the regions of Ghana with heavy concentration in the Northern, Upper East and Upper West Regions. These regions are beneficiaries of the various interventions probably due to issues of deprivation associated with these regions. These nationwide Early Childhood interventions were associated with challenging implementation issues, especially with consistent financing regarding child development.

8.2.3 Synergies with existing programmes

The involvement of a larger number of stakeholders from the DAs/DEOs in the programme implementation ensured a more synergistic approach to implementation. These officers were engaged in all areas of monitoring, supervision, coaching and mentoring. Synergy with existing programmes was explored in relation to the extent to which the various ECD programmes could leverage resources and experiences gained from the various interventions supported by both government and donors. These programmes also relate to ensuring quality ECD and adolescent initiatives in the state systems and indirectly strengthen the ECD and adolescent management systems at the national, regional, district and community levels. In addition, these programmes could help address the ECD and adolescent phenomenon in a more sustainable manner. The models and approaches adopted by such programmes at the various sectors and departments were, therefore, reviewed to identify their key strengths and how these strengths could be leveraged to optimize synergy. It was observed that all the initiatives were aimed at promoting effective approaches for child development but resource constraints, especially Department for Children, Department of Social Welfare and Community Development are the most affected, hence their inability to undertake effective programmes in ECD.

8.2.4 Learning on upstream activities

Most of the upstream activities on ECD are centred on policy initiatives, standards and guidelines formulation, high-level stakeholder engage-
8.2.7 Thoughts on design and access to communication strategy and advocacy materials

On communication, although most of the initiatives are on-going, they do not have any communication strategy in place to guide their outreach programmes. Except for the Ghana Health Service and the Ghana Education Service that have the Ghana Integrated Child Health campaign as a strategy and Social/Behaviour Change Communication Strategy respectively, most of the other projects/agencies and departments do not. Only one of the initiatives (Re-entry under the Girls Education Unit) under the MoE/GES could share a communication plan during the engagement. The Department of Social Welfare has two of their initiatives with communication strategy and these are the Livelihood and Foster Care programmes. It was also realised that the heavy dependence on donors and coupled with limited government budget allocations to these departments and agencies places a lot of challenge on sustaining these initiatives. Table 8 provides detailed analysis on the communication initiatives that stakeholders are carrying out to increase advocacy, sensitization and education on children and family welfare related issues to various target groups.

8.2.5 Learning on downstream activities

These are activities are largely focused at the regional, district and community levels for implementation. Among these are engagements with local level stakeholders and the implementation of initiatives. The over concentration of some initiative’s region/district tend to put lots of pressure on the staff, especially the Ghana Health Service and Ghana Education Service where different donors, for lack of intervention mapping converge in one area using the same officials to accomplish individual donor intervention. The presence of USAID Maternal Health Survival, JICA Maternal and Child Health and KOICA in the Upper East region puts lots of demand on the health officials.

8.2.6 Learning on the role of donor support driving initiatives

Majority of ECD initiatives are supported with donor funding. The government relies on foreign aid as a means of addressing host of developmental issues including the development of the child. The child welfare institutions, for instance, the Department of Children and Department of Social Welfare are challenged due to lack of government direct support towards their initiatives. Donor agencies such as UNICEF, JICA, USAID provide not just financial support but technical assistance to equip the local staff to ensure sustainability of the approaches of the initiatives. These donors have also provided support to the agencies such as the Ghana Health Service and the Ministry of Education to mainstream some of the initiative practices into the government system to promote continuous and sustained approaches of ensuring efficient ways of early childhood care and development.
9 | FINDINGS

9.1 Parents of children with special needs

9.1.1 Kinds and timing of disability

Mothers of CwSN reported diverse physical difficulties, which included sight, hearing impairment, sudden convulsion and seizures, spinal problems, autism, and walking/movement difficulties.

Some parents who had a child with one form or another of disability narrated that to the best of their knowledge, the disability occurred months and years after birth. Others were not quite sure about the timing of disability; to some it must have been hiding until the conditions fully developed. What seems clear for some mothers was that the time between onset of condition and proper diagnosis seemed long. A parent of a child with autism narrated:

‘We went for a check-up when she was 3 years old and the doctor confirmed she has autism. I was not informed, it was my husband they told, I got to know about it later’

Parent, CwSN, Accra Metro

Four mothers with a child with special needs (CwSN) reported that they detected certain abnormalities at birth. Some recalled:

‘Like I said, it started from birth. His eyes were red as though there was blood on his eyes from birth. So, we used to drop breast milk on his eyes and as we do that, the blood disappears. It is up to this age that we are realizing that he may probably be suffering from an eye problem’

Parent, CwSN, North Tongu

‘Right from the day of delivery’

Parent, CwSN, North Tongu

Some other mothers were unsure of the onset of the condition. One in Tolon (Northern region) would rather discredit anyone who would attempt to proffer any indications about the onset of the condition. She asserted confidently:
’Hmmm... for that one, no entity can know how she got her condition. Anyone trying to tell us the source of her illness will be a deception. Not that she was born looking sick; she was healthy at birth. All of us got to know she was ill when she reached a certain stage and we could not see any changes in her, then we started treating her with herbs’
Parent, CwSN, Tolon

In three instances, the disability was sudden following an illness episode. Below are some accounts of mothers with CwSN.

‘I didn’t see any sign of it right after giving birth to him, but the sickness attacked him when he was three months old. The doctor asked me whether I was sick when delivering and I said no. And he said this kind of sicknesses attacks the child brain. So, he gave me a medicine to cure it. So, it is prayers and the medicines we buy from Ankaful is what we give to him so far’
Parent, CwSN, KEEA

‘It was after birth, she was 10 months when she was down by severe malaria, and that lead her to be deformed, because now she cannot sit unless you hold her, when you hold her sometimes she sits a little, then she becomes tired if you are not there to hold her, she falls off, she can’t walk she can’t stand, she can’t talk but she hears when you call her, she turns and look at you’
Parent, CwSN, Lambussie

‘It is not from birth. He fell sick at some time, which has left him in this state.
Parent, CwSN, Wa West
Albert is a 10-year-old boy who lives with a family of in Elmina. Albert was diagnosed of Cerebral Palsy. He cannot talk, stand nor hold anything; he sucks his thumb.

At 3 months old, the mother found him lying stiff on the bed one day when she had finished bathing him and had stepped out briefly to pour away liquid waste. She immediately rushed him to a hospital. The nurse on duty diagnosed him of convulsion. Several treatment interventions - both orthodox and traditional have been sought since then but the condition persists with no improvement.

The parents provide routine care such as bathing, feeding and motor skills with the father teaching him how to hold things and how to play keyboard. The father helps to create a friendly environment and engages him in conversations even though he cannot speak.

Care for such children are reported to be stressful as the parents narrated and has caused them financial difficulties; the mother is a petty trader and father is a watch repairer.

Parent, CwSN, Central Region

In a hypothetical situation where parents noticed any developmental delays, diverse interventions were mentioned. Principal among them was seeking medical help assistance. However, some mothers indicated they would first inform either their own mothers or a trusted person in the community (e.g. religious leaders or “one who feared God”) for advice/counselling and guidance. Few others will adopt a wait and see strategy and if it remains persistent, they would seek assistance from health providers.

9.1.2 Community and traditional notions about CwSN

Parents with CwSN described community notions about such children in three broad areas; sympathy, indifference and abnormality. Of sympathy, some parents shared that some community members appeared to care and sympathize with them about their situation of their children. Some parents reported receiving pieces of advice from other community members on best practices in caring for CwSN including putting them in school. One parent recounted:

‘Okay anyone that sees him always advise me to send him to school. They always tell me to send him to school for proper education. No, they like him even when they see someone who wants to disturb him, they chase the person away’

Parent, CwSN, Lambussie

Narratives about abnormality were in the context of children’s physical appearances and the cause of the disability. In terms of appearance, it was primarily about people being scared/afraid or simply unwilling to get close to CwSN for the fact that they appeared different from others. On cause of disability, the notions were either it was because the child was gifted by the gods or marine goddess or because of curse or infidelity on the part of the woman. One mother from Volta region illustrated her views in the following:

‘I’ve heard people say that when I was pregnant, I had sex with another man who isn’t my husband and the result is what has happened to my child’

Parent, CwSN, North Tongu
In the attempts of some parents to understand the cause, and sometimes cure disabilities of children, they resort to consulting mediums and spirits. Nevertheless, no parent with CwSN reported getting the desired result—cure. One woman who had attempted a traditional method of healing testified of her experience:

‘They’ll say they can cure her from such ailment. Some people have attributed it to witches who have changed the destiny of the child, so they can help me. I made attempts by visiting them with the child, but it yielded nothing; I didn’t see the result I wanted to see’

Parent, CwSN, North Tongu

9.1.3 Perceptions and stigmatization of children with special needs

We revisit the questions on disability from the perspective of community leaders. We find anecdotes of stigmatization of persons with disability in some of the narratives. According to some community leaders, people may have stigmatizing ideas and behaviours but are often not publicly expressed. An interviewee in North Tongue, Volta region, described this observation as:

‘They take care of them but at times, they mock them in their absence. Truthfully, they have mercy on them, so they don’t punish them. They just talk to them but there are some that are stubborn so when they keep doing the things, you hit them at the back to stop. When we are doing match passing, they laugh at the children with special needs a lot. They try to imitate how they are also trying to follow the normal patterns’

Community Leader, North Tongu

We also glean from the data that some of the stigmatizing attitudes towards children emanate from misconceptions about causes of disability in children. For instance, regarding epilepsy, there was a reference to a misconception that it was communicable, making people uncomfortable to get closer to people with epilepsy.

‘...Traditionally when the saliva of such a child gets in contact with you, you are also likely to get the epilepsy; those are the issue and that is the stigma that I always see. Because I remember a similar case happened in my school where I just got to the school morning assembly the child fell and the teachers run away and they were calling the health teacher and so I got out and realized that that was the case so I just went and held the child because they were also afraid that they were being told that the saliva of such a child when it touches you, you are also going to get deeper understanding of the issue so I went and held the and asked that they should bring water so I cleaned the child and he was okay’

Community Leader, Lambussie

Some other community leaders also shared stories about infanticide of a child with disability. Children with extreme or uncommon forms of disabilities are considered evil and problem children who could bewitch other family members. In this account, the child is pointed as the cause of the mother’s death and father’s blindness. The full account is in the excerpt below:

‘It used to be so; they think that is not a proper human being. Such a child is not a proper human being; he is only coming to give problems. And it is even said that if you allow such a child to grow, he will bewitch everybody. So, such a child must not be allowed to live. One, doing away with some of the infants that come with; some of them will even live them to grow only to realize that she is bewitching the family. I had a mem-
Participating community leaders further discussed that there are no specific community-level programmes that support children with special needs. However, children with special needs receive support from community members on personal accord. One leader in Elmina commented:

‘There is nothing like that here. There was a guy who was deformed in one leg and could not walk well, with the consent of his parents the church pushed him into employment. Yes, they do especially the children who cannot walk well or have hearing impairment but with the hearing impairment when it’s noticed early, the child is made to sit in the front seats only so that they can get special attention from their teachers’

Community Leader, KEEA

District level KIIs however mentioned two main areas where they intervene or offer services to persons with disabilities. First, Department of Social Welfare participants reported conducting sensitization programmes for community members on the rights and capabilities of, and the need to avoid stigmatization and discrimination against CWSNs. They also help parents navigate the shocks and distresses of having CwSNs.

Another support KIIs reported is the mandatory 10% District Assemblies Common Fund that should be given to support the health, educational and job creation activities for persons with disabilities. The districts deliver these responsibilities through the Department of Social Welfare.

9.1.4 Services for children with special needs

All but one of the nine community leaders who responded to questions on capacity to deal with children with special needs affirmed that they had been trained in one way or another. Participants reported receiving training from different sources such as the church, NGOs and through formal education programmes (e.g. university course). Narratives from KEEA, Tolon, and Lambussie illustrate these assertions:

‘This year, we are giving a special training to our children ministry teachers to know how to treat or teach such children (disabled)’

Community Leader, KEEA

‘Yes, they come to train us. They ever invite chiefs, Mallams and Pastors to the market square, to teach how to handle and not to discriminate them in the community’

Community Leader, Tolon

‘Yes, just like I said this child and family life issue, I think either the beginning of this year or the later part of last year the disability group came and told they were, we had one day just interaction and they were trying to let us understand how children with disability can be sent to the formal system and that they are also trying, some teachers will be trained so that they will be in the normal school where these children will go and they will have the skills trying to also impact knowledge onto these children’

Community Leader, Lambussie

Figure 3: Word cloud depicting services available to children with disabilities
9.2 Experiences with parenting CwSN

9.2.1 What parents consider doing well

No parent desires for a CwSN. Parents are therefore usually not prepared for such events. The implication is that for parents to cope and parent CwSN effectively, they need to understand, accept and learn different skillsets for effective parenting of such children. We explore what parents with CwSN consider they are doing well and those areas they are not doing right.

In terms of what parents are doing right, three key things emerged as depicted in Figure 4; First, some parents are providing early stimulation environment for their CwSN through extra home tuition and developing motor skills such as writing and walking.

‘Am so focus on my child’s schooling and I want to make sure that my child goes to school so she makes use of her knowledge so she can become someone great in the future. When we are in the house there is a slate that I hold the hand to write and sings for the child and sometimes plays Ludu with them at home’
Parent, CwSN, Kumasi Metro

‘The exercise we have been doing. His father has been helping him to hold things, but he still cannot hold them properly. And his father says we should be conversing with him. So, his father converse with him a lot. Even though he doesn’t speak, his father asked him lots of questions’
Parent, CwSN, Accra Metro

Secondly, parents with CwSN reported conscious and sustained efforts in seeking health care for their children. These efforts, in the opinion of parents, could contribute to getting cure for the children: A mother narrated:

‘I am taking him round looking for medicine. Whenever I get money, I take him to the hospital also. Apart from that I don’t allow do any hard work’
Parent, CwSN, Wa West

The third stream comprised routine activities that are common in parenting and nurturing such as feeding, bathing, and playing with CwSN.
Parents practice with children with disabilities

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Parent, CwSN, Wa West

The third stream comprised routine activities that are common in parenting and nurturing such as feeding, bathing, and playing with CwSN.

9.2.2 Challenges parenting CwSN

Some participating parents with CwSN expressed considerable difficulties and frustrations in caring for children with special needs. Some of these related to their inability to put the children in school.

Other parents had stopped working to devote much time and attention to their children with special needs. For instance, a mother who is a seamstress had to quit full time operations to be able to cater for the child. Her experience is captured in this excerpt:

*I was a seamstress apprentice, but her condition made me dropout, so I am currently selling items to cater for her. Yes, a lot of things. I intended to go to*
the nursing training college before I got pregnant. I decided that after I deliver, I can give the child to my parents and return to school but it’s two years already and I am still home because of the child’s condition. There are many challenges. If she were healthy, she could’ve helped me in selling so that we can get money to buy her needs for her but because she is not healthy, she’s always at my back and I am able to achieve little with her behind me.

Parent, CwSN, North Tongu

One mother expressed profound social and economic difficulties in parenting a child with disability. The child’s disability had affected her social relations with friends and almost led to being divorced by the husband due to the child’s disability:

Hmm! A normal child should start crawling at least after 7 months, but I did not see any sign of that with my child. I planned to kill her, but her grandmother asks me not to kill her because it was for a reason God gave him to me. His grandmother encouraged me for that thought to fade away.

Yes, my husband nearly ended the marriage because of that. Because he was thinking, there is no such thing in his family. Therefore, his family had to meet with my family, and they advised him that, there is no trace of such illness in either family. If he should leave the marriage, who is he expecting to take care of such a child for him? That is why my husband stayed in the marriage. It is difficult because you must feed, bath and do almost everything for her. She cannot do anything for himself, she is 8 age years now, a normal child her age should be able to at least sweep but she cannot do anything. She still wears diapers at her age.

Most of my friends have left me because of her. In addition, I cannot leave her behind and go out for any social gathering. Those situations have thought me a lesson in life and made me trust in God. Because I did not know, my child could walk one day. It about finance because sometimes what to eat is very difficult; it is only my husband that work, I would not know what would have happened if I were not staying with my mother. I sometime give my children food and go to bed on hungry bell sometimes.

Parent, CwSN, Accra Metro

Another parent with CwSN recounted her frustrations in terms of their inability to adequately cater for the child’s health needs. According to this mother, the financial cost of obtaining adequate care for the child was far beyond her ability. It is simply exasperating as can be seen the account below:

‘It’s just like I said, he doesn’t love to sit at a place. I do not want him to be leaving home so that other children would beat him up, but he won’t listen. That is what worries me a lot. Like I said, it is because of the financial problems that I usually take him to the pharmacy or drug store instead of the hospital when he is not well. I feel like I am not able to do exactly what I must do to him because financial problems. I go through a lot. It has made even me almost like a patient. I am facing a lot of sicknesses; this has made it difficult for me to be active in working like before. Currently, I am working with the Zoomlion but they don’t pay us
regularly. So, if we are faced with sicknesses, it really worries me, and I struggle to take care of him.’

Parent, CwSN, North Tongu

For others, they simply appeared helpless with unspoken regrets. In one case, the mother had been advised to consider termination/induced abortion due to obvious abnormalities detected through abdominal scans during pregnancy. According to this mother, she declined this professional counselling and now living with the “burden” of caring for a child with serious abnormalities. She recounted:

‘It is very difficult for me to talk about my child; my eyes are usually filled with tears when I talk about it. She is my first-born and I love her. When I was pregnant, I was asked to abort her, but I insisted to deliver her for her to become whatever she ought to be. I have finally given birth and it’s 1yr 7months yet still my child could not sit nor do anything. I am a young lady of only 28yrs. I must work to cater for her and her education. Who do I have to take her for me whiles I go to work? It is burdensome for me; anytime I think about it, tears fill my eyes and I don’t want to even talk about it because it’s giving me headaches. She cannot see and cannot talk’

Parent, CwSN, North Tongu

9.2.3 Teaching children with special needs

We interacted with teachers involved in teaching children with special needs. Accounts of teachers show that facilities in the respective schools are not disability friendly. Observation was the main tool that teachers deploy in identifying CwSN. Also, the general notions about community support for children with special needs in schools was negative except in one instance where a participant reported that the community nurse does routine sight screening for pupils.

Again, teachers generally agreed that school level support was below optimum. When there is any support at all, it emanates from individual teachers but not at the system level.

Teachers’ account revealed that they rarely punished—using corporal punishment on CwSN. They refrained from punishment primarily because they considered CwSN as delicate and sensitive and that they could entirely withdraw from school voluntarily due the punishment. Mostly, they resorted to counselling in correcting CwSN.

Interaction between CwSN and those without was sometimes unfriendly. Teachers had experienced instances where CwSN are teased and ridiculed by their non-disable counterparts. Teachers rarely received any support from other teachers in handling children with special needs except one teacher each in Wa West and Kwabre East mentioning their head teacher and a teaching assistant who assisted them from time to time.

Only one teacher reported pre-service training early childhood education. The rest, while teaching one or two children with special needs, had not had any pre-service or in-service training.

9.2.4 Discipline and punishment

Overall, parents with CwSN s used different means to discipline or correct their children when they go wrong. Among the frequently cited corrective approaches include corporal punishment (mainly beating), shouting, caution and speaking to children. The most frequent, nonetheless, remained beating. But even among parents who resorted to beating they storied that they corporal punishment is exacted in ways that do not cause harm but rather as deterrence. This narrative illustrates how parents with CwSN s executed punishment:

‘I beat the hand when she is at fault to show her that what she did is wrong’

Parent, CwSN, Kwabre East)
‘If he is doing something and I tell him to stop and he doesn’t stop I beat him. For instance, this knife he is holding can cut him so if I tell him to put it down and he doesn’t listen to me’

Parent, CwSN, KEEA

9.3 Parenting practices of mothers and fathers

This section of the report looks at parenting practices of mothers and fathers. We specifically look early stimulation strategies, child protection and safety, health, feeding and nutrition and aspirations for children and interventions for children to achieve parental wishes and expectations.

9.3.1 Early stimulation

Parents can engage in several practices to stimulate the intellectual, social, physical and emotional development of their children. We highlight some specific activities and interventions mothers have in place in stimulating children’s development. We also explore parents’ perspectives on enrolling children in early childhood school programmes. Children under six years learn significantly with gadgets such as Legos. Asking mothers with children in this age group, we found spatial gradients of some sort about availability of playing items for children. Whereas mothers interviewed in the Central, Northern and Upper West regions mentioned that children (0-6) played mostly with empty tins (e.g. of milk), mothers with children of similar ages in Accra particularly mentioned “modern” items such as football, computer, toys/dulls, and Legos among other things.
9.3.2 Correction, reinforcement of positive values and discipline

Mothers and fathers interviewed resorted to different approaches to correcting, reinforcing positive behaviours and disciplining their children. Both fathers and mothers were unanimous in using praise and congratulatory messages or gifts to children as the primary tool for reinforcing positive behaviours. However, about two mothers expressed opposition to praising children for
good deeds as they could become complacent. These participants further dialogued that their immediate social context contributed to this approach; it was to avoid being accused of over-indulgent by other community members. The view was that parents should be stern to children lest they become “spoilt” children. An excerpted view is shared here:

‘If I give her that thing, she will feel more pampered. So, at first, I used to tell her you haven’t done anything and that you haven’t done well. Hmmm, you have not done well. And she will say mum, it’s not true; it’s not true. If she tells me that, I feel very shy. And I will tell her that if I tell you have done well, you will feel pampered so… Yes, do you know…here, this area we are staying, if you are not strict on your child, if you don’t give your child good foundation, those behind will say you are too known’ Mother (6-9) yrs, Accra Metro

The data also shows that both mothers and fathers apply different strategies to correct deviant behaviours. Popular among these were beating/canning, withdrawing privileges, advising, shouting, warning. However, between fathers and mothers, the preference for beating was higher among the later. Box 2 provides an extensive illustration of a mother’s perspective on beating children as a form of correction.

In those, days when a child refuses to adhere to instruction, that child is punished. They will put a braided type rope in water and lash you with it. If you see the marks on your skin, and ask to undertake any task the next day, you will be hesitant to do it because you don’t want to be disciplined again. No, we don’t do that, ours is to discipline them by lashing them. Did you see me instructing the kids to stop making noise and they responded quickly. If it were to be someone, they will have been there. In our Dagomba culture, we don’t entertain that. Yes, that is the prime tool to discipline a child, lashing. Anyone who refuses to discipline their child is spoiling them; they will end up disrespecting them. That is what we learned from our predecessors and saw the characters of children who were disciplined by lashes and those who weren’t lashed and came to that conclusion. Those who weren’t lashed, their parents find it difficult to interact with them that are the real truth. Even in their lifestyle, those who receive lashes behave differently from their counterparts who were lashed. The difference is that, if children were to be here, I would have given you concrete examples in such children, but we aren’t outside, making it difficult to distinguish for your understanding . If a child who has received nurturing is passing as we sit, you will observe it. The well-nurtured child will bend and greet us, but the child who is not well nurtured will pass without greetings and doesn’t care. It is as result of counselling the child received at home from parents, asking them to respect elders and older siblings.

**Mother (15-19) yrs, Tolon**

Another popular approach mother preferred to use in correcting children was withdrawing certain privileges and most parents who withdrew privileges mostly mentioned denying/refusing child/children food and/or money. Among those who withdrew food, they generally viewed hunger as a key deterrence tool for children to comply with rules at home.

### 9.3.3 Child protection and safety

Here, the report focuses on parents – mothers and fathers child protection and safety concerns. The concerns that emerge from the data are broadly cultural and economic. First on cultural, whereas most mothers and fathers couldn’t pinpoint any specific cultural practices that expose children to risks, two mothers in Volta region and a father in Accra mentioned keeping wake/vigils for dead people as a key cultural phenomenon that compromised safety for children. At these wake-keeping or vigils, so many vices such as alcoholism and sexually seductive dances among other unacceptable concerns arise.

Relative to economic safety, most parents mentioned money or poverty. This reflected in two key ways; parents’ inability to afford the needs of
children and children’s own desires to engage in money making activities, albeit it unacceptable. Participating mothers and fathers cited the inability of parents to adequately provide the needs of children including feeding as well as exploitation of children for economic/financial gains. Some mothers and fathers dialogued:

‘In case the child is hungry and there is no money, the child can go and steal. So, there can be an influence. If the child wants money, and he or she doesn’t get, he or she can go and steal. Or that TV game that they play, he or she knows if he or she tells you, you will not give so he or she will go and steal the money so that is the problem worrying the children’

Mother (10-14) yrs., Kwabre East

We know Jamestown is a fishing community, are there situations where children are used for fishing?

R: Yes. Some children around my son’s age go for fishing; even 10-year olds. If you can come here on Sunday morning, I can even take you to the seashore to see the small boys who go for fishing?

M: Do you think it is safe for them?

R: It is not safe for them.

M: How?

R: How can a 12 or 13-year-old go for fishing, if anything happens at sea what can he do? It is not safe for them. Here, it’s hunger so it doesn’t make here safe for the children. They are hungry, they are hungry and when they see someone passing then they call the person and ask for 1 cedi or 50 pesewas. If the person is having, he or she will give you a man of God he will give you from the heart and if the person has a bad intention then the person takes something from the child.

Mother (6-9) yrs., Accra Metro

For children, some participants argued that it is children’s own desires to get money that raised safety concerns. According participants, children did this mainly through stealing and gambling and for girls, some engaged in transactional sex or prostitution. A mother of 15-19-year child surmised:

‘These children are already spoilt … these children will go to town and get money. They are just sleeping with men around. They don’t have any other work’.

Mother (15-19) yrs., North Tongu

Another child safety concern that was examined related to sexual abuse of children. Specifically, we asked parents the actions they’d take if their child were sexually abused by a family member, teacher and stranger. On all three, participants overwhelmingly tilted towards making a report to the police for appropriate actions to be taken against the abuser. However, few participants had different views, particularly if it involved a family member. Some participants – mainly mothers, contended that the first step would be reporting the perpetrator to the family/clan head to question the abuser’s motive.

Similarly, some participants would also report to
school authorities if it involved a teacher. Here, more fathers than mothers would take this course of action. Illustrative quotes from both mothers and fathers are shared in the following extracts:

‘Hmm, if man member of my family defiles my daughter, I know where to take him. As a family, we have head, so I will report him to the head of the family, to summon him to enquire from him what necessitated that act, if the suspect\culprit explains and the head of the family thinks that, it merits punishment in any kind, he applies the punishment. Or whatever the head of the family decides, abide by all of us as a family’.

_Mother (0-3) yrs., Tolon_

**R:** I won’t make it a police case because I gave birth to the child, but the teacher is the one who takes care of my daughter for me, so I will make sure I know the background of the teacher well before I decide to talk to him or what to do. There is a way you can talk to someone for the person to know that what he has done has really affected you.

Father (7-9) yrs., Accra Metro

As regards why some parents would not report to police if it involved a family, a father of Dagom-ba descent related a norm among the Dagombas, which prohibited pressing charges against a family member to the police. He advanced:

‘The best thing to do is to report him to the police, but we Dagombas, it’s a taboo to send a relative to the police station so we will settle it in the house’

Father (4-6) yrs., Tolon

9.3.4 Nutrition and feeding

The quality of food for children play enormous role in intellectual development and long-term health and development. In terms of the main source of information and education on child nutrition and feeding, all mothers interviewed indicated that they received nutrition education from health providers during antenatal and postnatal clinic visits.

We further asked parents the key considerations that guide the preparation of meals and feeding of children. The considerations were taste and preferences, food availability and ability to afford what children demand and nutritional content.
Mothers, who in the contexts of the study prepare meals for children, were generally conscious of considering the nutritional needs of children in menu preparation. This view was more recurrent among mothers who had children aged 0-3 years. For instance, some mothers with children 0-3 years remarked:

‘Food that contains a lot of nutrients because if the food isn’t nutritious, he would not grow well’
Mother (0-3) yrs., North Tongu

‘I consider the nutritional value. I always make diet using soya beans, and groundnut and fish mixed together’.
Mother (4-6) yrs., Wa West

For women who had early and late adolescent children, they were more inclined to consider the taste and preferences of children in menu preparation. However, this was dependent on ability to afford what children preferred. One mother commented:

‘Sometimes, I consider his preference but if I don’t have enough money, I tell them that the money is not enough, so we should manage Fufu or Ampesi’.
Mother (10-14) yrs., KEEA

Of fathers, the key considerations in menu preparation were appetite of child (ren), cost of food and food availability. About appetite, many fathers recalled deliberate attempts to make children part of decision-making making on menu planning. Fathers recounted doing this by inviting children to state preferred meals at scheduled times. One participating father shared:

‘Children mostly like rice so once in a week we ask them what they will eat. We vary our food but once in a week I ask them what they will eat, and they will say maybe daddy we want our mother to cook rice for us with macaroni’
Mother (6-9) yrs, Kumasi Metro

A few others however contested any need for considering the preferences of children in menu preparation. Proponents of this view held that so long as parents were providing for children, they should be content with what is provided till such a time they can provide on their own. One such mother illustrated:

‘No, we don’t do that, if you should take children preference into consideration before cooking, you can’t fulfil them. We look at what we have, that is why I said, and it differs from households. Considering the system now, you must assess your resources before you know what to cook. There is a saying that, “an animal looks at the mother’s mouth, before grazing.” You must live according to your limit. If you try to go beyond your limit, you will have yourself to be blamed and end up suffering. It is the same food you must eat. Refuse to eat the food, then, you have created a new path for yourself, and bent to suffer because you
have disregard what you parents can provide for you and wants to depend on yourself, which you can’t sustain. A child can’t want to eat it; the child must eat whatever is provided. There will be a period they will cook other food, which they want.  
Mother (15-19) yrs., Tolon

In terms frequency of feeding, there was no consistent pattern. Most children were fed on demand although few mothers fed children at random. From the observation data, the clearest indication was that most mothers fed children on demand. Depending on the age and ability children either fed themselves or with the assistance of mothers.

The environment of feeding mostly reflected the household circumstances. In the less “affluent” households, we found some children sitting on the floor while being fed. Some of the foods that children fed on during the period of observation showed little traces of protein content, which is critical to brain development and growth. As shown in the pictures below, children were feeding on rice only rice and tomatoes stew with no traces of meat, fish or egg.
9.3.5 How mothers motivate children to eat

Children, like adults, can have difficulties eating as expected. Mothers and caregivers may therefore rely on varied ways to motivate children to eat. We noted three broad means mothers apply in feeding children, especially when they are not willing to eat. These were singing a lullaby while feeding or changing the food or seeking medical attention/care. Of the three, singing was frequently mentioned than the other two. However, one mother indicated she would do nothing in such a situation:

‘There’s nothing I can do. For example, the available food is TZ, if the child refuses such food. I will leave the child to fate’

Mother (4-6) yrs., Wa West

All mothers with children 0-4 years gave indications about being educated on exclusive breastfeeding, particularly on the benefits of the practice. Some mothers could narrate certain specific benefits. Of the known benefits, an adherent mother in Accra said:

‘Okay. I will say that, when I gave birth to him, I gave him breast milk but when he reached 6 months then I fed him with food. ... Oh, it is good. It makes the child brilliant. Because if you give birth and you don’t feed him/her with breast milk there is no way he/she will be brilliant. It also makes the bones strong. It gives it strength. It makes the child immune to diseases. Eh-heh. And you must send him/her for immunization. That also makes the child very strong. And it prevents him/her from getting attacked by some illnesses’

Mother (0-3) yrs., Accra Metro

9.3.6 Parental support and aspirations

Regardless of the sex of the child, almost all participating mothers and fathers reported no gender differences in their aspirations for children. Generally, parents were of the view that children – both boy and girls had similar capacities once they are properly nurtured with some fathers testifying that their daughters were more intelligent than the boys.

As to what parents were doing to help children achieve their potentials, parents reported two key activities. First, several participants stated prayer as the main means they are using to help their children. Parents with shared this approach contended that everything was possible through prayers. Some excerpts are:

‘Hmm... Everything is just with God. Everything is just prayers’

Mother (15-19) yrs., Tolon

‘I always pray to God to let this happen in future and I have started saving money (for their future’

Mother (6-9) yrs., Lambussie

‘I’m praying for God to give me strength and long life so that I can administer their plans for me. I’m praying that God will let it come to pass’

Mother (7-9) yrs., Accra Metro
Another section of parents – mothers and fathers, mentioned academic support to the children. Here, most stated they primarily helped the children learn at home as well as paying school fees and providing school needs including buying books.

Fathers bonding with their children

9.3.7 Work-child care balance

In the last couple of years, childcare arrangements are changing – from generally sit-home mother care to complementary care arrangements such as adoption of house helps, support of mothers and in-laws, and early childcare centres. These arrangements allow women to participate fully in employment. We explore mothers’ notions about complementary care arrangements.
Mothers shared both positive and negative experiences with complementary care arrangements. On the positive side, mothers argued that complementary care arrangements helped in reducing their workload and managed their time properly. To these mothers, it’d would have been more difficult for them but for provisions for complementary care. One mother in Wa remarked:

‘Yes, it does help me a lot. It reduces my workload and makes me feel like me and my children are important’
Mother (7-9) yrs., Wa West

Another asserted similar sentiment:

‘Yes, it is. My work is tedious and may affect my child growth’
Mother (0-3) yrs., Wa West

Some mothers who had complementary care arrangements reported they could influence choices for their children if the career was house help. However, for those relying on their own mothers or mothers-in-law, they would not likely interfered either because they trusted their mothers to do the right thing or it was inappropriate to question the decisions and practices of their mother-in-law. A mother of a child 4-6 years in Wa retorted:

‘No, it is impossible to give instructions to your mother-in-law. Out of the respect for my husband, you dare not give instructions to your mother-in-law. Yes, after all she also does visit the clinic hence has knowledge regarding how to handle a child. Beside she works at the clinic’
Mother (4-6) yrs., Wa West

A participant in Kwabere East who was receiving complementary care from her own mother expressed confidence in the mother as follows:

‘With my mother, I do not say much because she has the experience of taking care of your children and I have seen her do a good job at that. Therefore, I always prefer to leave the children with her. For Akua, I do not stay long when I leave the children with her to take care of them, am mostly back from wherever I went within 30min time. I do not leave them with her for long’
Mother (4-6) yrs., Kwabre East

For other mothers, the benevolence of a complementary career should be given some space to care for children ways they deem fit especially they are also mothers. Instructing them on caring practices could be upsetting to complementary careers. Two participants asserted vehemently:

‘No, I cannot give rules or instruction to someone that has opted to help me. I can’t say like give him this food and that food? The person too has things to do; it is just help so dare not give him instruction’
Mother (0-3) yrs., Wa West

‘No and if you do that you make that person angry because she is also a mother and the way she will handle her children that is the same way she will handle
my children for me. Yes, I do let him know everything he needs to know before leaving them instruct him to let everybody do their duties in the house’

Mother (7-9) yrs., KEEA

Five mothers didn’t have positive views about complementary care, to the extent that some would rather not work than contemplate complementary. The notion was that complementary carers do not give individual children adequate attention, may not feed children at the appropriate intervals.

‘I don’t want to give the child to anybody. I want to bring up the child myself, and so I ignore the work. Even if it costs a lot not to work, I won’t do it. They don’t have enough time to look after their younger sibling in the manner I would like. Even with that, I don’t like it. I don’t like it like that (laughing). A lot worsens the child’s character. The way you train the child is different or special from how the house help does, so that spoils the child. Someone may be keeping a meal supposed to be given to the child, even when it gets to the time to give it he or she won’t, and the child will be crying. All these spoils the child. That is to mean the house help has no time for the child (translated)’

Mother (7-9) yrs., Kpandai

9.3.8 Sexual and reproductive health education

The adolescence period is marked by profound physical and emotional changes. Evidence93 shows that adolescents who receive adequate information and guidance on sexual and reproductive health care are able to avoid many sexuality fallouts (e.g. early sexual debut, multiple partnerships, early motherhood, unsafe abortion etc) that characterise the adolescent period.

Parents critical in transmitting correct comprehensive sexuality education to adolescents. We asked parents about their competencies in discussing ASRHR needs of adolescents’ proxy by how comfortable they are in providing information and education on reproductive health.

Mothers and fathers with adolescent children participated in this section of the study. Their accounts show that apart from one mother in Ashanti region who expressed profound discomfort in talking about sexuality issues due to the child’s age (10-14 years) and another who could but not the details of sexual intercourse, the rest affirmed they could. This self-efficacy was primarily linked to the fact that they were their own children, and nothing should prevent them from having such conversations. Of the mother who has some discomfort, her words were:

‘Sometimes I am shy when it comes to that, so I have never discussed it with them before. Yes, please because they are too young, I can’t discuss such issues with them. For her I do discuss but because we were talking about Strogad that is why. The one after me I talk to her about those kinds of issues. I can talk to her because we are not close, so I can talk to her’

Mother (10-14) yrs., Kwabre East

9.4 Adolescent mothers of children 0-4 years

9.4.1 Home setting

Almost all adolescent mothers who participated in the study reported living with some relatives with only one living independent of other family members. Family members adolescent mothers co-resided included parents (especially mothers), siblings, grandmothers, uncles or sometimes the relatives of the child’s father.

9.4.2 Support services for adolescent mothers

Most adolescent mothers recounted receiving support from the family members they lived with. Some also received support from the child (ren)’s father albeit small usually.

In order of prominence, adolescent mothers will usually seek advice on childcare from their mothers. Fathers, father of the child, in-laws and other relations were not widespread. One participant in Elmina reported to have no family relation of preference and would therefore consult some elders in the community.

Figure 20: Frequently mentioned persons adolescents will discuss parenting and other challenges

The preference for mothers was largely because of perceived experience in parenting and childcare. Again, participants profoundly acknowledge the financial and emotional support their mothers have provided. One participant in Adumakaase Kese (Kwabere East, Ashanti) recounted how her mother impressed on her to abandon thoughts of abortion and one other from Mepe said:

‘... Before I returned to school, she took care of my child. After birth of about one month, she came to advise me to take the child to school. And when I was ready and came to her, she didn’t reject me; she aided me to send the child to a preparatory school. She pays the child’s school fees and any other thing the child needs. When I wake up and I’m engaged in my morning chores, she bathes my child, so I also do well to cook for her to eat. She helps me financially and if I need anything, she does it readily for me!’

9.4.3 Considerations in menu preparation

Adolescent mothers, like adult mothers were generally conscious of appetite of children in

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menu preparation. According to the adolescent mothers, if they knew that child preferred a food, they either prepared it or gave that child money to buy whatever she liked. For instance, a participant from Jamestown said she would usually give the child money to buy her preferred food and another from MampongTeng added that anytime she saw that the son showed interest in anyone’s food, she prepared same for him to eat. Adolescent mothers interviewed also knew about the importance of considering the health of children in menu preparation. They frequently emphasized that they usually considered the nutritional values of the food and how it boosted their child’s growth before feeding. Throwing more light on this, an adolescent mother from Mepe (Volta region) said:

*When I was visiting the hospital, I was given a book, which taught healthy diets for a pregnant woman, nursing mother and her child... I learnt that the child should take in water only after six months. After that, he can take tom brown after 1 year. Around one and half years, you can give the child foods with palm oil, leafy vegetable and soft banku⁴. Those strengthened the child. You can also get honey for your child; but not too much, just about one teaspoon would be okay.*

In addition to these reasons, a few of the mothers also considered money available before they prepared any meal for child (ren). An excerpt of a mother from Elmina goes:

*I buy and mix Nan 1 with his meals, but it is not something I can afford all the time. When I don’t have money to buy Nan 1, he eats whatever normal meal I have prepared for myself.*

### 9.4.4 Practices to motivate children to eat enough

For the practices to motivate their children, many of the adolescent mothers said they would pamper their children, so they could eat to their fill. They further explained that they would buy a drink for that child since that would motivate him to eat; ask what the child wanted to eat so it was prepared for him; played or sung for that child to be happy so he could eat more of the food or in some instance, pleaded the child if that would make him/her eat more of the food.

However, others reported that they would do nothing. They thought since the child didn’t want to eat anyway, it was better to leave that child alone. Besides, one mother stated that her child would not eat anyway even if she tried force-feeding her. But two participating adolescent mothers Pinaa and Elmina communities resorted to force to get their children eat if they did not voluntarily eat enough food. For the former, she added that she usually supported the baby with her legs during feeding, so she easily held the baby’s nose and hands to force feed him if the child refused to eat. The latter said she held the child’s hands and forcefully put the food into his mouth, so the child could eat more.

### 9.4.5 Health practices

#### i. Child(ren) Birth registration

Except for one, all of them affirmed that they had registered their children. The one who had not yet registered the child attribute the occurrence to financial difficulties although did not know how it cost in registering a child.

#### ii. Growth monitoring

For the growth monitoring, almost all the adolescent mothers took their children for weighing. Many of those who responded said the weighing exercise helped them to know whether the child was feeding well and growing or not. However, not all of them followed through all the stipulated weighing sessions. However, about two adolescent mothers indicated they couldn’t comply consistently with all the required number of visits for their children – due to busy schedules and lack of support to doing so.

#### iii. Management of child ailments

When the adolescent mothers were asked how
they managed their children's illnesses, most of them resorted to hospitals even though they sometimes self-prescribed or bought drugs over-the-counter. Some participants from Ajumapese Kese and Lambusie admitted that they resorted to herbs to cure their children in addition to drugs from drug stores.

iv. Mother’s knowledge about immunization for child

Several adolescent mothers were aware of the need to immunize children although they were mostly unable to differentiate between the vaccines. They could therefore not tell exactly why those vaccines were administered. Only a few of the participants in this phase of the study did not know anything about immunization, so they hardly took their children for any form of vaccination. This is noted from narratives of some adolescent mothers in Elmina, Jamestown and Osu.

Figure 21: Health practices of adolescent mothers

9.4.6 Child care assistance options

i. Complementary care arrangements for children

About half of the adolescent mothers interviewed said they left their children with their biological mothers or were planning to do so since they were available to cater for their grandchildren, so they could either attend school or go to work. The remaining said they either left their children with some other relations including the child’s biological father, sister and grandmother; or would take their children to the kindergarten (KG).

For those who responded to the question of whether they had a say in how their children were catered for, many of them responded in the affirmative. The others said they could not tell their mother or any of the child(ren)’s care givers what to do. They explained that their mothers especially have been supportive since the birth of their children and had more experience than they did.

ii. Relationship with child’s father

Most of the adolescent mothers mentioned that the relationship between themselves and the child(ren)’s fathers was strained. That notwithstanding, some of their children’s fathers bore some responsibilities including sometimes giving them money for their upkeep and visiting as well as helping on school work of the children. However, most of them had no support from their children’s father. One of the mothers from Wechialu explained that her child’s father abandoned them and refused to take care of them when she delivered as his preference for induced abortion was ignored. Another from Mepe said the relationship with the child’s father had deteriorated over the period and shirked all his responsibilities because she confronted him over suspected infidelity. She narrated:

“We’ve been together for three years now, but I realized some odd behaviour in him. I heard he’s dating a different lady so when I asked him about it, he wanted to beat me up. ... He used to take good care of the child, gave us money and paid the child’s school fees but since last term, he’s not paid the child’s school fees. I paid myself. He hardly sends money home of late. He didn’t even tell me anything, he only called his mother that he would send the child’s school fees later but up to now, we have not received any money.’

For the few who still had strong bonds with the fathers, they regularly received financial support for the upkeep as well as showing keen interests
in the welfare and development of the child; regularly visited or spoke on phone or played with them anytime the opportunity arose.

9.4.7 Discipline

As shown in Figure 13, many adolescent mothers reported advising disobedient children or beat them when they err. Some others would ignore the child. Interestingly, almost all the mothers preferred to sit the child down and advise him against any vice as compared to beating the child or any other form of punishment known.

9.4.8 Child Safety in community

i. Safety of children

Participants from the different study sites mentioned different social concerns that made children unsafe. A participant in Adwumakaase Kese (Kwabre East, Ashanti) for instance, mentioned prostitution, gossiping, stealing and rape whereas the one from Mamponteng (Kwabre East, Ashanti) listed stealing, fighting, children begging for food as well as gambling in the locality. In Agona Abirem, a participant stated teenage pregnancy among girls and marijuana use among boys. In all instances, poor parental monitoring was mentioned. Fishing at the expense of education was a widespread view in Elmina. A participant in Elmina put it succinctly:

‘As for this place when you don’t go to school, you end up at the beach. My father never allowed us to go to the beach. Some of the children followed their friends to the beach and then become truants; instead of going to school they follow their friends to the beach. Some ask permission to go to toilet and then end up at the beach; and the more the child goes there the more he develops the interest in going there and then loses interest in going to school.’

However, at the mothers’ level, we observed that most mothers and fathers were profoundly prompt in responding to children in distress, including crying. Mothers and fathers will often inquire from children reasons for crying and will normally attempt to comfort them by being playful of telling children to ignore those bothering them.

ii. Economic conditions

For the economic conditions that threatened the safety of the children, most teenage mothers mentioned proximity of roads and highways to people’s homes, which could expose children to pedestrian vehicular accidents. Whereas we noted few of these settings (some children could only play in the streets), in most cases, we observed that children had enough space to play in and around household compounds. In Mepe, a participant was concerned about the impact of dredging a river on safety of children. She narrated an incidence where a child was drowned in the river due to increased depth.

9.4.9 Approach to handling sexual abuse

i. By family member

Most adolescent mother will take actions that did not directly involve the police if their child was defiled. One adolescent from Adwumakaase Kese (who reported being a victim of defilement in Primary five in which case no criminal charge was preferred against the perpetrator) would report it to her mother but could consider other alternatives if she was not satisfied with the solutions her mother proffered. Indeed, one other from Lambusie said she would leave the perpe-
trator to God since that person is family and so cannot do anything whiles another from Pinaa said she would prefer to fight that person instead.

### ii. By Teacher

With regards to the teacher defiling their children, about half adolescent mothers would report the case directly to the police station. Additionally, some others mentioned that they would prefer to inform the head teacher first but if no action was taken then they can go ahead to report to the police whiles the rest stated that they would drag the teacher to the chief’s palace. An adolescent mother from Adwumakaase Kese said:

‘As for that one, I will report the teacher to the headmaster and if the headmaster cannot do anything about it, then I will report the case to the police so that he will be dealt with.’

Regarding a stranger, just a handful of mothers thought the perpetrator should be reported to the police. The others were divided amongst reporting the case to the chief’s palace, elders in the community or their relatives. For those who will report to their relatives, they believed these relatives will act and report to the appropriate authorities. For instance, one adolescent mother from Tolon said she would report the issue to the grandfather who would forward to a higher authority.

### 9.4.10 Early Stimulation and Cognitive Development

Many adolescent mothers said they played with their children, even among those who were schooling or working. Almost all adolescent mothers did not tell their children any stories except two who did because they fundamentally believe children (0-4) years were too young to understand.

However, for those who did, they espoused the importance of it. According these mothers, stories afford children important life lessons to draw from when they encounter similar situations in real-life. Participants were not very much forthcoming with how stories impact on the intellectual curiosity of children.

### 9.4.11 Support, Stigma and Discrimination of Adolescent Mother

All the adolescent mothers reported being discriminated against at some point in time by the different groups of people such as community leaders, health workers, peers, parents and teachers.

For those who experienced discrimination and disrespectful treatment, adolescent mother was sometimes described in derogatory terms. In Jamestown for instance, one adolescent narrated that she’s seen as an emblem of shame to her parents by becoming a mother at an early age. Adolescent mothers are labelled as bad and undesirables in certain instances. One participant in Elmina narrated how her parents hid her at home almost the entire duration of her pregnancy for fear of condemnation by community members. However, some community leaders provided counselling and guidance to teenage mothers aside the discrimination they suffered. In two accounts, while participants conceded to not heeding advise against unsafe pre-birth sexual activities, their leaders discouraged them against abortion and encouraged them to return to school after delivery.

The accounts of adolescent mothers also reveal a mix of positive and negative attitudes of health workers. Although most recalled positive experiences in encounter with health providers, there were isolated instances where adolescent mothers felt discriminated by health workers. An adolescent mother interviewed in Osu recalled:

‘Health workers pointed fingers at me when I visit-
ed the hospital when I was pregnant. I was accused of poor upbringing at home that was why I got pregnant at that young age’

Another from Mepe added:

‘I was mocked whenever I took my child to the hospital. Sometimes when I wanted to ask any question at the hospital, they shouted at me so much that I was even afraid to speak up.’

Several adolescent mothers reported experienced discrimination from peers. These manifested in gossips, ridicule, or completely shunned their company. One adolescent mother elaborated on her experienced:

‘When I was even 5 months pregnant, it was not showing, and I was still going to school with it. When I went to do the scan, they told me I would give birth on May 21 before the BECE starts. So, I was confident that I could write the BECE but when I went to school, the boy had already gone to tell our mates that I was pregnant. When I got to school, they already knew, and they teased me a lot... So, I decided to stop the school because of the way they used to tease me; I informed my economics teacher and headmistress about it because I was no longer happy about going to school. But after my teachers and the head teacher sounded warnings to my classmates, the teasing stopped.’

Some other adolescent mothers noted they were simply avoided by their mates and had to terminate schooling entirely.

On the flip side, there were welcoming accounts of some adolescent mothers; their peers accepted them or probably did not hear any stigmatizing comments from friends. One adolescent mother shared that her friends were rather happy she had given birth and looked at her with admiration and wished they too were married with children.

In relation to attitudes of teachers, half of the adolescent mothers had not encountered any discriminatory signals from teachers—teachers rather advised them. Teachers often advised such girls to return to school or learn a trade after delivery.

9.4.12 Avenues for addressing social challenges

Almost all the teenage mothers interviewed said there were no avenues in their various communities to address the social concerns of adolescent mothers. Just about half of respondents were of the view that some social challenges such as men refusing paternal responsibilities for child care, rape or sexual victimization or parents refusing to take their children to school were usually addressed in the chief’s palace.

9.5 Adolescents 10-19 years

9.5.1 Self-Efficacy and Aspiration

Self-efficacy is known to have a strong association with assertiveness, health and problem-solving skills of young. We explored different perspectives of young people on aspirations and how they could be achieved. All the adolescent participants had a clear vision/dream of what they wanted to be in future. Participants aspired to be nurses, teachers, engineers, accountants, priests, lawyers, military officers, footballers, medical doctors, and mechanics among others.

To achieve these aspirations/goals, participants reported several personal interventions being used to achieve their goals. Of note were formal
education (serious attention to books and teachers), keeping good company of friends, courage (of joining military), and constant practicing (of football). Others added that with prayers, they could achieve their goals.

Adolescent participants raised several prospective challenges that could derail them from achieving their aspirations. These can be grouped into job-related concerns, personal weaknesses and familial difficulties (e.g. finance and parent-child aspiration conflict), injuries and accidents and metaphysical beliefs and fears (fear of witchcraft and spiritual retributions).

On job-related concerns, some participants mentioned that night shifts that nurses and doctors go through discourage them. Others also expressed fears about certain aspects of the careers they want to pursue such as performing surgeries among doctors.

Some adolescents expressed concerns about possible financial constraints in the course of pursuing their goals. This group of participants viewed finances as the major ingredient in shaping dreams. Eventually, one could be stacked and abandon dreams due to financial constraints e.g. in paying school fees and procuring relevant accessories.

Another section of adolescents who have aspiration of working in security agencies and being footballers were concerned about injuries either before or while enlisted into a football club or security establishment. For instance, an adolescent aspiring to be a footballer worried about sustaining an injury while another who hoped to be in the military was anxious about reprisal attacks by criminals and terrorists.

Some adolescent girls and a boy were disturbed about becoming pregnant and getting a girl pregnant. Participants of this perspective argued that this obstruction could arise from boys and girls own sexual desires or arise out of some financial need, which could expose a girl to trans-

If you are going to school and you don’t get money from parents/guardian, you might see a boy and request for financial assistance and he’ll in turn request for sex before giving you something which could lead to pregnancy.

Adolescent (10-15) yrs, Kpandai

The data also point to a metaphysical (of witches and voodoo) fear in hampering one from achieving their career or future aspirations. Here, the normative belief was that witchcraft could be used to detract one from pursuing a certain ideal future. Finally, we note from the data anecdotes of conflicts in parents and children’s career aspirations. Some adolescents argued that certain parents might impose their ideal career notions on children contrary to the children desire themselves. In such instances, some parents may be intransigent to the point of terminating financial assistance if the child did not oblige.
Adolescent responsibilities at home

Figure 23: A child grilling guinea fowl at Tolon

Figure 24: A child washing her bowl at Accra Metro

Figure 25: A child sweeping the front yard at Accra Metro

Figure 26: A child preparing lunch at Tolon

Figure 27: A child washing dishes at North Tangu
9.5.2 Parent-child relationships

Positive parent-child connectedness is documented to provide a positive nurturing environment for children, especially adolescents. It reduces significantly their risk of debuting sexual intercourse, drug use and school truancy. In seeking to understand the nature of relationships between parents and children in the study areas, we first explored for participants definition of an ideal father and mother. First on ideal father, adolescents’ views converged around father as a provider. For almost all participants, an ideal father should be capable of providing for the needs of his children such as clothing, feeding and school fees and accessories. Despite the overwhelming tilt towards ideal father as provider, there were other important affective elements, although sparsely mentioned. These affective ideals were patience, disciplinarian, caring (not abusive) and teaches children on manners and morals.

Contrary to the dominant notions of an ideal father as a provider, the ideal mother was framed more around affective domains and few others in terms of socioeconomic status of the mother (one likened her ideal mother to the MP of the community). For instance, descriptions such as a “a woman who doesn’t like trouble”; “a woman who does not like quarrelling”; “a woman is not reckless”; “a woman who is not hot tempered like my mother”; “a woman who is kind to her children and also loves people” and several others of similitude were constantly mentioned.

Again, adolescents’ fancied parent-child relationship was more inclined towards cordiality and affection. This entailed a relationship where adolescents could share their emotions and feelings without being reprimanded or rebuked. Simply, adolescents want parents whose arms are open, flexible, caring, and genuinely concerned about their successes and failures and could be confided in. Some narratives from an FGD among 15-19-year olds in Adumакааааase Kese (Kwabre East, Asante) were:

‘I expect her to be conversing with me so that I can pour my grievances out to her’. ‘The relationship I expect to have with my mother is one which I can sit at the dining table with her and eat together’
‘The relationship I want from my mother is the one which could make her get closer to me enough’.

The reflections and views of participating adolescents about the typical parent in their communities were diametrically opposite to the desired parent they wanted. Although this view was not universal, the voices that parents did not meet their idealised notions were resounding. Put differently, adolescent participants appeared dissatisfied with the parenting experiences in their communities. As illustrated in the excerpts below, the dissatisfaction of adolescents was a common theme in all the study sites, both urban and rural. Some of these excerpts are as follows:

‘The parents in this vicinity do not advice their wards. They only allow their wards to misbehave’.

“They back their children when their wards misbehave and so for the parents, most of them do not” advice their wards.
Adolescent (10-14) yrs., Kumasi Metro

‘Madam some are reckless, and others are not’.
 Adolescent (10-14) yrs., KEEA

‘Some of the parents are irresponsible’
 Adolescent (15-19) yrs., Accra Metro
 ‘Yes, they are not caring at all’.
 Adolescents (15-19) yrs., Accra Metro

‘Some of the parents they push their children into bad things’.
 Adolescents (15-19) yrs., Accra Metro
 ‘There are some parents who don’t know how to play with kids, they are always shouting at kids’
 Adolescent (15-19) yrs., Lambussie

‘They do tell us; for us as adolescent females, if you practice unprotected sex you will be pregnant’.
 Adolescent (15-19) yrs., Tolon

9.5.3 Needs of adolescents

As the adolescence period marks a transition from childhood to adulthood, it is characterised by an avalanche of needs. For instance, at the emotional level, adolescents tend to desire more freedom and independence of thought and action. It is also characterised by rapid burst of physical changes, which require proper cultivation to prepare them for the future. Investments in education and health (especially sexual and reproductive) are some of the key elements needed to prepare them for future responsibilities.

Our participants mentioned several things considered important needs. These needs are grouped into basic, emotional support, social needs and others categorised as secondary. Referencing basic needs, commonly mentioned ones included clothing (including for school, underwear and shoes), personal rooms/shelter, nutritious foods, health and toilet facilities at home and sanitary wears (pad/tampons). The prominent ones are summarised in Figure 16 below.

Adolescents’ topmost emotional need was love, parental support, positive influence (role models), counselling and encouragement. Others added that they want parents who true confidantes and would not be quick to judge them about sexuality concerns. Finally, some preferred praising for good deeds.
For those we categorized as secondary needs, computer/laptops and phones were commonly mentioned. Two participants mentioned needing means of transportation to school, preferably a bicycle.

To meet the diverse needs of adolescents, our participants mentioned different strategies that are used by some adolescents to meet needs. These approaches included borrowing ["There are sometimes we borrow from our friends and we do return them"], savings [], exchange of sex for money ["Girls of today in this area, they are dating fraud boys because of the money. Yes, money (laughter). Because they like dress, so when they see that that man is rich, they will follow him for money"], and support from family members [Sometimes if your uncle comes, he will give you money and if you get that money, you can save it] and teachers. Support of family members was more common among all participant groups.

9.5.4 Adolescents perception on discipline

As earlier alluded, the adolescent period is an era of emotional turbulence, self-recognition and sometimes fraught with identity crisis. Consequently, adolescents may resist and oppose certain forms of punishment from parents and other adults. We therefore explored adolescents’ views about punishment.

First, most adolescents recalled that parents in their communities employed beating to correct children. Other adolescents also mentioned advice and counselling while others stated withdrawing privileges (e.g. no food) from wayward children.

As demonstrated in the parental accounts, children are generally rewarded with gifts such as clothes and shoes, candies, and praises. However, adolescents expressed strong opposition and disdain towards beating but few will accept it provided they had erred. Parents, however, were spoken to the preponderant preference, when they went wrong.

We presented a scenario to adolescents to gain further insights into discipline and responsibility. The scenario involved an adolescent who over-stayed out in the evening under the pretext of catching-up on schoolwork from a friend’s home. We asked adolescent participants three key questions; what parents’ immediate reaction on his/her return will be, what should the child do on return, what the parents should have done while he/she was away and how best the parents and child can resolve the issues.

On the immediate reaction of the parents, many adolescent participants affirmed that the parents would be upset and will either scold, insult, shout or violently beat the child. Expressions such as “Immediately you reach home you will receive a very heavy slap”; “Your parents will beat you”; “Madam, they will insult him” and “they will beat him” were prevalent themes. Only a few talked about advice.

As to what the parents should have done while the child was away, adolescents were unanimous in responding that the parents should have gone to look for him or her. In terms of what the child should have done on return, all of the participants agreed that the child immediately apologize on return and for harmonious relationships to prevail, parents and child should sit down and discuss the issues in a more matured manner and show the child more love.

9.5.5 Media and phone use

Media pluralism and diversity, particularly those described as New Media (e.g. Facebook, Twitter, WhatsApp), is one of the defining moments of the 21st Century. Young people extensively drive design, development and use of the so-called new media. We therefore sought participants’ views on use, influence, and perception of positive and negative effects as well as parental concerns about new media use. Phone ownership and use was widespread among participants aged 15-19 years and also among 10-14-year olds in Accra and sparsely in other regions and districts. Most-
ly, those who owned mobile phones reported either their mums (usually) or fathers or other family members (e.g. uncles, siblings) acquired phones for them. Only four older adolescents (15-19 years) claimed or were pointed by other FGD participants to have acquired the phones on their personal accord.

Sources of phones for usage

![Figure 31: Sources of phones for adolescents](image)

In terms of use, the most widespread all the southern study districts were WhatsApp, Facebook, Instagram, Twitter and Google. We note, however, that participants in the Upper West and Northern regions appeared less knowledgeable about these new media. They tended to mention traditional media (radio) frequently than their counterparts in the south.

A prevalent influence of new media gleaned from the data is networking and connecting with old friends. According to those who spoke about networking, people are able to re-establish communication with friends and relatives whom it would have been difficult or impossible to connect again. Examples of narratives are:

‘Sometimes the person in question completed school with his or her friend but after completion, have not been able to see him or her and so due to this Facebook platform they can reconnect with each other’.

Adolescents (10-14) yrs., Kwabre East

“You can get to meet with a family member you didn’t know through liking and commenting on stuffs.”

Adolescent (10-14) yrs., Tolon

On the positive side, participants constantly mentioned building and cementing relationships as a major benefit of social media. Parents, siblings, uncles, nephews and friends alike could re-connect with relations easily at different times. Accounts of participants also demonstrate how social media could be used to further one’s education, research and job search. Related to education is the recognition that social media play a major role in broadening people’s scope by knowing what is happening in other areas. Some FGD participants in Tolon observed: “It can broaden your scope”, another added: “Things you never know about, can be learnt”.

Positive influences of social media

![Figure 32: Adolescents views about positive aspects of Social Media](image)

Adolescents were mindful of the negative effects of new/social media too. Predominant notions about negative effects of social media were stated to include exposure to pornography and sexual exploitation, distraction from school work, social and culturally unacceptable behaviours, fraud, hacking and scamming, copyright infringements (re-distribution of unauthorised materials), identity theft and intruding into people’s privacies
among others. Of all these, exposure to and use of pornography was a widespread recognition.

**Negative influences of social media**

Due to some of these potential negative effects of social media, adolescents know that their parents are concerned about increasing use of these platforms by young people. Among some known concerns of parents are about the amount of time adolescents spend on Facebook, Twitter, Instagram and others and how young people fund the data used on social media. For instance, an FGD participant in KEEA in Central Region recounted:

‘When I go to Facebook my mother thinks that I take her money to buy credit to bundle’

Adolescents (15-19) yrs., Elmina

To some others, their parents couldn’t simply appreciate and understand this generation’s unrestrained fond of social media and parents asking questions such as:

“My mother always questions me about what I get from social media”,

a participant in an urban FGD in Kpandai.

**9.6 Grandparents and Foster Parents**

The grandparents interviewed reported the number of grandchildren between one and fourteen. Economic difficulties, child abandonment, parental work-related issues, assisting and running errands for grandparents and death of biological parents were the main circumstances that led to parenting grandchildren. While some few children reside intermittently with grandparents – during school breaks, the most had been with grandchildren for three to eighteen years. For foster parents, they had lived with 1 to 7 children with at least one of these children been fostered and had lived with foster children for 2 to 12 years. Child fosterage among these participants was occasioned by death of one or both parents and the prospects of better material and educational support. Some foster parents considered child fosterage as a form old age social security. Only one foster child was engaged in child labour – the rest primarily undertook household activities and were mostly in school.
generational differences in parenting

Generally, grandparents did not point to much difference between on parenting then and now. Several grandparents noted that they are applying about the same measures and strategies used to nurture biological children and grandchildren. The data shows a tilt towards unanimity among interviewed grandparents signalling no differences in style in parenting biological children and grandchildren. A grandparent in Ashanti region noted:

‘For my grandchildren, I train them like my own children, even when their parents are come around, they don’t worry about anything because they know how I raised them when they were young. Before the all left the house, I raised all of them’

Grandmother, Kwabre East

While several grandparents and foster parents would admit to no differences in parenting grandchildren and biological children, some participants were conscious of differences in malleability of children then and now. For those sharing this notion, they argued that the current generation of children are more egalitarian, and difficult to regulate; they are less likely to accept instructions. One grandparent in Elmina (Central Region) agonized:

‘Yes, there are differences. In the past, when children are misbehaving and you look at them in certain way, just that look makes them stop... Children of today are different. When they are doing something wrong and you stare at them, they won’t bother, they will continue with what-

ever bad thing they are doing until they get hurt or something before, they realize they were misbehaving and then stop. Those days we could even use our legs to communicate with children to stop them from continuing with a bad act, but today, even when you signal them with your leg they are not bothered and keep on with whatever they are doing. So, children of today are more stubborn than children of yesterday’

Grandmother, KEEA

An alternative view to this assertion was that grandchildren could sometimes be more obedient than biological children given that such children consider grandparental care as a privilege that should not be abused. This was more the case if the biological parents are, by circumstances of economy or death, incapable of raising children. All but one foster parent concurred with this view, stating that there was rarely a difference between raising biological and foster children. To this view, parenting grandchildren or foster children under these circumstances could make children more sober, respectful and obedient. One participant in Kpandai (Northern region) described:

‘Yes please there are differences with you been a parents when you talk to your child he or she will talk to you back and so with your grandchildren they will look at the place they are and since they don’t have any helper they will humble themselves since they grandmother is their helper but to be sincere when I gave birth to my children and the way we related with one another made me very happy and whatever I say that is what they do and that is the kind of discipline and values I have instilled in my grandchildren’

Grandmother, Kpandai

A few grandparents expressed some level of caution in parenting grandchildren especially if the biological parent (either mother or father) were not alive. In such circumstances, parenting grandchildren required a lot of tact in order that children do not feel that they are being maltreated and that if their parents were alive, they would have been treated differently. Below is a remark by one a grandparent in Upper West (Wa West):
‘The difference is that, you cannot handle her in certain ways for the fear that, she might begin feeling the loss of her mom. Am also sure that, I handle her better even if her mom was still alive’

Grandmother, Wa West

9.6.2 Grandparents and early stimulation

Grandparents are instrumental repertoires of customs and traditions and transfer of the same to next young generations. Story telling is one of the major tools’ grandparents deploy in transferring customs to children and impart values and norms. Telling children stories are also a profound mental and intellectual tool for stimulating the minds of children. Grandparents interviewed tell stories to children on two accounts – on demand from children and when children request. Sometimes too, grandchildren seek clarification on stories they have been told in school. Indeed, a participating grandparent in Volta region was mindful of the intellectual stimulation of children. They narrated:

‘They say that in school so when she comes home, she will be laughing and be saying some. So, if it is not true or she doesn’t know all, I tell her. When she is saying some that is not true, I just teach her. When you tell these children folktales, it opens their minds in education. When she grows up, she will be a responsible citizen’

Grandmother, North Tongu

‘Yes. I do that. I tell all of them even those that were with us before they left. I tell them stories a lot. I tell them stories about things they are to do; because I want them to know old stories. Sometimes, I tell them some folktales and ask them to give me the meaning and if they are not, I give them the meaning. Just as I was also thought, I am teaching them as well. So that when I am dead, they can also teach their children’

Grandmother, North Tongu

9.6.3 Role of biological parents in children’s life

Two main issues are explored here; role of biological parent in the life of children and the relationship between child and biological parent and the perceived effect of this relationship on the child. All but two participants indicated that the relationship between biological parent and children was either good or very good. The only grandparent who reported ambivalent relationship attributed the situation to the fact that the child does not have enough time to play when with the mother. She stated:

‘When I ask her to go and visit her parents, she refuses. She will say she will not go. She wants to stay here which means she plays here and is happy here than that place’

Grandmother, North Tongu

As would be expected, all the participants who reported positive/good relationship between biological parents and children, they recounted very positive effect on the welfare of the children. A grandparent interviewed in Accra elaborated in-depth:

‘The one in abroad for instance, she always wants to call and ask how the child is fairing. And she told me that I shouldn’t be pampering him. You see. I shouldn’t be pampering the child. I should let him be bold. And that if I pamper him when he comes there, she can’t control him. You see. When she takes her to abroad, she can’t control him? He will be already grown. So, if he does something wrong, I should let him know what he did is not right. We don’t do it like this or like that. You see. So as for her she normally calls to ask and speaks with the child. We do video call so that they see each other. Even if I call her right now and talking to the child, she will say, grandma, I can’t see you. I can’t see you. Then I will tell her that mine is not video call but rather your mom’s own is the video call. With that you can see her, but you can’t see me. And Kim too, the one here with me, her mom is here with me. So, if I say something and she doesn’t want to follow the mother takes over. And also gets involve and if there is something, she also says it’

Grandmother, Accra Metro
Grandparents also recounted very active roles in the daily lives of the children. This view was more prevalent among grandparents who lived with grandchildren because of work and travel (out of Ghana) constrains to biological children. According these participants, the biological parents are prompt in providing the needs of children whenever necessary. Expressions such as;

‘they also do their best. They sometimes send us food from Akosombo and send us money. Maize, cassava dough and other things so they also support’

Grandmother, North Tongu

‘They treat me well. Sometimes, they send me something to look after the children’

Grandmother, KEEA were common in this group of respondents.

Among foster parents, only two of the seven interviewed gave indications about any active role of biological parents of children in their upbringing. In one instance, the foster parent was even giving material and financial support of the biological parents in support of their other children. Contrary to this notion, other grandparents agonized about the poor uptake of financial responsibilities of some biological parents. The widespread chorus in this participant group was that, biological parents had abandoned their provider roles and virtually everything was on them. Characteristic views included:

‘When they come, they do not even give a dime to her. They do not know about anything. Ever since I went for her, they don’t do anything, and I think because they know I do everything for her. I can sew dress for her, but the parents will not be aware’

Grandmother, North Tongu

‘The father of this boy is not even in the northern region here, he is down south, Accra to be specific. And now that he is in Accra, can I also say I would let the boy to suffer; no, I cannot. You know, women have human feelings for children than men, when a child is born, is the mother who would do everything possible to make sure that the child is healthy and grow up to be responsible

in future, men don’t care. We have not seen the father, not to talk of getting support or offer from him. I don’t even know the father; you can call the small boy to ask him about his father. I only heard he is in the south, Accra precisely’

Grandmother, Tolon

9.7 Perspectives of community leaders on parenting

Community leaders (e.g. chiefs, religious leaders, local political leaders), especially in towns and villages in Ghana wield a lot of influence over community level norms and practices. Chiefs for instance may be called upon to arbitrate conflicts and disputes between parents and children and among siblings or other non-related people. The implication is that they contribute to parenting in diverse ways, albeit indirectly. Understanding their views on existing parenting practices is relevant in shaping norms, policies and programmes on parenting.

Sixteen community leaders and twenty stakeholders from Department of Social Welfare, Domestic Violence and Victim Support Unit of the Ghana Police and Department of Gender playing formal and informal roles in parenting participated in this component of the study. To start with, the views of community leaders on the roles of fathers and mothers in parenting run vertical to the prevalent notions adolescent participants expressed; fathers as providers, and mothers as careers and responsible for translating fathers’ provisions into proper upkeep of children. Put differently, while fathers for instance purchase foodstuffs, mothers are supposed to make meals out of the stuff. Of fathers, some participants surmised:

‘When it comes to fathers, we know that the general role of a father is to give the child his/her basic needs.
That is food, water, education and moral support’

Community Leader, KEEA

‘Their role is to feed the children, clothe them, and help send them to school to educate them. Aha!

Community Leader’ Kpandai

‘Fathers, what we do are, after enrolling the child in school, any expenditure from the school of the child, you provide them. You buy the child school uniform, bag, pay the school fees, P.T.A level, sandals to wear to school and books. The woman can help in the settlement of the expenses, if she knows you the man do not have’

Community Leader, Tolon

While this was the generally accepted the roles of fathers, participants were not oblivious to some of the failings of a cross-section of fathers. One community leader remarked:

‘Most fathers are not responsible, so children’s training becomes a one-parent business. And in this community too, people has travelled from various places to settle here. So not all of the stubborn children are indigenes of the community. And because living along the coast comes with a good memory, many people love to live here; they are now living in ghettos here’

Community Leader, KEEA

Community leaders also added that mothers are responsible for upbringing of children in ways that are consistent with social norms and values. However, some community leaders were concerned that some mothers were failing on this responsibility. One opinion observed: ‘Just last three days a guy did something wrong here, but his mother defended him’. Community Leader, KEEA, however, the views about community leaders about mothers were positive.

On sociocultural norms that expose children to harm, the only new theme that emerges from the KII is concerns about child marriages and teenage pregnancies. Early marriage was reported by two participants in the Wa West with words that perhaps describe a widespread practice in the areas. Another concerning phenomenon that was reported in Elmina was norms that promoted early childbearing among teenagers. According this key informant, young women who have not given are treated with contempt and ridiculed for being incapable of reproduction. The extract below captures this as:

In KEEA, there are times some parents will tell you giving birth is a nice thing; its expands their family and they boast of their number of children and that makes them happy; there is this cultural something that when you are in your teens and you have not yet given birth they call you “Saadwi “, you are considered useless.

Child labour (e.g. fishing with young children), gambling, use of narcotic drugs, household poverty and prostitution of young girls are recurrent espoused by parents, adolescents and adolescent mothers.

9.8 Discipline and punishment

The first issue we explored in this section related to community leaders’ perspectives on whether between adults and children, the former was always right in disputes. The responses were mixed. While some thought that adults are always right, others argued otherwise. The notion of adults always being right was more typical among participants from the south compared to those from the north. As the narratives below demonstrate, a participant in the north – a Dagomba authoritative asserted:

‘We enquire from the two, to ascertain the truth. If it’s shows that the elderly man is not right, we tell him and let him know, if someone did that
to his son, how would he feel as a father. But if it otherwise, we tell the boy and warn him not to repeat that again. Even in the customs and tradition of Dagombas, if an elderly man and young boy has disputes and they bring it to the chief for settlement, after enquiring from the two people, the chief tell the person who is at fault. If it’s the elderly man who is at fault the chief blame him and if it’s the young boy, the chief warns him and apologizes to the elderly on behalf of the young boy.’

Community Leader, Tolon

The opposite of this position is captured in an extract from a participant in Accra:

‘That is the society’s view that if something happens and a child does something, even though a parent or an adult may be in the wrong, they say that you don’t have to judge an adult before a child so definitely they will condemn the child because they can’t compare the child with the adult. It will bring something like disrespect to the adult because if you go and try to correct an adult in front of a child, that child may not respect the adult.’

Community Leader, Accra Metro

Interviewed community leaders expressed diverse views about the prevalent means of punishing children in the respective communities. In some communities, beating was reported to be acceptable while in others it was abhorred. For those who accepted using canes on children, they rationed that it was a form of deterrence against deviant behaviours. However, due to emerging emphasis on child rights, this is changing, yet not helpful in training children. A community leader in Kpandai asserted:

‘Well to us in this area, we think that if the child goes wrong, he should receive some strokes of cane. But now both parents and teachers are crippled because of the human rights. The children even know it, that this time they don’t allow to cane us. So, you can’t even do it. So, everybody is now relaxed. All they can do is talk; talk, talk and then; they won’t change.’

Community Leader, Kpandai

Another community leader shared similar sentiments about the changing norms around child discipline:

‘With regards to punishment, these days you don’t see parents punishing their children. Even when the child is doing something, and it is like they don’t even take the pain to correct the child. These days you see young children running around doing things that will even hurt them, yet the parents look on then it is like they don’t care. It’s like it has become a norm and parents are not able to even discipline their children like the way our parents used to discipline us.’

Community Leader, Accra Metro

9.8.1 Intergenerational changes in parenting

Most community leaders accepted and pointed to certain observed inter-generational differences in parenting. The key areas of change were nature of disciplining children, and practices that upheld “positive” behaviours as well as perceived undertones of these changes. Narratives about changes in disciplined cantered on the incremental shift away from using canes on children both in the home and school settings. A clearly dissatisfied participant in Tolon brooded:

‘Talking about 10 to 20 years back, there were punishment, that were meted out to children who refuses or disobey their parents, but now parents cannot punish their children for disobeying them. So, the children do what they want, being it good or bad. The worse of it all is, with least challenge or provocation, the child elopes to Accra and you the parents don’t know Accra, left alone to say, you are going to Accra in search of your child.

Another change is that, in past years’, parents use to cane their children but now, you cannot cane your child, that the child is too young to be cane; courtesy child protection. You cannot give your child to marriage because; they said we should allow our girl child to go to school. So, if you give her to marriage, she cannot continue the school.’

Community Leader, Tolon
Another facet of change reported was in relation to marriage rites. Certain community leaders appeared frustrated about the fact young people are beginning marital relationships, usually cohabitation before proper marital rites are performed. Hitherto, proponents of this view, argued were not the case in the past. One religious summarised this view in the excerpt below:

‘Yeah, some of them have changed. Because marriage rites for example, before you realised your daughter is pregnant. And sometimes, the man will even say I am not responsible. The children can choose to go and stay with the men without the consent of the family. So where is the rite coming, only a few people still have this opportunity. Like in the church you have weddings and the normal, as for us the church we educate our people. You cannot have marriage without having gone through the marriage rites. And so, within the church; it is very key to ask which. We don’t allow our members to have such free-range kind of marriage.’

As can be noted from the preceding discourses, community leaders pointed to current dispositions that emphasised on child rights, which barred parents and guardians from corporal punishment. In fact, a participant in Lambussie district of Upper West laid the blame squarely on rights-based NGO who staunchly promoted child rights without commensurate emphasis on responsibilities of responsibilities of children to parents, teachers and other adults. Here is a narration of a participant:

‘Just like I mentioned, it is solely by reason of the nuclear families that extended families seems to be ceasing, and the intervention of some of this NGO’s that seek to educate so much on child rights forgetting of their responsibilities and all those things. There are some of the reasons that personally I can see they are also some the issues that parents raise’
Community Leader, Lambussie

9.8.2 Conflict resolution mechanisms

In all study areas, community leaders recounted the dual application of formal and informal conflict resolution mechanism. According to participants, police/courts are used if a matter has criminal dimensions and the magnitude of perceived criminality. They cited examples such as stealing and child neglect, with the latter being typical cases that would be reported to the police for further action while the former will be handled by traditional institutions such as chief palace. But even in using the informal route, people who felt dissatisfied reserved the right to further pursue their case with the courts/police and social protection institutions. Some community leaders in Wa and Tolon illustrated:

‘Yes, a certain boy run away with a girl to Kumas and when we heard the information, we immediately call for their return and they came. I interrogate them and beg the girl to go back to school, which she did, which was compliment by child protection agency. Both the formal and informal way of protecting the child is good. Even in this community when a child is having problems with his father or mother, the formal way is sometimes applied, which is through social protection agency and sometimes too are channel through the chief and his elders. Sometimes too issues are solved through police station’
Community Leader, Wa West

‘In this community, the chief, except some few occasions that the chief fail to settle the case and it can be reported to police, settles all cases. Even, before the case is reported to the police, the chief of the community have to transfer it to higher chief in another community, if the chief also fail to settle it, I then send to the paramount chief of the area to settle, and if the paramount chief too fail to settle the case, then the case is now reported to the police’
Community Leader, Tolon

Six out of nine community leaders who spoke to this issue, were of the view that people who apply both the traditional and formal conflict resolution
mechanisms tend to show satisfaction after pro-
ceedings but as earlier alluded, those who appear
dissatisfied resort to other forms of resolutions.

9.8.3 Common cases community and govern-
ment leaders resolve in communities

Typical cases community and government per-
sonnel usually handled revolved around child
marriages and/or teenage pregnancies, neglect
of maintenance and child abuse cases (physical
and sexual). Apart from cases that had criminal-
ities such as sexual abuses, all the others were
mostly resolved out-of-court as the first step.
Where no resolution is reached, then they could
recommend court proceedings. However, as so-
cial workers recollected, they were usually suc-
cessful. A Social Welfare Officer in Kwabere East
recounted a recent case managed:

‘Okay! I’ll talk about the case of child abuse as-
sault of a 9 years old child who was a girl. She
was brought from Mali to stay with a family
member, that’s, paternal grandfather. I was in the
office one day and a call came from the FM sta-
tion that a Child’s right is being abused and the
child has been locked in the room shouting for
help. So, the neighbours had to run to the scene,
when they got there, the room was locked whiles
the child was inside. This happened in an Islamic
community. Together with myself, the police, and
the media and the person who reported the case,
we quickly got to the scene and broke into the
room. We found the little girl with sores all over
her body. We questioned her, and she was like she
was accused of stealing GHC 60, which she knew
nothing of. So, her grandfather of whom she was
staying with placed an iron into fire and used it
on the girl ... So, the court asked that her grand-
father should be brought, and the man was sen-
tenced to 8 months in jail. The courts stated that
this man is off age that’s; 65 years and instead
of him behaving like “God” by taking care of the
child he is rather abusing their rights. The courts
then wrote a letter to the Mali embassy for the
biological parents to come but the report given
was that, the biological father of the girl is men-
tally ill so the mother came and the court handed
over their daughter to them and the social wel-
fare gave them the necessary documentation to
sign and the girl was handed over back’
Social Welfare Officer_ Kwabere East

9.8.4 Services to government personnel
provide to parents

District level government personnel (e.g. Social
Welfare, Ghana Education Service, DOVVSU etc)
interviewed also shared some insights into some
of the support services offered to parents. These
are counselling of parents who abuse children, post-
abuse rehabilitation, return to school counselling
and prosecution of persistently errant parents. On
counselling of abusive parents for instance, a social
worker in North Tongue discussed with us:

‘Yeah, we do it in a form of sensitization, in a form
of talks. We can invite the parent, opinion leaders,
or together with the community elders to talk to
the person concerned. Because if we think that,
we are going to talk to the person concerned, we
may have problems with him or her, so we try to
involve opinion leaders in such cases. Sometimes,
we even involve chiefs’
District Social Welfare, Tolon

9.9 Stakeholders views on
parent-child interaction

Most stakeholders were dissatisfied than not with
the quality of parent-child interactions in the
communities they operate. They attributed these
poor interactions to parental dereliction of duty
and responsibilities. Consequently, certain par-
ents are not aware of what is happening in the
life of their children. As a result, some children are
more comfortable confiding in their friends than
parents. In the perspective of one KII in
Mamponteng Social Welfare office;

‘Sometimes children have problems; they then
find it difficult in telling their parents but rather
with their peers. It will interest you to know when
some of these adolescent boys and girls come to
our department, the things they can tell us but
don’t feel comfortable telling their parents and
through our conversation between parents and
children. Let me give you an instance, we are
monitoring this kid at a juvenal home and any
time he tries to find his way out back to the com-
munity and then when the child is back the par-
ents will hide him; they refuse to inform the de-
partment that he’s come back. If the child goes
to commit an offence the parents will be like this
boy is giving us trouble. When we were interview-
ing the child, he told us that somebody in the
community gave him an odd ring that whenever
he is going to steal or rob he should put on the
ring that he will never be caught, this child has
been wearing the ring, but the parents haven’t
bothered to ask their child where the ring is from.
When the Probation officer questioned him, he
told us that it was Mallam who gave the ring to
him ... that whenever they go out to rob, he would
go and pay a percentage of the money to the
Mallam. The kind of relationship between parents
and children, others are cool, but some are not.
We suggest that parents should encourage good
communication skills with their wards’
DOVSU, Kwabre East

In a very gloomy rendition observation on par-
ent-child interactions, a Social Worker in Kpand-
ai submitted that some parents in the town ap-
peared to care more for their farm animals than
their children; they allow children vast latitude to
roam most part of the night without any regula-
tions. He observed:

‘Here the adults leave the children... because chil-
dren could move around in the evening till day-
breaks and the biological parents won’t care. Yet
they shepherd their animal; make sure they back
to the pen but not the same for children. You can
even come here and confirm in the night; you can
see, they can walk in the evening meanwhile, they
have homes. They will walk till daybreak; they will
not go to sleep’
District Social Welfare, Kpandai

These concerns by some stakeholders were not
uniform across all the study communities. In the
presence of timely interventions, some social
workers told of gradual changes occurring in par-
enting styles. In Tolon, the district social welfare
officer linked the changing parenting environ-
ment to ongoing child protection programmes.
He shared:

‘It is improving. When I say it is improving, some
communities, especially where child protection
programs exist, they are realizing that there is the
need for them to give attention to children, to let
children to also have a voice. But notwithstanding,
some communities still have a few challeng-
es. ... They relate well, they listen to them. But
some communities too, we still face a lot of chal-
lenges with regards to parent-child interactions’
District Social Welfare, Tolon

District Health Directors and Community
Health Workers
Health workers play crucial roles in supporting
parenting efforts of mothers and fathers and
other guardians, including institutional care
homes. They do this primarily by offering parents
expert guidance on health and nutrition, which
is key to growth and development of children. As
part of the secondary stakeholders, this section
of the report presents findings on perspectives
of district directors and service providers existing
capacities, expert views on health of children in
their catchment areas and interventions to
address health needs of children.

9.9.1 Capacity of health workers on early child-
hood development

Among the 10-community health workers (CHW)
surveyed, and most were community health nurs-
es with diploma as the prevalent level of
education. Most had worked for 3-5 years with
just few (2) reporting experiences spanning more
than 7 years. All conceded to having the basic
qualifications to deal with child welfare concerns.
However, those with additional capacity building
needs mentioned adolescent reproductive health
One thing I would like to talk about is the feeding, the feeding problem. When a baby is from 0 to 6 months, we encourage exclusive breastfeeding. And afterwards they will start with the family foods. And with that time if you don’t try your best to feed the baby very well, you will have these issues. And with this district or let me say Kpandai we are having a lot of infections. Most people will even build without toilets. So, most people will go outside to free themselves; and at the end of the day our water system is very bad. It will drain into our wells and we will go and fetch the same water in cooking. So, a child can run diarrhoea. And when it persists for a long time, this low weight we are talking of can come in. If the child is sick, I can’t eat. At the end of the day you won’t get the healthy child you want’

CHW, Kpandai

And on poor and ineffective/improper use of treated bed nets, others contributed:

‘For example, is malaria, when you tell them to sleep under the treated mosquito net, they don’t sleep, they will rather hang it in front of their doors’

CHW, Tolon

To help parents overcome the reported health concerns, health workers rely on counselling and education to support parents. These services are delivered through routine counselling sessions at static clinics, mobile outreaches including home visits and community durbars. In severe cases, they provide focus care for mothers and children. District directors reported that routine screening exercises were conducted for children, especially in identifying nutrition related problems – both under and over nutrition.

In pursuit of these important parental support services, CHW mentioned several additional resources that could facilitate their work effectively. Among these are regular in-service capacity programmes, and equipment and infrastructure (e.g. weighing scales, office space etc.) and financial incentives.
While routine in-service training was a major of CHWs, district directors reported that they used in-service training programmes to build the capacities of health workers to meet the needs of parents.

9.10 Teachers – KG

Teachers are instrumental in raising of children. In some instances, teachers spend more time interacting with children than parents. This is increasingly becoming the case of children whose mothers are in active labour participation. Some of these children spend more than 10 hours a day with teachers, especially in urban areas. Understanding the perspective of teachers on parenting practices is therefore important for policy and practice. The issues explored among KG teachers were classroom routines, physical appearance of children, intellectual development, and prevalent teacher-student/pupil interactive methods, and availability of support services for teachers. The section also explores school and classroom safety concerns as capacity of teachers to deal with students of special needs.

9.10.1 School and classroom realities

Teachers may employ different pedagogical methods to achieve their learning objectives. Teachers interviewed mentioned different classroom routines. Key among these were playing (with toys) and singing, reading and writing and general teaching.

Most teachers appeared concerned about the physical appearance of most children. They gave insights into the quality of dressing and general appearance of children in their classes. The main concerns of teachers on appearance related to dressing and personal hygiene (nails and hair). Teachers went further to assign common reasons underlying such observations. Of mention was inability of parents to procure quality school accessories for children and parents/guardians time constraints due to work commitment. About parents/guardians busy/time schedules, some teachers narrated:

‘The parents don’t have time for them. Here in Kumasi, most of the parents go to Kjetia so they make sure they go at dawn so by the time the child wakes up his/her money is on the table and whether you bath or not your mother is not there to take care of you so they just pick any dress they like, take their money and come to school. That is mostly the routine that means the parent did not even see the child coming to school. She will just drop the money and go but some parents to do well, they bring the kids before they go, some of them even come for their children when they close but for the others it is not like that’

School Teacher, Tolon

‘Most of the parents in the community are farmers. They do not have time to properly dress their wards for school. Some children come to school barefooted, others come wearing slippers, and some wear unwashed uniform for a whole week’

School Teacher, KEEA

But the narratives were not all negative about the physical appearances of children in school. Some teachers recounted positive experiences about how neat some children came to school on daily basis. For such children, teachers will agree that it is most probably due to parents’ ability to afford quality clothing for their children. Here are some remarks by a sample of teachers.
‘I realize some of them are neatly dressed from home while others are not. So it’s clear to me that some are from rich homes while others are not.’
School Teacher, North Tongu

‘Most of them in my class their appearance is okay but I have just 2 or 3 who have that problem...’
Kindergarten Teacher, Accra Metro

In respect of teachers’ assessment of the intellectual development of their pupils, most seemed unimpressed except few. Even for the two, the rated the intellectual development of children in their classes as okay. Some narratives of teachers are exemplified here:

‘I will say badly because, when the children come back to school the following day, they would have forgotten all what was taught. Yes, because about 90% of the children cannot recollect what was taught a day before. It is even worse now that we are on vacation; all what was taught have gone down the drain. What I have realized is that, the children in the community likes to play a lot and the parents do not act like parents in the city, whom will check for their children homework and help them solve it. The parents in this community do not have time for such things. Moreover, the parent perception is that, it is the teacher who has done everything’
School Teacher, KEEA

‘Haha! Some of the pupils do not even speak when you ask them question. They may know the answer to the question, but they will not answer, we have such pupils too. Those types of pupils you have to be patient with them, if you try been harsh on them, they end up coiling in. Some of the pupils too are very stubborn. Therefore, we have different characters in class, there some who are everywhere’
Kindergarten Teacher, Accra Metro

9.10.2 School health and safety environment

School environments can be hotspots of infection in absence of necessary health and sanitation interventions. We therefore explored the views of teachers on existing practices on health and safety as well as infrastructure to promote the same. Regarding sanitation, all schoolteachers admitted to availability of handwashing facilities. All teachers reported that their schools had toilets, but few had urinal facilities. They also mentioned that the toilets are kept clean.

With respect to health facilities, none of the schools reported having a school nurse or a sick bay. However, in most schools, they had first aid items to manage and treat basic health issues such as injuries. Again, some teachers reported receiving training in basic first aid. Teachers also accepted responsibilities for the health of pupils while and their care.

Generally, accounts of teachers indicate that classrooms are safe. This was more related to the quality of infrastructure and classroom seating arrangements. On the contrary, two teachers in Upper West, Wa West and Lambussie reported that their classrooms were not safe. They shared:

‘We don’t have safety classroom environment at all. We don’t have furniture to sit and learn. We don’t have structure to sit. We move about’
School Teacher, Wa West

‘The safety of classroom arrangement is poorly done because there is no furniture they sit anyhow’
School Teacher, Lambussie
Almost all teachers shared that school equipment and supplies for schools are safe. All materials are kept in school offices. Teachers used several approaches to commend (e.g. gifts) and punish (e.g. use of canes or weeding plots) to reinforce positive behaviours and values in pupils.

9.10.3 Early childhood education

Participants interviewed were generally aware of the concept of early childhood education. They knew the prospects of ECD for the intellectual development of children. However, none of the interviewed KG teachers reported having been trained on ECD neither did anyone knew about the national guidelines on ECD.

9.10.4 Challenges with Early Childhood Education

Teachers reported two core challenges of ECD education; instructional materials and inability of pupils to participate in classroom activities (e.g. writing). Between the two, however, teaching and learning materials (TLM) was the most frequently mentioned. One teacher in Kwabre East described the situation as thus:

‘We don’t have so we improvise and even the tables and chairs that they will sit on is even a problem, even work books are not coming, apart from a few UNICEF donated; the government doesn’t give us any work book, parents must buy and that is the problem. If a parent knows that the child will come to school and wouldn’t have to buy books that parent will let the child come but if they are to buy books and the parent doesn’t have the money to buy it, he/she will allow the child to stay in the house, so that one too is a problem’

School Teacher, Kwabre East

9.10.5 Teachers preferred support from parents/guardians

Teachers’ expected/envisioned three forms of support to pupils both at home and school. At school, teachers will be happy to have parents visiting students from time to time. They also wanted parents to provide pupils with relevant school materials and accessories and finally, they wanted parents to assist children revise more at home. The following three narratives reflect each of the three expectations of teachers:

‘If parents can provide their kids with what they need and correct them I think that it will be the best’

School Teacher, Kwabre East

‘What I would wish for is that, parents visit their children in school and know how their children are faring’

School Teacher, KEEA

You know they said, education starts from when the child is born, when the child is born ‘education starts from there. And I don’t know whether parents are supposed to be called, even when you call them, they will not come. So those who come, we tell them we train the child in the school, in the house so that when they come to school it will be well, always, it is only 6 hours they are in the school after that they are in the house ‘

School Teacher, Kpandai

‘That is a big problem, we sometimes give homework’s and the children would return with the
work undone because the child could not find someone to help with the homework. However, when you do not give assignment or homework, the parents would come complaining, therefore, we keep giving the assignments while the assignments are not done’

Kindergarten Teacher, Accra Metro

9.10.6 Teachers support for cognitive development

Teachers play considerable roles in cognitive development of children. However, the approach and process is not uniformed. Children with hearing, sight, self-care and recall may require different interventions to come to terms with efforts of teachers. Teachers recounted personal experiences of pupils with one or another difficulty and the approaches they deploy to getting along with pupils. These included repeated pronunciation of words and concepts while the teacher gives the pupil with difficulties dedicated time, variation in teaching methods (e.g. varying teacher-cantered and student-cantered methodologies).

Some teachers narrated:

‘The child in my class who doesn’t hear well, when I finish teaching all of them and I give them work to do then I attend to him alone’

School Teacher, KEEA

‘I have one girl like that. She stays close to where I stay, when we close from school and we come home she plays too much so when I teach them, and I ask them the day everyone will say something, but she alone will not remember. So, when we close from school, I make her go home and go and change and come to my place and I give her some colouring or drawing to do but now of late when I call her, she doesn’t come’

School Teacher, KEEA

All the ECD teachers interviewed admitted to using storytelling as part of their pedagogical approach and this was done virtually on daily basis. Storytelling, music and dance were resorted to particularly when teachers notice that pupils are tired and fatigued.

In terms of pupils’ language of preference or what pupils were more comfortable in communication, all participating teachers mentioned the predominant local languages in the study areas – termed L1.

The use of technology in teaching was less frequently mentioned. Only three of the sixteen teachers reported some use of technology. These technological devices were computers and TV. While technology is less frequently used, all teachers aptly recognized the immense benefits of using technological content to aid pedagogy.

9.10.7 Engagement of boys and girls in teaching and learning.

The narratives of teachers point to practical inclusive approach to teaching and learning in respect of the sexes. Every teacher interviewed shared that both boys and girls are assigned tasks without consideration of gender. Tasks such as sweeping and cleaning classrooms and school compounds, group assignments were allocated without gender concerns. Assessment of pupils work also followed non-gender discriminatory trajectories. Some excerpts from teachers are:

‘Okay, they are rated equally. I could call female or male to clean the board. Both genders do the sweeping’

School Teacher, Wa West
‘They do things together. At times we put them into group and give them the same activities to do. The girls compete against the boys and get the best. In such cases the classes become hot, interested and lovely’

School Teacher, Wa West
10.1 Understanding of parents and caregivers and care among children and children with special needs

Almost all parents with CwSN recounted that children’s disabilities developed after birth. In seeking to understand the causes of disabilities, most had utilised health services, but some few others had consulted deities and spirits to either get cure or know the reasons or who was the cause of the disability. The probable late detection of disabilities gives an indication of low coverage of early screening programmes as envisaged in Ghana’s Disability Act.

For most parents, particularly mothers, parenting CwSNs could be extremely stressful, causing some disruptions their usual life courses (e.g. terminating full time work) as well as strained social and marital relationships (threats of divorce due to child disabilities. The implication is that parents are either not utilizing existing services (e.g. special schools) although very limited resources for children with special needs or service providers (e.g. social welfare) are not fully reaching out to parents with CwSNs.

Parents with CwSN claimed credit for three things; providing suitable academic environment for children through home tuition, regular care-seeking activities (some, to the extent of seeking alternative traditional care), and general routine parenting activities such as feeding, bathing and playing with CwSN.

Community perceptions about children with special needs were couched in sympathy, indifference and abnormality. We note that these views and expressions about CwSN were not unidirectional – they were shaped by relationships and contexts. While in some communities, people could show open disapproval of CwSN due to myths and misconceptions about CWSNs, in others they are accepted. Indeed, suspicions of pretentious sympathies are observable from the narratives, but most narratives leaned towards genuine sympathies others showed.

10.2 Notions of care, safety and protection of children and adolescents

Whereas parents with children aged 0-3 years hailed the considerable benefits of early childhood education on children’s intellectual development, they do not on their own engage in early stimulation activities such as storytelling to their children; they randomly played with their children from their narratives and only a few reported their children played with modern gadgets such as logos, tablets, toys and computers. Put differently, early stimulation practices did not seem particularly extensive apart from singing to chil-
Accounts of mothers and fathers revealed that funeral activities such as wake-keeping, poverty, fishing, begging, Internet fraud (Sakawa), transactional sex (among girls) and vehicular movements exposed children to considerable risks in their respective communities. Adolescent mothers shared similar concerns on these matters. Mothers and fathers shared varied views about how they will handle sexual abuse of children. Overall, there was high preference for involving the police in dealing with child with sexual abuses. Nevertheless, sexual abuses perpetuated by family members could be handled a little bit leniently, less harshly with teachers but more harshly with strangers.

Resolution of disputes and conflicts in communities occur at two levels – formal legal institutions (e.g. courts and police) and informal structures operationalized at chiefs’ palace and “courts” of other community gatekeepers. The latter is considered the first point of call for matters not too grave while matters seen as weighty are left to the state to handle through the courts and police. Of such weighty matters were rape and murder among others and community leaders and stakeholders (e.g. Social Welfare and DOVVSU) accepted the right for one to escalate matters when resolutions in the informal institutions are not satisfactory.

10.3 Recognition of care, feeding, physical, cognitive, social, emotional needs and safety of adolescents

Both fathers and mothers considered appetite, nutritional value of food items and affordability or availability in menu preparation. Yet, few parents thought that the views of children should be shrugged off in decisions on menu; allowing them such a say will be tantamount to “spoiling them”. Narratives of adolescents appear to show disconnect between their worldview of ideal mothers and fathers. Two words sum adolescents’ expectations of ideal mother or father – affectionate for mothers and provider for fathers. However, mixed adolescents’ notions were, it swayed more towards dissatisfaction of fathers and mothers they observe in their communities. Not surprisingly, adolescents repeatedly mentioned emotional support as one of their major needs.

Community leaders accept the traditional roles of fathers and mothers – the former as provider and the later as homemaker. However, community leaders concede that many fathers were failing on provider roles, putting more stress on mothers. Parents who discussed sexual and reproductive health with their adolescent children focused extensively on abstinence and few talked about maturation and physical changes. Other important SRHR contents such as emotional changes, and interpersonal skills (e.g. sexual negotiation) were never mentioned. This may reflect extent of parental knowledge on the core elements of sexuality education.

Although adolescent mothers reported having a say in complementary care arrangements for their children, it was less so when the career was their own biological mothers; they would not question the caring practices of their mothers. However, stigmatization and discrimination of adolescent mothers seemed prevalent in all the study communities but there were positive indications about promotion of second chances; some community leaders and teachers constantly urged adolescent mothers to return to school after delivery.
10.4 Stakeholders’ understanding of gender and caregiving

Parents – mothers and fathers were gender neutral in relation to what aspirations they had for children. The popular view was that both boys and girls have equal capacities/abilities in achieving whatever they set out to do with proper guidance and nurturing. Cognizant of these, either parents were supporting the academic work (providing school supplies and paying fees) of their children or praying for them to achieve their potentials. Positively, the accounts of teachers show that both boys and girls are treated equally in classwork, school compound activities (e.g. cleaning) and assessment. Teachers’ frequently mixed boys and girls in classwork activities.

10.5 Views about discipline at home

All parents interviewed showed considerable consciousness about the positive role of correction and discipline in reinforcing positive values in children. However, the tools of exerting positive values varied among parents. Corporal punishment (beating), gifts, withdrawal of privileges, and counselling/advising were used at one time or another. However, fathers preferred talking to children out of negative behaviours while mothers seemed more inclined towards beating and withdrawing privileges including food.

While some community leaders felt that corporal punishment was an important and acceptable corrective measure in their communities, others thought the norms around the practice is shifting towards rejection. For instance, there were accounts of some parents openly confronting teachers who meted out corporal punishment on their children.

Adolescents’ preference for discipline and correction was guidance and counselling than shouting, scolding, and withdrawal of privileges, which, unfortunately, were common methods of parents in their communities.

10.6 Use of interventions to support parenting

Accounts of all categories of mothers showed high utilization of government and non-governmental interventions to support parenting. Among these services investigated included birth registration, child growth monitoring services, knowledge of child immunization requirements, and patronage of formal health services in managing child health problems was prevalent among adolescent mothers. Mothers recalled that knowledge on these services were acquired mainly during ANC visits. However, adolescent mothers utilized these services at lower scale due to stigmatization, discrimination, disrespect and abuse of service providers.

On education, the narratives show that parents view ECD education programmes highly. However, teachers were either poorly equipped to deal with ECD education pedagogy or lacked the relevant materials relevant for stimulation of children.

10.7 Media use, community views about parenting and parental aspirations for children

WhatsApp and Facebook are common modern media platforms adolescents relied on for information, and connect with friends and in some few instances, for job and educational opportunities. With adolescents spending more time on these platforms, parents were rightly worried.
Adolescents will benefit immensely from education programmes on responsible use of social media.

Many community leaders felt that the parenting landscape in this generation is changing in terms of how parents exacted punishment and disciplinary interventions. The predominantly corporal punishment is effacing amidst increasing emphasis on child rights but less emphasis on responsibility of children. These were attributed to the increasing involvement of NGOs communal living.

All parents interviewed had one or another aspiration for their children. These aspirations centered around supporting the children to achieve their educational and career goals. A remarkable finding from the data is that while some parents seemed to have an “ideal” career and professional aspirations for their children, they generally conceded and accepted children’s agency in choosing what they felt capable of doing. They are supporting children achieve these aspirations by providing for their basic needs and with prayer.

10.8 Knowledge of service providers on care, feeding, physical, cognitive needs among children

Community Health Workers (CHWs) generally felt capable of dealing with some of the basic issues earmarked for primary health care providers. However, most felt incompetent in dealing with adolescent health concerns, of which they would require further on-the-job training interventions.

Health stakeholders note malaria, nutritional deficiencies and diarrhoea as the predominant child health concerns in communities they work. In their views, poor sanitation, poor compliance to ITN use and poor feeding practices (on account of food availability and skills in food preparation) are main drivers of poor child health.

A mix of opinions about the physical appearances of children are reported in the stories of teachers – while some children appeared healthy and neat, most teachers did not share this sentiment. The underlying causes, teachers perceived, were parents being busy with work commitments or inability to afford basic needs of children for school. Teachers report of intermittent support of NGOs in this direction but, like the proverbial Oliver Twist, more was needed.

Most teachers were not impressed with the academic work of their pupils. In their assessment, most children are not able to recall previous lessons, hardly spoke in class and submitted assignments as required even when parents have complained about the low frequency of homework’s for pupils. There is suspicion of low parental involvement in academic work of students. Consequently, a major assistance that teachers expected from parents is showing keen interest in the school work of their children by providing for the school needs of children as well regularly visiting their children during school hours.

Another finding is that in all the schools that teachers were sampled; water (for handwashing) and toilet facilities were available. However, there were sparse accounts of dedicated urinals for pupils and teachers. Another school level deficiency especially with those in early childhood education programmes is limited availability of stimulating activities and gadgets for children to play with. Although some teachers had CwSNs in their classes, most had no pre-service or on-the-job experience in teaching and managing children with special needs. They usually identified such children through casual observations. Teachers will require in-service interventions in honing their skills in dealing with special needs children to advance the quest for inclusive education.
Parents and caregivers showed understanding of children with special needs and other special needs. However, some demonstrated anxieties and stresses parenting children with special needs due to certain prevailing myths and misconceptions about children with special needs and apparent lack of appropriate and adequate services for children with special needs.

Parents, caregivers and stakeholders recognized the cultural, economic and social conditions that could compromise the safety of children in their communities. Funeral and its related activities, especially wake keeping, was a constant matter of concern in all the study communities and among secondary stakeholders too. Depending on locality other activities like child labour (e.g. fishing along the coastal areas), teenage pregnancy, sexual exploitation of girls and perhaps boys, and gambling/Internet fraud and betting games were also seen as threats to children's safety.

Parents and caregivers (adolescent and adult mothers and fathers) are conscious of using state institutions (e.g. courts and police) to address child sexual abuses, but when it involves family members, the inclination to address it leniently exists. With sexual abuses more likely to be perpetuated by people family or kin members, children who suffer sexual abuse may not get the needed protection and could be repeatedly abuse without appropriate sanctions.

Parents and caregivers resort different strategies in addressing feeding, social, health and emotional needs of children. Feeding is driven extensively by children’s’ appetite, affordability/availability of food products and health needs. Few exceptions remain – that allowing children a say in menu preparation will be tantamount to over-indulgence and could make children “spoilt”. Early stimulation activities such as storytelling are less frequent among biological parents and the use of modern equipment (e.g. toys, logos, tablets etc.) to play was not widespread, regardless of maternal age, being adolescent or old.

Grandparents play both “direct” and complementary parenting roles and are more inclined to use storytelling as a stimulating activity for children. Grandparents did so directly or served as reference check for children on stories told in school. Mothers who had their own biological mothers supporting child care expressed considerable confidence in the ability of their parents (grandparents) to offer acceptable standards of care than “others” (e.g. house helps) providing complementary care.

Mothers, fathers, adolescents, and teachers admitted to the importance of discipline and correction to the sound development of children. The methods, however, differed; rewards - gifts and praises are common across participant groups; mothers were more inclined to use corporal punishment than fathers – fathers abhorred extremes of corporal punishment and most thought their physical strengths as men did not support beating children as they could be hurt. They’d rather talk to children. Adolescents prefer affectionate
counselling and guidance of parents and teachers and other adults to shouting, scolding, and beating.

It is worth noting that most parents with adolescent children will be comfortable in discussing SRHR issues but were also concerned about age-appropriateness and seemed to lack capacity in many aspects of sexual and reproductive health education for adolescents. Discussions with adolescent children often took the form of cautions and more fear-based than developing interpersonal skills of adolescents. Interpersonal skills are a major known maker of adolescent girls delaying early sexual debut for instance – they can negotiate for delayed and safe sexual practices.

Service providers – especially health care workers have reasonable capacities in addressing ECD needs of children. However, the output of CHWs will be enhanced with further capacity development activities, especially on adolescent health. For health leaders at district levels, key ECD care delivery gaps are related to the spread and distribution of health personnel as well as infrastructure.

The narratives of teachers demonstrate limited capacities in identifying and screening children with special needs/disabilities and have barely any specialised skills in teaching pupils with special needs and disabilities.
12.1 Ghana Health Service

* Inter-sectorial approach to communication and data generation:
Adopt inter-sectorial approach to communication strategies to address issues on stigmatization of children with birth defects, sexual and reproductive health related issues to effect change among stakeholders such as community members, leaders, children and teachers.

* Capacity Challenge:
The GHS should work closely with the Ministry of Education and the Ghana Education Service to build capacity of the staff on the Information Education and Communication (IEC) materials used by the various departments at the community levels.
- Build capacity of health professional on inter-personal communication with adolescent mothers
- Strengthening the adoption of adolescent health programs with emphasis on the Safety net and adolescent health corners

* Data Management:
The GHS should expand the health screening initiative, build a strong database for programming.

* Costing and budget of C4D activities and included in the various departments budget and initiate:
budgetary provision should be made for C4D activities. This should be included in the various departments budget to enhance implementation of planned ECD initiatives.

12.2 Ghana Education Service

* Medical Screening:
The Ministry of Education and the Ghana Education service should develop comprehensive communication packages/tools to influence key stakeholder (parents/caregivers, teachers, churches, mosque and community leaders etc) to become aware that in order to raise healthy and confident children they must get their wards screened when enrolled in school.

* Generation of Data:
Data generated from the screening exercise must be used as basis for advocacy at the national level for policy change and used at inter-sectorial level for different interventions and programme. Making data available will also contribute to what key messages to give and the right audience to target.

* Communication campaign:
There should be strong advocacy efforts on dealing with stigmatization of children with special needs. Slogan : ‘Abnormality is normal’
12.3 Child Protection and Community Development

* Scale up of Child protection community tool kits beyond districts:
Intensify community engagement on the prevention of child abuse, neglect and exploitation using the existing tool kit.

- Build capacity of officials who engage the community members to be able to handle cases of family members who abuse children.

* Scraping of cost element of reporting of abuse:
The government should eliminate charges for producing medical report on child victims. The National Health Insurance Scheme (NHIS) could be made to cover such cost. In order words all cost related issues for complaints from abused households should be absorbed by the state (e.g. securing of birth certificates as proof of age).

* Parenting styles should be promoted at the household levels:
There should be sensitization on alternative forms of discipline as against corporal punishment, which appeared popular in households.

* Management of breastfeeding:
The GHS should communicate clear messages to parents on how to manage the transition from exclusive breast-feeding to a proper balance and nutritious diet.
13.1 The objective of the communication plan

The objective of the communication plan presented here is to serve as a guide to stakeholders in support of national- and community-level communication interventions to drive change. This communication plan should be read in conjunction with the main report on the formative study.

As a result of the findings as presented in early chapters, there are four key behaviours we seek to promote among Ghanaian parents, children and key stakeholders.

13.2 Communication Strategy

The strategy is situated in the Socio-Ecological Framework of UNICEF which posit that in order to understand individual behaviour development and social transformation, the entire ecological system – the interconnected influences of an individual’s social environment: family, peers, community, institutions and society need to be considered. This model was effectively used in exploring the main research questions underpinning the formative study on parental practices and forms the basis for developing communication approaches for this strategy. It has direct and practical implications for communication planning and programming for it underpins the logic of behaviour and social change decisions and communication strategy development based on levels of influence.

The inner circle represents the core or primary target group. The communication addressing this level seeks to bring about positive individual behaviour change and social change with collective groups at the community and societal level.

The middle circle represents groups of key influencers, the secondary participant groups who can provide a supportive environment and engage those in the inner circle toward the desired change through social mobilization.

The outer circle represents the participant audiences for policy and structural change and resource allocation. To effect long term change and for impact and sustainability of development programmes and service delivery, policies, political will and resources need to be mobilized through advocacy with leaders and decision- makers who have the power to create policies, programmes and structures and to allocate resources96.
key communication approaches

behaviour change communication (BCC): Behaviour change communication aims to bridge the gap between information, a person's knowledge, attitudes and subsequent behaviour. It is an interactive process, for developing messages and approaches using a mix of communication channels in order to sustain positive and appropriate behaviours.

Behaviour change communication has proven to be more effective when complemented by well-planned and implemented advocacy and social mobilisation strategies and envisages social change and individual change as two sides of the same coin.

Communication channels used for the BCC communication are mostly Information Education Materials (IEC) materials. They are a quick way to reach a large number of people. This form of communication typically leads to 'awareness raising' of an issue, and serves to reinforce existing knowledge and practices, such as the importance of hand washing, but this may not necessarily lead to changes in behaviour. IEC materials include radio public service announcements in print form, posters, leaflets, brochures, videos, flip charts, banners, and promotional items like T-shirts and badges.

Communication for Social Change (CFSC): The CFSC approach focuses on moving towards collective community action and long-term social change and away from individual behaviours.

The purpose of social mobilisation is to bring together relevant inter-sectoral partners to determine needs and raise awareness for an objective. It involves the identification of organisations, institutions, groups, networks and communities who can contribute their efforts and resources.

Social mobilisation helps build the capacity of these mobilised groups in the process, so that they are able to mobilise resources, plan, implement and monitor programme activities with the community. This approach should support actions and priorities identified by communities, especially the most vulnerable groups whose rights tend to be consistently denied. Social mobilisation activities should stem from community action but must receive support and coordination services.

Communication for social change included the following channels:
- Interpersonal communication (drama and role play and community group activities)
- Community mobilization (community meetings, community events and skill enhancement trainings)
- Mass media (print, radio, television)

Social Mobilization: Is the process of engaging a wide network of partners, stakeholders and allies around a common cause. It provides a supportive environment for individuals and families to change or reinforce

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97 Communication for development-strengthening the effectiveness of the United Nations
98 Communication for development-strengthening the effectiveness of the United Nations
99 UNICEF ROSA 2006: Behaviour change communication in emergencies: A toolkit
100 UNICEF ROSA 2006: Behaviour change communication in emergencies: A toolkit
desired practices. Social mobilization partners include communities (community mobilization); civil society organizations, organized networks and associations, the media, religious groups and individuals who can influence change.

Social mobilization strategies used were, mobilization through community influencers, traditional and religious leaders, community groups and community NGOs/CBOs.

**Advocacy:**
Advocacy is directed at different levels of decision makers - people who have the power to create policies, programmes and structures and to allocate resources. By persuading decision makers to decide in favour of a cause, advocacy seeks to develop, change or modify an existing law, policy and/or administrative practice that would enhance the practice of good behaviour. It is a continuous and adaptive process of gathering, organising and transforming information into arguments.

These arguments are then communicated to decision makers, to influence their choices to raising resources (human and financial) or demonstrate political or social leadership and commitment to a situation. The goal of advocacy is to influence leaders and decision makers at different levels to make it easier for affected communities, families and individuals to make healthy choices for their own physical and social well-being. The results of advocacy—a legislative framework, policies, resources and structures that provide the enabling environment for behavior and social change.

**Media Engagement:**
National and local print media- print, radio, television the internet and telecommunication are valuable allies in communication strategy. Establishing effective partnerships with media executives, managers, journalists and reporters including from local radio and TV, cable TV stations and local newspapers, social media sites and mobile phone companies is important for implementing the communication strategy.

Managing media relations, involves the internal capacity to:
- Prepare and execute a media plan;
- Organize and conduct media briefings and media conferences;
- Produce and distribute timely press statements, press releases and other media materials;
- Coordinate responses to media enquiries and respond promptly;
- Support spokespersons with accurate messages and materials

We present the behaviour change guide for the communication plan addressing all four identified behaviours in Table 9 at the Appendix.

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101 UNICEF ROSA 2006: Behaviour change communication in emergencies: A toolkit
Table 1:
Summary of research questions by objective area

<table>
<thead>
<tr>
<th>Research Objective</th>
<th>Objective Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the understanding of parents and caregivers vis-à-vis care among children (biological and non-biological) and children with special needs?</td>
<td>X</td>
</tr>
<tr>
<td>What is the recognition of the care, feeding, physical, cognitive, social, emotional needs and safety of the child?</td>
<td>X</td>
</tr>
<tr>
<td>What is the recognition and notion of care, safety, protection of young adolescents and children in 10-18 years?</td>
<td>X</td>
</tr>
<tr>
<td>What do parents, caregivers and different stakeholders do and how do they behave with regards to care and feeding, physical, cognitive, social and emotional needs, protection and safety of the child (0-6 years)?</td>
<td>X</td>
</tr>
<tr>
<td>What do parents and different stakeholders understand about gender – the social and cultural expression of attributes and opportunities associated with being girls and boys or women and men? How does this impact their caregiving?</td>
<td>X</td>
</tr>
<tr>
<td>What are the views of different stakeholders including children about disciplining at home and what is their understanding of the effect of violence in the home – between parents, with siblings and with children of 0–18 years?</td>
<td>X</td>
</tr>
<tr>
<td>What are the different government and non-government schemes/services that support parenting? What do different stakeholders know about these different schemes and services and what are the barriers/motivations why parents don’t use/continue using these schemes?</td>
<td>X</td>
</tr>
<tr>
<td>What, in the opinion of different stakeholder, influences or shapes parenting and parent-child interaction – media, community role models, parental aspirations for their children, etc.?</td>
<td>X</td>
</tr>
<tr>
<td>What is the level of knowledge of service providers’ vis-à-vis the care, feeding, physical, cognitive, social, emotional development aspects and needs among children, including children with special needs?</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 2:
Study locations

<table>
<thead>
<tr>
<th>Region</th>
<th>District(s)</th>
<th>Communities</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper West</td>
<td>Wa West</td>
<td>Wenchawu and Verempari</td>
<td>High concentration of UNICEF interventions</td>
</tr>
<tr>
<td></td>
<td>Lambushe Karni</td>
<td>Lambussie and Plina</td>
<td>High concentration of UNICEF interventions</td>
</tr>
<tr>
<td>Northern Region</td>
<td>Kpando</td>
<td>Kpando and Leseni</td>
<td>High concentration of UNICEF interventions</td>
</tr>
<tr>
<td></td>
<td>Tolo</td>
<td>Tolo and Toli</td>
<td>High concentration of UNICEF interventions</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Kwabre East</td>
<td>Mampongtau and Aduwamakasi Kese</td>
<td>Low concentration of UNICEF interventions</td>
</tr>
<tr>
<td>Volta</td>
<td>North Tongue</td>
<td>Bater and Mepe</td>
<td>Low concentration of UNICEF interventions</td>
</tr>
<tr>
<td>Central</td>
<td>Komenda-Edna-Eguafo-Abirem</td>
<td>Elimina and Aguna Abirem</td>
<td>Low concentration of UNICEF interventions</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>Accra Metropolis</td>
<td>Osu and James Town</td>
<td>Low concentration of UNICEF interventions</td>
</tr>
</tbody>
</table>
### Table 3: Target population, data collection approach, sample size and sampling technique

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Geographic area from which participants are selected</th>
<th>Mode</th>
<th>Number of interviews/focus groups per geographic area</th>
<th>Number of geographic areas</th>
<th>Total interviews/ focus groups</th>
<th>Individual data points</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>National Volunteers at Ministry of Education, Gender and Social Protection, Health and Interior</td>
<td>National</td>
<td>IDS</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Regional</td>
<td>Domestic Violence Support Unit of Ghana Police Service</td>
<td>Regional</td>
<td>-</td>
<td>2 DO/GSU, regional commanders</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>District</td>
<td>District Health Directorate - Nutrition and Children’s office</td>
<td>District</td>
<td>KII</td>
<td>8 (1 per district)</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Department of Social Welfare/Department of Women</td>
<td>District</td>
<td>KII</td>
<td>4 Social Welfare Staff (1 per district)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Domestic Violence Support Unit of Ghana Police Service</td>
<td>District</td>
<td>KII</td>
<td>4 DO/GSU District commanders</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Community</td>
<td>Mothers/Care-givers of children 0-3 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Mothers/Care-givers of children 3-6 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Parents of children 0-6 with special needs/birth defects, development delays</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Mothers/Care-givers of children 6-9 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Mothers/Care-givers of children 10-14 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Mothers/Care-givers of children 15-18 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Observations, Photovoice</td>
<td>-</td>
<td>16 observations/photovoice – 2 per district</td>
<td>8</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Grandparents living with children 10-18 years</td>
<td>Community</td>
<td>IDS</td>
<td>16 parents/caregivers (2 in each district)</td>
<td>8</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Community leaders (e.g. Assembly members, Unit committee members, traditional leaders, religious leaders – pastors, imams, female human rights members etc.)</td>
<td>Community</td>
<td>KII</td>
<td>10-20 participants from 6 districts</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>School teachers (teacher, kindergarten, primary, junior high and secondary schools)</td>
<td>Community</td>
<td>KII</td>
<td>-</td>
<td>8-10 participants from 4 districts</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Early Adolescence (10-14)</td>
<td>Community</td>
<td>IDS</td>
<td>-</td>
<td>16 IDS in 6 districts</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Older adolescence (15-18 years)</td>
<td>Community</td>
<td>FGID</td>
<td>-</td>
<td>8 FGID, 1 per district</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Children - 4-year old</td>
<td>Community</td>
<td>Participatory Rapid Appraisal</td>
<td>-</td>
<td>16, 2 per district</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>56</td>
<td>328</td>
</tr>
</tbody>
</table>
Table 4: Locations of interventions across the 10 regions.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Intervention</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ashanti</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brong Ahafo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eastern</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater Accra</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Northern</td>
</tr>
<tr>
<td></td>
<td></td>
<td>North East</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper East</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper West</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Western</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Western North</td>
</tr>
</tbody>
</table>

- **McGESTES**
  - Right of the Child
  - Re-entry
  - Safe School
  - Screening

- **Community Development**
  - Child Protection
  - Community Health
  - Sanitation
  - Social Drive to protect children, neglect, exploitation and abuse

- **Social Welfare**
  - Child and Family Welfare
  - City Care
  - Foster Care
  - Justice for Children
  - Livelihood and Steertern
  - Residential Homes

- **Department for Children**
  - NCDs
  - All initiatives

- **Ghana Health Service**
  - USAID
  - Maternal and Child Survival
  - The programme also focuses on early brain stimulation to enhance cognitive development of the child

- **Maternal Care**
  - Malnutrition Management
  - Infant and Young Child Feeding
  - Integrated Management of Childhood Illness (IMCI)
  - Growth Promotion
  - JICA Maternal and Child Health
  - Continuous Care (CaC)
  - Child health record book
## Table 5: Initiative description

<table>
<thead>
<tr>
<th>Ministry/Agency</th>
<th>Initiative</th>
<th>Description of Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoE/GES</td>
<td>The right age enrolment at KG (leave no child behind)</td>
<td>Ensure children are enrolled at the right age of four/five at kindergarten and six years at primary one including those with special needs and ensure retention</td>
</tr>
<tr>
<td></td>
<td>Re-Entry Initiative</td>
<td>To prevent pregnancy among school girls and facilitation of re-entry into school after childbirth</td>
</tr>
<tr>
<td></td>
<td>Safe School</td>
<td>To drive the agenda of safety of the child to make the educational institution or environment safe for children</td>
</tr>
<tr>
<td></td>
<td>Medical Screening</td>
<td>Screening for new entrants for early identification and detection of children with disability for early intervention</td>
</tr>
<tr>
<td>Community Development</td>
<td>Alternative Livelihood Programme (ALP)</td>
<td>Build capacity for trade opportunities in 18 districts across five regions and educate the youth on dangers in illegal mining</td>
</tr>
<tr>
<td></td>
<td>Other on-going campaign activities (Child Protection)</td>
<td>Uses policy objectives by the government through NDPC each year to engage with communities and also on the following issues in the communities:</td>
</tr>
<tr>
<td></td>
<td>Community Health</td>
<td>Child Protection (with a tool kit to sensitize communities on abuse and exploitation)</td>
</tr>
<tr>
<td></td>
<td>Sanitation</td>
<td>Community Health Sanitation</td>
</tr>
<tr>
<td></td>
<td>Social Drive</td>
<td>Social Drive promotes and protect children, neglect, exploitation and abuse</td>
</tr>
<tr>
<td>Social welfare</td>
<td>Child and Family Welfare</td>
<td>An initiative to protect children from all forms of violence, abuse, neglect and exploitation and to ensure an effective coordination of the child and family welfare service at all levels</td>
</tr>
<tr>
<td></td>
<td>Day Care</td>
<td>To support working parents to care for their children (0-3 years) while at work</td>
</tr>
<tr>
<td></td>
<td>Foster Care</td>
<td>Provide capacity building for individuals who are willing to support children who otherwise would have been found in orphanages</td>
</tr>
<tr>
<td></td>
<td>Justice for Children initiative</td>
<td>Ensures children are given correctional direction in family tribunal courts and borstal institutions where young offenders are kept.</td>
</tr>
<tr>
<td></td>
<td>Livelihood and Streetism</td>
<td>An initiative to provide alternative care for children in the streets</td>
</tr>
<tr>
<td></td>
<td>Residential Homes</td>
<td>A family-based intervention for children who require care and protection. Children are placed at residential homes in the interim until the cases are fully investigated after which children are either placed under adoption, re-integrated or foster care. These are mostly children who suffer from abuse. These are either orphans, parents with mental challenges or abandoned child.</td>
</tr>
<tr>
<td>Department for Children</td>
<td>Child Welfare policy review</td>
<td>Is to protect children from all forms of violence, abuse, neglect and exploitation and to ensure an effective coordination of the child and family welfare service at all levels</td>
</tr>
<tr>
<td></td>
<td>Justice for Children policy review</td>
<td>This ensures children are given correctional direction in family tribunal courts and the borstal institutions where young offenders are kept.</td>
</tr>
<tr>
<td>Ghana Health Service</td>
<td>USAID Maternal and Child Survival</td>
<td>A global maternal and child survival programme that targets 0 to 5-year-old children. The programme integrating ECD simulation activities into the routine duties of health officials. The programme also focuses on early brain stimulation to enhance cognitive development of the child which was absent in the GHS routine</td>
</tr>
<tr>
<td></td>
<td>JICA Maternal and child survival programme</td>
<td>A global maternal and child health programme that built CHPS compounds focusing on the building of the systems already in place at the CHPS. It built a strong supervision and support systems with supportive supervision at the district levels and facilitative supervision to the CHPs. Focuses on preconception with emphasis on the first 1,000 days. The project developed a life course approach to health care at the national level with stakeholder engagement.</td>
</tr>
<tr>
<td></td>
<td>CHPS for Life</td>
<td>Child care records that contains all data of the child in one record book that serves as a guide for health professionals for child care, community engagement, etc.</td>
</tr>
<tr>
<td>Continuous Care (CoC)</td>
<td>Medical Screening</td>
<td>Screening for new entrants to identify those with disability challenges for early intervention</td>
</tr>
<tr>
<td></td>
<td>Maternal Care</td>
<td>An anti-natal care for a period of eight months. A service delivered by the unit after one month of a lady missing her period. Urinal of the pregnant lady and BP are check on a regular basis to prevent the mother and baby from any challenges. This prevents death of mother and child during pregnancy and at child birth. Thus, reducing maternal mortality rate</td>
</tr>
<tr>
<td></td>
<td>Malnutrition Management</td>
<td>Rehabilitation of malnourished children</td>
</tr>
<tr>
<td></td>
<td>Infant and Young Child Feeding</td>
<td>Is an initiative that promotes breast feeding of children 30 minutes to an hour after delivery. Promotes exclusive breast feeding for six months of the child. However, the children are to be fed with breast milk for two years. Since the milk in the breast reduces after six months, complimentary feeding is introduced. Nurses are trained to guide parents in feeding children with breast milk and the complimentary foods in terms of quantity, quality and feeding intervals.</td>
</tr>
<tr>
<td></td>
<td>Integrated Management of Childhood Illness (IMCI)</td>
<td>IMCI is an integrated approach to child health that focuses on the wellbeing of the whole child. It aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age. It includes both preventive and curative elements that are implemented by families and communities as well as by health facilities. In summary, the IMNCI strategy includes three main components: Improving case management skills of healthcare staff.</td>
</tr>
<tr>
<td>Ministry/Agency</td>
<td>Number of Interventions on ECD/Adolescence</td>
<td>Initiative</td>
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<td>----------------</td>
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</tr>
<tr>
<td>1</td>
<td>4</td>
<td>The right age enrolment at KG</td>
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<tr>
<td></td>
<td></td>
<td>Re-Entry Initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safe School</td>
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<tr>
<td>2</td>
<td>4</td>
<td>Screening</td>
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<tr>
<td></td>
<td></td>
<td>Alternative Livelihood Programme (ALP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other on-going campaign activities</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>Child and Family Welfare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day Care</td>
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<tr>
<td></td>
<td></td>
<td>Foster Care</td>
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<tr>
<td>4</td>
<td>2</td>
<td>Child Welfare policy review</td>
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<td></td>
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<td>Justice for Children policy review</td>
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<tr>
<td>5</td>
<td>8</td>
<td>USAID Maternal and Child Survival</td>
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<tr>
<td></td>
<td></td>
<td>Continuous Care (CoC)</td>
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<tr>
<td>Ministry/Agency</td>
<td>Number of Interventions on ECD/Adolescence</td>
<td>Initiative</td>
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<tr>
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<td></td>
<td>Medical Screening</td>
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<td>Maternal Care</td>
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<td></td>
<td></td>
<td>Malnutrition Management</td>
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<td></td>
<td>Infant and Young Child Feeding</td>
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<td></td>
<td>Integrated Management of Childhood Illness (IMCI)</td>
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<tr>
<td>Ministry/Agency</td>
<td>Initiative</td>
<td>Main Target population</td>
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<tr>
<td>Community Development</td>
<td>Other on-going campaign activities (Child Protection, Community Health Sanitation, Social Drive)</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>ALP (piloted in 18 districts in five regions on illegal mining)</td>
<td>Galamsey Miners</td>
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<tr>
<td>Department of Children</td>
<td>ECD Initiatives</td>
<td>Parents and caregivers</td>
</tr>
<tr>
<td>Social Welfare</td>
<td>Child and Family Welfare</td>
<td>Children (0-18)</td>
</tr>
<tr>
<td></td>
<td>Day Care</td>
<td>0-3-year old</td>
</tr>
<tr>
<td></td>
<td>Foster Care</td>
<td>Orphans</td>
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<td></td>
<td>Justice for Children</td>
<td>Juveniles</td>
</tr>
<tr>
<td></td>
<td>Livelihood and Streetism</td>
<td>0-18-year-old</td>
</tr>
<tr>
<td></td>
<td>Residential Homes</td>
<td>Children who suffer abuse, neglect and orphans</td>
</tr>
<tr>
<td>GES</td>
<td>Right age enrolment</td>
<td>Children aged 4 to 5-year-old</td>
</tr>
<tr>
<td></td>
<td>Re-Entry</td>
<td>Pupils/students from primary 4</td>
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<tr>
<td></td>
<td>Safe School</td>
<td>School Children Teachers</td>
</tr>
<tr>
<td></td>
<td>Screening</td>
<td>New entrants from K/1 to Primary 3</td>
</tr>
<tr>
<td>GHS</td>
<td>Growth Promotion</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>Integrated Management of Childhood Illness (IMCI)</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>Malnutrition Management</td>
<td>Parents</td>
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<tr>
<td></td>
<td>Maternal Care</td>
<td>Parents</td>
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<tr>
<td></td>
<td>Medical Screening</td>
<td>KG Pupils</td>
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<tr>
<td>Ministry/Agency</td>
<td>Initiative</td>
<td>Communication Approaches</td>
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<tr>
<td>1 MoE/GES</td>
<td>The right age enrollment at KG</td>
<td>Radio and Television commercials, advertisements, orientation sessions for 47 districts</td>
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<td>Interpersonal Communication (IPC) such as Sensitisation at Town Hall meetings, community engagement, community</td>
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<td></td>
<td>Re-Entry Initiative</td>
<td>radio &amp; community Information centres (CIC)</td>
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<td>Radio, Use of Boys and Girls Clubs to raise issues in the policy guideline through drama, role plays, durbar etc to educate parents and communities</td>
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<td></td>
<td>Safe School</td>
<td>Introduction of one box that restricts students in accessing educational materials online</td>
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<td>Introduction of E-base</td>
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<td>Advocacy and campaign on programmes including inclusive education</td>
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<td></td>
<td>Screening</td>
<td></td>
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<tr>
<td>2 Community Development</td>
<td>Alternative Livelihood Programme (ALP)</td>
<td>Social media, TV/Radio, Musicians, documentary and the use of Village theatre groups that move from one community to the</td>
</tr>
<tr>
<td>Department/Service</td>
<td>Activities/Programs</td>
<td>Resources/Tools</td>
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<tr>
<td>Social Welfare</td>
<td>Radio and Television Discussions</td>
<td>Posters</td>
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<tr>
<td></td>
<td>Use durbars, festivals, community information centers for sensitisation</td>
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<td></td>
<td>Child and Family Welfare</td>
<td></td>
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<tr>
<td>Day Care</td>
<td>Visit to schools for sensitisation and inspection</td>
<td>Platform for all proprietors</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Educate communities and share information on fosterage</td>
<td>Foster Care Training Manual</td>
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<tr>
<td>Justice for Children initiative</td>
<td>Posters</td>
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<tr>
<td>Livelihood and Streetism</td>
<td>Flyers and Stickers</td>
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<tr>
<td>Residential Homes</td>
<td>Embark on sensitisation</td>
<td>National Standards for operating residential homes, Checklist for inspection and case management forms</td>
</tr>
<tr>
<td>Department for Children</td>
<td>Child Welfare policy review</td>
<td>None</td>
</tr>
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<td></td>
<td>Justice for Children policy review</td>
<td>None</td>
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<td></td>
<td>Provide one-stop education and record keeping on child to mother and health facility</td>
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<td></td>
<td>Dissemination through the health centres to mothers</td>
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<td>Provide verbal training on content</td>
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<tr>
<td>Continuous Care (CoC)</td>
<td>Out-patient Department (OPD) health talk by Health professionals</td>
<td>Maternal and child health record book, patient folders</td>
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<tr>
<td>Event</td>
<td>Type</td>
<td>Activities</td>
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<tr>
<td>Medical Screening</td>
<td>Medical outreach</td>
<td>Posters</td>
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<tr>
<td></td>
<td>Health Talk</td>
<td>Flyers</td>
</tr>
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<td></td>
<td>Media</td>
<td>Banners</td>
</tr>
<tr>
<td>Maternal Care</td>
<td>Antenatal visit</td>
<td>Maternal and child health record book, Posters</td>
</tr>
<tr>
<td></td>
<td>Health talk</td>
<td></td>
</tr>
<tr>
<td>Malnutrition Management</td>
<td>Health talk</td>
<td>Maternal and child health record book, Books (Weight for Height, Z-score chart) Posters, flyers and banners</td>
</tr>
<tr>
<td></td>
<td>Medical outreach</td>
<td></td>
</tr>
<tr>
<td>Infant and Young Child Feeding</td>
<td>Post-natal visit</td>
<td>Maternal and child health record book, Weight for Height, Z-Score chart, Posters and flyers</td>
</tr>
<tr>
<td>Integrated Management of Childhood Illness (IMCI)</td>
<td>Post-natal visit</td>
<td>Post-natal record book, Posters, banners</td>
</tr>
<tr>
<td>Early Simulation</td>
<td>Use exiting CHPs and health centres to reach to mothers at the facility. antenatal, post-natal clinics.</td>
<td>Flip charts Training manual books</td>
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<td></td>
<td></td>
<td>Posters</td>
</tr>
<tr>
<td>Behaviours</td>
<td>Who needs to change? (primary, secondary and tertiary targets)</td>
<td>Drivers to change</td>
</tr>
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</tr>
<tr>
<td>Stopping the discrimination against children with special needs</td>
<td>At schools – teachers and pupils, school management.</td>
<td>Strategies within the education system to prevent bullying to be put in place – appropriate reporting processes and admonishments. Early integration of CwSN within the pre-school system.</td>
</tr>
<tr>
<td></td>
<td>Community level – parents, community members, chiefs / leaders.</td>
<td>Negative attitudes are based on societal beliefs and lack of knowledge. So, education to overcome misconceptions. Persuasion can be adopted to emphasize that there is no &quot;normal&quot;.</td>
</tr>
<tr>
<td>Health workers</td>
<td>Training of health workers on how to treat CwSN and their parents with respect.</td>
<td>Help community members know how to communicate to CwSN – and model correct behaviours. Abnormality is normal – Organize community outreach programmes in local languages (drama, community radio, etc.) to sensitize members to accept children with special needs and understand that abnormality is normal.</td>
</tr>
<tr>
<td>Social protection agency</td>
<td></td>
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<tr>
<td>Sub-behaviour: late detection or screening for birth defects or disability</td>
<td>Parents, teachers, community health workers.</td>
<td>This is largely a lack of knowledge. Raise awareness on early signs to look out for and provide for parents and health workers.</td>
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<tr>
<td>Enabling environment by GES / GHS</td>
<td>Primary target is health workers,</td>
<td>Stopping stigma and discrimination against adolescent mothers</td>
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<tr>
<td>Also, similar messages should be made visible at pre-natal checks.</td>
<td>Again, government should have established policy and advocate early screening to be done periodically at school.</td>
<td>Advocacy for legislative framework and policies</td>
</tr>
<tr>
<td>GHS, GES, NGOs/CBOs</td>
<td>GHS, Media, NGOs/CBOs</td>
<td>GHS, Media, NGOs/CBOs</td>
</tr>
</tbody>
</table>

**Stopping stigma and discrimination against adolescent mothers**

- Primary target is health workers,
- The behaviour of health workers who insult and discriminate against adolescent mothers is deliberate given that adults perceive teenage pregnancy as largely the behaviour of "bad girls."
- Organize reorientation workshops for CHW and other community health service providers on service delivery protocols towards adolescent mothers when they come to a facility.
- Promote the GHS concept of friendly environment known as the "adolescent corner" (a designated area within health facilities for adolescent mothers) to promote openness and make them feel comfortable about their visit.
- Continuously measure the performance of health centres in terms of service and provide feedback to health centre managers so they can track change and put in place additional training if needed.

**Parents of teenage mothers**
- Adolescent mothers, their peers
- Opinion leaders
- The stigma and parents' reactions are largely driven by emotions.
- Development of family counselling package for teenage mothers and their households.
- Provide platforms that will encourage mothers who have similar experiences to share their stories so that adolescents can learn from them.
- Embark on Community engagement efforts to reduce teenage pregnancies. Provide information on sexual and reproductive health issues to empower young women to avoid pregnancy.

**Community engagement**
- Community meetings, drama, theatre at town squares
- Family counselling
- Mass Media: Radio, TV
- Social Media: WhatsApp, Facebook, twitter

**Education and persuasion are required to deal with this**

- Social media activations around stopping teenage
- Social Media: Facebook, twitter, WhatsApp.

**DAAs, GHS, Traditional and Religious Authorities, Media.**
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</thead>
<tbody>
<tr>
<td>Parents Other Adolescents</td>
<td>Community-level campaign through outdoor programs such as drama, talks, etc., to address this issue. Promotion of family counselling to households with teenage mothers. Provide platforms that will encourage mothers who had similar experiences to share their stories so that adolescents can learn from them.</td>
<td>Community engagement: community meetings, drama. Communication: Materials: posters, video documentaries. Mass media: TV, radio</td>
<td>Social Welfare, GHS, NGOs.</td>
<td></td>
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</tr>
<tr>
<td>Encouraging parents at home to use alternative disciplinary measures to corporal punishment</td>
<td>Parent Care-givers Teachers</td>
<td>It is believed that beating or use of the cane is one of the most effective ways of making children change. There is a deliberate action to use cane as discipline measure. Most mothers will resort to canes or beat their children because it is the norm. This has become a habit.</td>
<td>Persuade parents that alternative methods are just as effective and make them understand the negative outcomes or costs to their child of continuing with physical punishment. As above, show teachers the costs of using corporal punishment and show them alternative methods and the benefits of using alternative methods.</td>
<td>Communication: Materials: posters, stickers, video documentaries. Mass Media: TV, radio and print. Advocacy for policy.</td>
<td>Social Welfare, GES, Media, GHS, Traditional and Religious Authorities.</td>
</tr>
<tr>
<td>Community members</td>
<td>Promote community engagement packages to promote habit change through drama and role play at the community level and demonstrate other effective ways of disciplining children and the benefits of them.</td>
<td>Community Engagement: community meetings, drama</td>
<td>DAs, Traditional and Religious Authorities, NGOs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging community members and households to use the legal channels to report sexual</td>
<td>Parents Children</td>
<td>This is strongly embedded in societal behavior – protecting the family member is important to avoid discrediting the family’s image among those in the community.</td>
<td>Strong advocacy to empower children and parents on their rights to report such abuses to the police.</td>
<td>Community Engagement: drama and role playing. Mass Media: Radio and TV. Enlisting role models</td>
<td>DOVASU, GHS, Media, Religious and Traditional Authorities.</td>
</tr>
</tbody>
</table>
| Community members | Demonstrate the costs of not stopping child abuse and the ineffectiveness of potential community methods of handling this. | Community Engagement: Drama and role playing  
Mass Media: Radio, tv and print.  
Communication materials: posters, stickers. | GHS, DAs, Religious and Traditional Authorities, Media |
|-------------------|------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------|
| Law enforcement agencies | Enforcement agencies to be clear on how to handle such cases, demonstrating that these are critical and important.  
Make it easy: ensure community members are aware of channels for reporting and consider an anonymous reporting channel. | Mass Media: Radio, tv and print.  
Communication materials: posters, stickers.  
Capacity building for law enforcement agencies  
Advocacy for legislative framework. | GHS, Media, DOWSU, Social Welfare. |


Cusick, S., & Georgieff, M. K. (2014). The first 1,000 days of life: the brain’s window of opportunity.
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Catholic Relief Service. Early Childhood Development— Basic Concepts in training for early childhood caregivers and teachers.


