SCHOOL OF NURSING AND MIDWIFERY

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA, LEGON

UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS AT ASANTE AKYEM NORTH DISTRICT

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(10552018)

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JULY, 2017
Utilisation of SRH Services among Adolescents

DECLARATION

I declare that this thesis is the result of my research work, with the exception of references to other people’s work which have been duly acknowledged. This thesis has neither in part nor whole been submitted to this University or elsewhere for another degree or certificate.

.................................................. ..................................................
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(Student)

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Dr. (Mrs.) Patience Aniteye Date
(Supervisor)

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Dr. Daniel Kojo Arhinful Date
(Supervisor)
DEDICATION

This work is dedicated to the Almighty God whose faithfulness and unfailing mercies have brought me this far. It is also dedicated to my parents and siblings.
ACKNOWLEDGEMENTS

It would have been impossible to carry out this research without the support of many persons to whom, I express my thanks and appreciation.

First and foremost, I give thanks to the Almighty God for giving me the strength and wisdom to bring this work to a successful end.

I wish to express my profound gratitude to my supervisors, Dr (Mrs.) Patience Anithey and Dr Daniel Kojo Arhinful for their efforts and immense contributions through technical advice, constructive supervision and suggestions throughout the study.

I also appreciate the management and staff of Agogo Presbyterian Hospital, Juansa, Anansekom and Nyampenase health centres as well as the participants for assisting me to have meaningful data for this study.

I also thank the staff of the School of Nursing and Midwifery of the University of Ghana for the knowledge shared which assisted me to put this work together.

Furthermore, my sincere gratitude goes to my parents, Mr Albert Amoako and Mrs Christiana Amoako. I thank them for their moral and financial support, advice, prayers and their ultimate care.

I acknowledge the authors and publishers of the books I used as references and to all those who helped in diverse ways for the success of this work.
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>GSS</td>
<td>Ghana Statistical Service</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>LAPM</td>
<td>Long Acting Permanent Contraceptive Method</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>TPB</td>
<td>Theory of Planned Behaviour</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

Adolescents encounter general as well as sexual and reproductive health problems which if not resolved can affect them not only at this stage but in adulthood. Given this, globally, there is an increased concern about the sexual and reproductive health and adolescents’ development and Ghana is no exception. The purpose of the study was to explore the utilisation of sexual and reproductive health (SRH) services among adolescents at Asante Akyem North district. The study was guided by the Theory of Planned Behaviour (TPB) and was ethically approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research at the University of Ghana. The study employed a qualitative interpretive, descriptive design. Fifteen adolescents (15 to 19 years of age) who have utilised SRH services were purposively sampled from the various health facilities in the district. An interview guide was used to gather data, which was audio-recorded, transcribed verbatim and analysed using thematic content analysis. Six main themes emerged from the analysis which was further categorised into sub-themes. The major themes described the attitudes of adolescents towards SRH services, social pressures (subjective norms), perceived behavioural control and the intentions of adolescents to use SRH services. The other emerged themes included state of adolescents before using SRH services and perceptions of adolescents on SRH services which were additional themes to the constructs of the TPB. The findings indicated that most adolescents have positive attitudes towards SRH services. Their utilisation of SRH services was influenced by social pressures and faced a lot of challenges and barriers when using SRH services. However, most of the adolescents were willing to use SRH services in the future. The adolescents had sentiments as the considered moral issues associated with their use of SRH services but rationalised it by weighing benefits over cost. Adolescents also gave recommendations on how SRH services should be packaged to
meet their needs. Participants were confident that if their significant others approve of their utilisation of SRH services, it will be easy for them to use the services. It was recommended that policies should be made to strengthen the existing SRH services at the general hospitals and clinics to ensure that services are youth friendly by providing private rooms for adolescents to serve them at their convenient hours. Future research should focus on the sexually active adolescents who have not used SRH services.
CHAPTER ONE

INTRODUCTION TO THE STUDY

1.0 Introduction

This chapter introduces the reader to a research which was conducted in the Asante Akyem North District on the utilisation of sexual and reproductive health services among adolescents. It covers the study background, statement of the problem, the purpose of the study, objectives, research questions, significance of the study and operational definition of terms.

1.1 Background

Adolescence may be defined as a transitional stage from childhood to adulthood (Kwankye, Amedoe & Cash-Abbey, 2014). The World Health Organization (2011) categorises adolescence as the period of growth and development of humans that happens between childhood and adulthood, from 10 to 19 years of age. Adolescence is further divided by certain writers into early and late adolescence as 10 – 14 years and 15 – 19 years of age respectively (Cobb, 2001; James-Traore, 2001). This stage is sometimes noted as the beginning of fertility or puberty, and it is specified by physical, emotional and social development. Logan (2016) posited that in the course of puberty, the fluctuating levels of hormones contribute significantly in stimulating the development of secondary sex characteristics.

According to Diers (2013), there are about 1.2 billion adolescents (10 to 19 years of age) making up 18% of the world’s population. As of the year 2010, adolescents (10-19 years) accounted for 25% of the total population of Ghana (GSS, 2012). Females between 15-19 years of age represented 20% of women in the reproductive age group of 15-49 years (GSS 2012), which indicates a very high momentum for population growth.
Adolescents encounter general as well as sexual and reproductive health problems which if not resolved can affect them not only at this stage but in adulthood (Omoni, 2009). Given this, globally, there is an increased concern about the sexual and reproductive health and adolescents’ development (Omoni, 2009) and Ghana is no exception.

Reproductive health is a state of total physical, social and mental safety and not simply the absence of infirmity or disease, in everything concerning the reproductive system and to its processes and functions (United Nations, 1994). Adolescents are included in all persons that are to profit from this provision in the definition. Sexual health was initially characterised as an element of reproductive health. However, the concept of reproductive health has changed to sexual and reproductive health currently. Sexual and reproductive health (SRH) includes matters such as gender, education, mobility and poverty together with the original components of reproductive health (Shaw, 2009).

According to Ajzen (2006), behaviour is the apparent, visible rejoinder in a given condition with regards to a particular target. During the adolescence stage, a number of adolescents take up behaviours like adults by engaging in sexual activities (Mulye, Park, Nelson, Adams, Irwin & Brindis, 2009). Moreover, adolescents involve themselves in deeds such as unprotected sex and substance abuse (Lassi, Salam, Das, Wazny, & Bhutta, 2015). Conversely, most adolescents who involve themselves in sexual deeds do not engage in safe sex behaviours such as making use of condoms which reduces the likelihood of pregnancy and STIs/HIV acquisition (World Health Organization, 2008). Globally, about 1.3 million adolescents died in the year 2012 (WHO, 2014) and nearly 70% of all deaths occurred in two regions of the world: Africa and South East Asia (Lassi et al., 2015). Pregnancy related death was the second main
cause of death among females of 15 to 19 years of age while interpersonal violence and road
injuries were the major cause of death among males in the same age group (Lassi et al., 2015).

The 2014 Ghana Demographic and Health Survey (GDHS) shows that approximately
14% of women from age 15 to 19 years have begun childbearing: 11% have had a live birth, and
3% were pregnant at the time of the interview. The survey indicated that the percentage of
adolescents who have begun childbearing increased rapidly with age, from 1% to 15% at ages
15 to 19 years (GDHS, 2014). Adolescent childbearing remains a burden in many countries,
mostly in sub-Saharan Africa which includes Ghana despite the fact that the number of births
among adolescent girls is decreasing around the world (Nyarko, 2015). Early childbearing poses
serious effects to the development and health of young girls and also limits female adolescents’
opportunities for education, training, and livelihood development. Pregnancy is not the only
problem adolescents face when they engage in unprotected sex. It was reported that adolescent
males (3.4%) and females (5.2%) having had STIs/HIV prevalence among adolescents in Ghana
was 5.5% and 1.9% respectively (GSS, GHS, ICF Macro, 2009). However, in Ghana, discussion
on sexual and reproductive health issues particularly with young people is delicate and thus
makes service utilisation difficult (Appiah, Badu, Dapaah, Takyi, & Abubakari, 2015).

Teenage pregnancy and prevention of its consequences are considered a priority by
policy makers due to its high economic, health and social costs for adolescents and their parents,
families and the nation at large (Solomon-Fears, 2015). Many governments worldwide have
worked at some policies to address the needs of adolescents regarding sexual and reproductive
health after the 1994 International Conference on Population and Development (ICPD) had put
sexual and reproductive health of adolescents on the global policy agenda (Mbizvo & Zaidi,
2010). However, the high percentage of adolescents in low and middle-income countries,
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maternal mortality, unsafe abortion and associated high rates of HIV amongst this group points out the need for improvement in reproductive health services usage (Bearinger, Sieving, Ferguson, & Sharma, 2007). Regardless of unceasing global investments in sexual and reproductive health programmes for adolescents, restrictions such as inadequate knowledge as well as access to resources and services exist in spite of the effort made to effectively meet the Adolescent Sexual and Reproductive Health information and service requirements of adolescents (Nyarko, 2015). These restrictions are predominantly evident in sub-Saharan Africa where unplanned pregnancies and adolescent childbearing continue to be a challenge (Haub, 2013).

Findings in Ghana do not differ from those found globally. The government of Ghana has worked hard to meet the sexual and reproductive health needs of adolescents through the Adolescent Reproductive Health Policy (2000) and National HIV/AIDS and STIs Policy (2001) after the ICPD in 1994. The Ghana Health Service has also promoted youth friendly services (Gbagbo, 2015). Nevertheless, evidence shows that Ghanaian adolescents still do not utilise sexual and reproductive health services, mainly due to the stigma around premarital sex and attitudes of health care providers (Dapaah, Appiah, Badu, Obeng, & Ampiah, 2015). According to Awusabo-Asare and Annim (2008), two in every three young women and 4 in every five young men with STIs did not seek treatment. The study also revealed that about half of sexually active female adolescents who are unmarried and more than one-third of sexually active male adolescents did not use contraceptives. Even though adolescents do not want to experience early pregnancies and sexually transmitted infections, they do not use reproductive health services regularly (Fitzpatrick & Walton-Moss, 2011).

Most adolescents do not even have any intention of utilising sexual and reproductive health services especially contraceptive services. The most commonly cited reasons are
opposition to family planning, followed by a fear of side effects, with the least being the cost (Abubakari et al., 2015). However, inconsistent utilisation of reproductive health services by adolescents substantially contributes to high maternal mortality, the spread of HIV and AIDS and school dropouts (Chilinda, Hourahane, Pindani, Chitsulo, & Maluwa, 2014). If adolescents should keep on experimenting with sex but fail to protect themselves, the probability of many of them turning out to be pregnant is very high. Therefore, exploring adolescents’ utilisation of sexual and reproductive health services was imperative.

The study drew on the Theory of Planned Behaviour (TPB) which postulates that human behaviour is guided by behavioural beliefs, normative beliefs, control beliefs and intentions towards a particular behaviour (Ajzen, 2006). The theory is made up of attitudes towards behaviour, subjective norms and perceived behavioural control that influence behavioural intention which predicts the behaviour.

1.2 Problem Statement

Adolescent pregnancy happens in all societies even though the extent and consequences vary from place to place (Gebreselassie, 2015). Most of these pregnancies are unplanned and unwanted and mostly result in unsafe abortions. It is associated with a higher threat to both the mother and her new born. Child and infant deaths are equally lower among those born to adult mothers compared to adolescent mothers (Ringheim & Gribble, 2010).

In Asante Akyem North District where this research was conducted, adolescents from ages 15-19 years accounted for 10.7% of the total population of the district according to the 2010 census, (GSS, 2014). Statistics from the Reproductive Health Unit of the Agogo Presbyterian Hospital shows that the number of adolescent pregnancies outweighs the number of adolescents who utilise the preventive reproductive health services. This is shown in Table 1.1
Utilisation of SRH Services among Adolescents

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV</th>
<th>Other STIs</th>
<th>Unsafe abortions</th>
<th>Total Number of registrants (Adolescent Pregnancies)</th>
<th>Total Adolescent Registrant (Preventive reproductive health service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>38</td>
<td>Nil</td>
<td>10</td>
<td>367</td>
<td>161</td>
</tr>
<tr>
<td>2012</td>
<td>21</td>
<td>Nil</td>
<td>4</td>
<td>422</td>
<td>211</td>
</tr>
<tr>
<td>2013</td>
<td>25</td>
<td>Nil</td>
<td>Nil</td>
<td>393</td>
<td>257</td>
</tr>
<tr>
<td>2014</td>
<td>20</td>
<td>Nil</td>
<td>14</td>
<td>323</td>
<td>289</td>
</tr>
<tr>
<td>2015</td>
<td>20</td>
<td>8</td>
<td>27</td>
<td>252</td>
<td>274</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td>Not yet available</td>
<td>258</td>
</tr>
</tbody>
</table>

Source: Agogo Presbyterian Hospital yearly report 2011-2016

Even though adolescent pregnancy has been steadily declining, it is still visibly high. Moreover, the above statistics do not cover all adolescent pregnancies in the district because some adolescents who get pregnant do not attend antenatal clinic, do not utilise skilled birth attendants and also do not go for postnatal clinic and as such, no records are available on them. This report suggests that adolescents in the Asante Akyem North district have sexual and reproductive health challenges. Sexual activities outside marriage is on the rise among adolescents, but less than half of those who want to avoid pregnancy are using a modern method of contraception (Darroch & Singh, 2011). Despite the efforts of the Ministry of Health/Ghana Health Service to provide adolescent sexual and reproductive health services, there is low
utilisation of the services in the district. Consequently, adolescents in the district are at risk of unwanted pregnancies, pregnancy related complications as well as sexually transmitted infections including HIV/AIDS. Sexual and reproductive health behaviours are among the main causes of school dropouts and diseases among the adolescents. The adolescents in the district are vulnerable to these problems because they often venture into sex unprepared and have sex with multiple partners (Dapaah et al., 2015). There are several reasons for which the adolescents utilise or do not utilise the reproductive health services. The utilisation of sexual and reproductive health services is, however, a vital component in helping adolescents to avoid diverse sexual and reproductive health problems. Whether they are aware of their sexual and reproductive health needs and whether they have intentions of utilising the sexual and reproductive health services in the district was an issue worth investigating. This study, therefore, explored the utilisation of sexual and reproductive health services among adolescents at Asante Akyem North District.

1.3 Purpose of the Study

The purpose of this study was to explore the utilisation of sexual and reproductive health services among adolescents at Asante Akyem North District.

1.4 Objectives of the Study

Specifically, the study sought:

1. to identify the attitudes of adolescents towards utilisation of sexual and reproductive health services,

2. to explore the perceived social pressures (subjective norms) that affect adolescents’ utilisation of sexual and reproductive health services,
3. to describe adolescents’ perceptions of their abilities to utilise sexual and reproductive health services,
4. to identify the adolescents’ intentions to utilise Sexual and Reproductive Health Services.

1.5 Research Questions

1. What are the attitudes of adolescents towards utilisation of Sexual and Reproductive Health Services?
2. What social pressures affect adolescents’ utilisation of Sexual and Reproductive Health Services?
3. What are the perceptions of adolescents concerning their abilities to utilise sexual and reproductive health services?
4. What are the intentions of adolescents towards utilising Sexual and Reproductive Health Services?

1.6 Significance of the Study

Exploring the utilisation of sexual and reproductive health services among adolescents (15-19 years) in the Asante Akyem North district would assist in planning for adolescents’ reproductive health services. It will help policy planners and service providers to know how the adolescents perceive the utilisation of the sexual and reproductive health services and plan towards implementing measures to intervene. The rendering of adolescent sexual and reproductive health services according to their needs and in a way acceptable to them and suitable to their needs would enable them to utilise the services thereby reducing the cases of
unwanted pregnancies, sexually transmitted infections including HIV/AIDS cases in the district and the nation as a whole.

1.7 Definition of Terms

The under listed key concepts or terms used in this study have the following meanings.

**Adolescent(s):** These are young people, both males and females aged between 15 and 19 years

**Intention:** the willingness or preparedness of adolescents to utilise the sexual and reproductive health services.

**Sexual and Reproductive Health Services:** services that promote a state of physical, mental and emotional well-being in all aspects of sexuality and the reproductive system and not merely the absence of disease.

**Utilisation:** the ability to access and make use of, in an appropriate manner, the sexual and reproductive health services that are available.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section describes the theoretical underpinning of the study and reviews literature relevant to this research. The review was done using databases such as Hinari, Popline, Pub med, Science Direct and Google Scholar. It was guided by the constructs in the TPB. The literature review, therefore, covers the following areas; overview of utilisation of adolescent sexual and reproductive health services, attitudes towards utilisation of the sexual and reproductive health services and the perceived social pressures that affect the utilisation. It also covers perceptions of the abilities to utilise the sexual and reproductive health services, intentions and utilisation of sexual and reproductive health services.

2.1 Conceptual Framework

The study was underpinned by the Theory of Planned Behaviour (TPB). According to Polit and Beck (2008), theories assist in the prediction of the occurrence of a phenomenon, but the TPB as the organising framework in this study helped the researcher to explore adolescents’ utilisation of sexual and reproductive health services and its essence. Consistent and correct use of the sexual and reproductive health services may help reduce the adolescent SRH problems and its consequences. The TPB constructs were therefore operationalised for use in the study.

2.1.1 The Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) was developed by Icek Ajzen from the Theory of Reasoned Action (Ajzen & Fishbein, 1988) as an endeavour to forecast human behaviour (Ajzen, 2006). The theory postulates that attitudes towards the behaviour, subjective norms and
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perceived behavioural control influence behavioural intention which predicts behaviour. The behavioural intention to perform a given behaviour is a central factor in the theory.

i. Attitudes towards the Behaviour

This is the degree to which the performance of a given behaviour has a favourable or unfavourable appraisal. Attitudes comprise of behavioural beliefs and outcome evaluations. These are positive or negative.

ii. Subjective Norms

This is the perceived social pressure to perform or not to perform a given behaviour. This consists of normative beliefs and motivation to comply. Subjective norms determine others’ approval or disapproval of the behaviour.

iii. Perceived Behavioural Control

Ajzen and colleagues added perceived behavioural control to describe factors outside individual control that may affect one’s intentions and behaviour. Perceived behavioural control refers to people’s perceptions of one’s abilities to perform the behaviour of interest. It is the belief of the amount of control or direction one has over the environment. It indicates the ease or difficulty of the task to accomplish. This is ascertained by beliefs about the existence of factors that may enable or impede the performance of a given behaviour.

iv. Intentions

Intentions are the factors that influence or motivate behaviour. It is one’s readiness or willingness to perform a particular behaviour. The intention to perform a particular behaviour is dependent on attitude towards the behaviour, subjective norm and perceived behavioural control as proposed by the theory. It is considered as the immediate antecedent of behaviour. The more
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positive the attitude towards behaviour as well as the subjective norms and the greater the perceived behavioural control, the stronger the individual’s intention to act the given behaviour.

v. Behaviour

Behaviour is the apparent, visible rejoinder in a given condition with regards to a particular target. In the Theory of Planned Behaviour, the behaviour is a function of intentions and perceptions of behavioural control.

Figure 2.1: The diagram of the Theory of Planned Behaviour

Source: (Ajzen, 1991)

The purpose of using the TPB as a framework in this study was to explore the route through which adolescents utilise or their reasons for not utilising SRH services. The behaviour under study, in this case, was the utilisation of sexual and reproductive health services.

Intentions are considered to be the immediate antecedent to behaviour (Ajzen, 2006). Consequently, once an adolescent makes use of SRH services, then he or she might have
intentions that motivated his or her utilisation. Given the adequate degree of tangible control over the behaviour, adolescents are expected to accomplish their intentions of utilising the SRH services when the chance arises.

Attitudes towards the behaviour, subjective norms and perceived behavioural control affect the intentions of the adolescent in utilising SRH services. These components are motivated by beliefs (Ajzen, 2006). Individual’s belief can be innate, acquired or learned. The adolescent’s attitudes towards utilisation of SRH services may be liable to what he/she expects as an outcome of utilising the services. If he or she gives a positive appraisal of the outcome, he or she may utilise the services and vice versa.

With regards to the subjective norms, the adolescent may feel that the people she gives reverence to or decides with in the society may approve or disapprove if he/she utilises the SRH services. Therefore, the adolescent will most probably utilise the SRH services if he/she considers that the significant others in her life accept and approves of the behaviour and the contrariwise.

Perceived behavioural control may independently cause the behaviour (Montano & Kaspersky, 2008). This is the adolescent’s ability to prevail over her beliefs to have confidence in utilising SRH services. It may be due to an experience she has had in the previous utilisation of the services or observations made or might have heard negative things about the behaviour.

2.1.2 Justification of the Model used for the Study

The Theory of Planned Behaviour (TPB) has been used in many behavioural studies such as blood donation (Holdershaw, Gendall, & Wright, 2011), weight control (Mc Connon et al., 2012), promoting fruit and vegetable consumption (Kothe, Mullan, & Butow, 2012), entrepreneurial behaviour (Kautonen, Van Gelderon, & Tornikoski, 2013) and social network
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sites use (Pelling & White, 2009). It has also successfully predicted and explained a broad range of health behaviours and intentions including drinking, smoking, breastfeeding, substance use, and health services utilisation, among others.

The TPB has assisted in explaining and predicting the use, misuse and frequency of alcohol use among fifth to eighth graders in a school in Michigan. Intentions to use alcohol explained 26% of the variance in use, 30% of the variance in misuse, 38% of the variance in frequency of use of alcohol. Moreover, about 76% of the variance in intention to use alcohol was explained by attitudes towards alcohol use, subjective norms and perceived behavioural control. The findings led to strengthening of the need to employ substance abuse prevention programmes in the elementary schools (Marcoux & Shope, 1997).

Another study tested whether the TPB can predict blood donation behavioural intentions and actual donation behaviour. Following a mobile drive by the New Zealand blood service, a comparison was made between intentions to donate blood and blood donation behaviour. The TPB was noted to be less effective in predicting intentions to blood donation because the performance of the model dropped when the observed outcome was donation rather than intention (Holdershaw et al., 2011).

In the area of sexual and reproductive health, the TPB has been used especially in condom use. For example, Asare (2015) in a study used the TPB to determine condom use behaviour among college students in the United States. A sum of 218 college students with 20.9 years of mean age took part in the study. It was a cross-sectional survey which made use of a questionnaire. The constructs of attitude towards behaviour, subjective norms and perceived behavioural control significantly predicted condom use intentions and they explained 64% of the variance. There was a significant relationship between behavioural intention and condom use
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which was 15% variance. However, since a convenient sampling approach was used in recruiting the participants, there may be bias and thus cannot be the correct representation of the population. Hence, the results cannot be generalised.

The same researcher in a different study used the same theory to predict safer sexual behaviour by Ghanaian immigrants in a large Midwestern U.S. City. A total of 137 Ghanaian immigrants participated in the study. The study revealed that the constructs of subjective norms and perceived behavioural control significantly predicted intentions to use condoms and they explained 38% of the variance. The behavioural intention for condom use predicted significantly the use of condoms, and it explained 21% of the variance (Asare & Sharma, 2010).

Abamecha, Godesso, and Girma (2013) conducted a cross-sectional quantitative study with the use of 336 health professionals to predict the intentions to voluntary counselling and testing (VCT) and associated factors among health professionals in Jimma zone, Ethiopia using the TPB. The constructs of the theory were measured after collecting data using structured questionnaire and analysing data. Attitudes toward behaviour, subjective norms and perceived behavioural control explained the variance in intentions to use VCT services by 30.3%. Both components of TPB and socio-demographic characteristic in the final model explained 32.7% of the variance in the intentions to use VCT services. The strongest predictors of intentions to VCT were attitudes and subjective norms. None of the socio-demographic variables and past VCT experience which the researcher added to the model significantly predicted the intentions to use VCT.

The TPB may be considered as a practical framework for handling the intricacies of human social behaviours that are difficult to understand like adolescent behaviours. The concepts are explained in a way that permits for prediction of behaviours in particular circumstances.
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Other studies aside the studies reviewed above reveal that the constructs in the Theory of Planned Behaviour are effective in predicting sexual and reproductive health behaviours (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Heeren, Jemmott III, Mandeya, & Tyler, 2007). Permission was sought from the theorist to use the theory as a guide in this study (Appendix L).

2.2 Overview of Adolescent Sexual and Reproductive Health Service Utilisation

As at the year 2009, there were 129 adolescent health corners that rendered preventive, curative and rehabilitative SRH services to adolescents in Ghana (Ghana Health Service, 2009). Adolescent health corners are rooms for adolescents which render SRH services that are youth friendly within the Reproductive and Health Units (NHADP, 2005). The utilisation of SRH services among adolescents as proposed by WHO (2003) can be increased by obtaining support from community leaders, training non-judgemental and empathetic service providers and making health facilities youth friendly.

With diverse experiences of adolescents demand, getting in touch with them with sexual and reproductive health services before they initiate sex as married or unmarried sexually active people is important (Ringheim & Gribble, 2010). Atuyambe et al. (2015) highlighted that SRH needs of adolescents would be solved by establishing adolescent friendly clinics with standard recommended characteristics (sexuality information, friendly health providers, a range of good clinical services such as post abortion care, and so forth).

Mosavi et al. (2014) in a qualitative study assessed “Iranian Adolescent Girls’ Needs for Sexual and Reproductive Health Information”. In this study, it was discovered that there were six major reasons why there is the need to provide sexual and reproductive health services for
adolescent girls. The reasons are: lack of knowledge about SRH, easy access to incorrect information sources, cultural and social changes, cultural taboos and increased risky sexual behaviours among adolescents.

Adolescents have preferences for sexual and reproductive health services. Their preferences must be known to plan to meet their needs so that the rate at which they utilise the services will increase. When these preferences are taken into consideration in rendering services to adolescents, it will maximise the utilisation rate and reduce the rate of school dropouts among adolescents (Lim, Chhabra, Rosen, Racine, & Alderman, 2012). Some adolescents suggest that an adolescent-friendly office should include a separate adolescent waiting area equipped with entertainment units (Lim et al., 2012). Others responded in a different study that the services they prefer to have must be free of charge, friendly and polite staff with a good smile. Participants added that they need separate clinics which are well resourced and provide accurate information. Moreover, their discussions should be held confidential and must be opened till 10:00pm. The staff should show videos on such matters and take the time to counsel them (Kalo, 2006).

The report of the GDHS (2008) highlighted that 18% of female adolescents (15-19) years of age used contraceptives before having children as compared to 5% of women aged 40-45 years. This shows that women in Ghana use contraceptives at an early age to suspend childbearing.

In a study to examine the youth friendliness of SRH services delivery and utilisation in Kwadaso Sub-Metro in the Ashanti region of Ghana, Appiah, Badu, Dapaah, Takyi, and Abubakari (2015) reported that a large number of the youth never used SRH services. The study found that most of the adolescents were not aware of any youth friendly services although some (marginal) were aware. This shows that the level of awareness is likely to increase the
knowledge of adolescents on SRH services and utilisation. Interestingly, among those who had utilised sexual and reproductive health services before, a greater number said that they would not visit for services any more regardless of the fact that they were greatly satisfied with the services. This finding is contrary to others’ argument that youth friendly services can entice the youth and thrive in retaining them for continuity of care (Kane & Colton, 2005). The fact that they would not utilise the services anymore despite their satisfaction could be that encouragement to subsequently access the services was very poor (Maclean, 2006). Most of the responses of the study, however, were restricted to forced-choice responses (e.g. yes/no) and was likely to exclude in-depth responses as the results of the qualitative side of the study are only on out of school youth.

Abajobir and Seme (2014) aimed at assessing the level of reproductive health knowledge and services utilisation among rural adolescents in Machakel district, Northwest Ethiopia. The study employed both qualitative and quantitative approach which is the best for such a study to generate in-depth knowledge and numerical data. Similar to other findings, the researchers posited that adolescents’ level of knowledge is paramount to having access and utilisation of SRH services. This means that education is an important social variable influencing SRH services utilisation. The study found that the association of SRH services utilisation and knowledge of SRH was significant. The researchers concluded that reproductive health knowledge and utilisation of services among adolescents living in the rural areas is low. However as indicated in other studies in Bangladesh, Ethiopia and Kenya, there was no association between being from a rich family and SRH service utilisation among the adolescents (Tegegn & Gelaw, 2009). There was no association between sex and reproductive health knowledge nor SRH services utilisation which was in opposition to the findings by Kotecha et al.
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(2009) that males have more knowledge and female counterparts have more propensities to using SRH services. However, Bilal, Spigt, Dinant, and Blanco (2015) recently figured out that the utilisation of SRH services is higher among male adolescents, lower among senior high students and the basic reason for utilising the services was to receive information.

Several studies have shown that adolescents face many barriers in accessing sexual and reproductive health services. Biddlecom, Munthali, Singh, and Woog (2007) noted that sexual and reproductive health services are underutilised in African countries because they do not know that the services exist. Some anecdotal evidence has showed that some health workers turn away young adolescents who visited health facilities for family planning services (Abdul-Rahman, Marrone, & Johansson, 2011). Tilahun, Mengistie, Egata, and Reda (2012) and Mbugua (2007) have also shared the view that the health workers in the various health centres are reluctant to teach the youth issues regarding sexual and reproductive health. Although, Tilahun and colleagues found that some health workers had negative attitudes towards adolescents’ use of services, they indicated that most of the healthcare providers have positive attitudes. However, some of the participants had either neutral or negative attitude towards health education to give information on safe sex.

Denying adolescents, the services they need, such as information, medications, or contraceptives is obviously a serious barrier to reproductive rights. Administrative barriers, like demanding unapproved fees for services and refusal of services are very difficult to document because providers do not exhibit these behaviours when they are being observed (Awoonor-Williams, Vaughan-Smith, Phillips, & Malarcher, 2010). However, elsewhere, mystery clients have been used to exhibit the behaviours of healthcare providers. While it is difficult to measure
how often medical and administrative barriers result in denial of SRH services, experts contend that these barriers are rampant and have been underrated.

A study by Dako-Gyeke and Ntwusu (2012) in Tamale metropolis of Northern Ghana figured out that adolescents utilised the promotive, preventive and curative services provided by the adolescent health corner and found the services useful for their sexual and reproductive health. Reports on adolescents’ use of promotive SRH services, especially the use of contraceptives remain divisive, because, in the study, the respondents indicated that adolescents utilised these services, but other studies have reported otherwise. This could be as a result of the fact that in some hospitals in Ghana, adolescent SRH services are youth friendly. This shows that more must be done to increase the utilisation rate.

While studies have indicated that the barriers faced by the youth in the utilisation of services are attributed to the quality of the SRH care offered (Godia, 2012) others view cultural norms as a critical component that continues to influence youths’ behaviours and actions with regards to SRH matters (Chege, 2005; Kaler, 2004). There are even instances where facilities are not available to the youth (Senderowitz & Kirby, 2006). This stems from the absence of a proper appreciation for the importance of sexual health care complemented with the current rapid social, political and economic transformations which have profound impacts on the social norms affecting the youths (Blum, 2007). In a qualitative study to assess the barriers to accessing sexual and reproductive health services among adolescents in Grenada, Khan and Richards (2014) identified religion, fear of individuals being scandalised by their community, family or religious organizations as well as social stigma as the major barriers. Other studies have also revealed misconception, poor attitude of health workers and accessibility as factors that contribute to low utilisation of the SRH services among adolescents (Muula, Lusinje, Phiri, & Majawa, 2015).
The review shows that while some adolescents are aware of the SRH services, others are not aware of it. This impedes and reduces the pattern of utilisation. Adolescents’ SRH problems, however, continue to be on a rampage although there are services to help curtail these problems they go through. This may depend on their attitudes towards utilisation, social pressures that influence adolescents’ utilisation of services and their perceived control over it. It was therefore imperative to explore these determinants using a qualitative research approach to get an in-depth knowledge on their behaviour.

2.3 Attitudes towards Sexual and Reproductive Health (SRH) Service Utilisation

According to Tegegn, Yazachew, and Gelaw (2008), adolescents’ utilisation of sexual and reproductive health services is influenced by their attitude towards the services. Attitudes towards utilisation of services may be positive or negative. A positive attitude towards SRH services will facilitate utilisation while negative attitudes towards SRH services will hinder utilisation. Chen et al. (2008) stated that SRH services are lining at the back of current attitudes and demands of university students.

McIntyre (2002) recounts that youth friendly services for adolescents must be available, acceptable and appropriate for them. If the services do not have these characteristics, the consequence is a negative attitude towards the use of the services (Bearinger et al., 2007). For example, Biddlecom, Munthali, Singh, and Woog (2007) found out that adolescents’ positive appraisal of sexual and reproductive health services was based on accessibility, confidentiality, affordability and being treated with reverence.

Knowledge of SRH services can also influence adolescents’ attitude towards utilisation of services. For instance, Lebese, Maputle, Ramathuba, and Khoza (2013) highlighted that lack or inadequate comprehensive knowledge about contraception and contraceptives leads to
negative attitudes towards using the services. Since studies have established that inadequate information on services yields negative attitudes, adequate information on details of services may yield positive attitudes towards adolescents’ utilisation of SRH services. This confirms the importance of educating adolescents on SRH services and its significance as well as the variety of services provided. Contrary to the above findings, Motuma (2012) on youth-friendly SRH services utilisation and associated factors in Harar in Ethiopia concluded that most youths had a positive attitude towards services but had poor knowledge on the services.

According to Mkumbo (2013), adolescents attitudes towards SRH education in schools were more favourable in relation to the aspects that relate directly to HIV prevention. He attributed it to the weight of AIDS crisis in Sub-Saharan African countries. This implies that adolescents view sexual and reproductive health education as a means of helping them avoid infections in relation to sexual behaviour than as a channel for promoting their sexual health in general. The same study revealed that attitudes toward sexual and reproductive health education as part of the general SRH services was related to sex, age and religious affiliation. Measor (2004) found the same determinants of attitudes towards SRH education. This shows that adolescents cannot be regarded as a homogenous group. Their SRH challenges besides perceptions towards utilisation of available services are varied and show disparities between boys and girls.

Godia, Olenja, Hofman and Van Den Broek (2014), agrees on these disparities between male and female adolescents. They found that young people’s views of the SRH services available are not uniform and display with disparities between males and females. In the study, young girls utilising family planning clinics and antenatal care services had a positive appraisal of the use unlike young boys. Similar outcomes have been testified in Mozambique where an
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An appraisal of youth-friendly health services provided within public health facilities figured out that the services met their needs on contraception and antenatal care and had a positive attitude towards utilisation of those services (Hainsworth, Zilhao, Badiani, Gregorio, & Jamisse, 2010). However, the study by Godia, Olenja, Hofman, and Van Den Broek (2014) cannot be generalised to even the whole of the Kenyan population and largely sub-Saharan African countries because it made use of a qualitative approach. On the other hand, it is possible that there are some shared experiences among adolescents across the countries in this region. Focus group discussions with adolescents in the study were not unified by age and marital status classifications. Moreover, the study relied on self-reported data mostly which is vulnerable to bias particularly concerning sexual behaviour.

Evidence shows that younger adolescents do not have the same attitude and needs as older adolescents and that marital status of adolescents affects utilisation of SRH services. Service providers are more open to providing contraception to adolescents who are married and have begun childbearing than those who are single and without any child (Tilahun et al., 2012).

Berhane, Berhane and Fantahun (2005) conducted a study to assess health service utilisation of adolescents, their attitudes towards the existing health services and their preferences. The study pointed out that the adolescents did not find the existing services fully accessible, affordable and acceptable. It was also discovered that adolescents prefer to contact their peers or rather suffer in silence anytime they have reproductive health problems. Most of the adolescents who suffered reproductive health illness in the last three months before the study did not seek treatment. This is an indication of their negative attitudes towards SRH services. Once more, the same determinants of attitudes were discovered in their study. A significant fraction of adolescents preferred services within the general services as they view that it will be
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hard for people who are familiar with them to detect the reason why they utilised the health services. Others also preferred services outside their residential areas to overcome the attached stigma to the utilisation of services. Regardless of the disparities in preferences, all wanted confidential and friendly services. This implies that there is a need to make use of all opportunities to provide adolescents with suitable services to influence their attitudes positively towards reproductive health service utilisation. The study was a cross-sectional quantitative and made use of a self-administered questionnaire. The method was appropriate in assessing attitudes and patterns. However, generalising the findings may not be appropriate, because, in places where adolescent SRH has advanced, the attitudes of adolescents towards service utilisation are mostly positive (Lesedi, Hoque, & Ntuli-Ngcobo, 2011). For instance, adolescents in a study in Botswana positively appraised SRH services and had the perception that such services are of utmost significance for their development. The researchers observed that it was very possible due to the fact that in Botswana, all persons of reproductive age have the basic right to decide for themselves how many children to have and when to have them irrespective of age or marital status (Lesedi et al., 2011). In Sri Lanka, adolescents were happy to accept and utilise services available in public clinics, and other health services rather than other organizational set ups (Agampodi, Agampodi, & Piyaseeli, 2008).

Adolescents’ attitude towards SRH and utilisation of the services is dependent on many factors and it may vary from one culture to the other. In a study in Nigeria, it was found that family planning services were available but were not utilised well because most of the adolescents were not bothered about unexpected pregnancies and other outcomes of engaging in unprotected sex (Isonguyo & Adindu, 2013). Fear of imprisonment and imposed marriage in case of impregnating a young girl changed the attitudes of young men towards contraceptives.
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(Nalwadda, Mirembe, Byamugisha, & Faxelid, 2013). These researchers also found that young women were influenced to use contraceptives to avoid unplanned pregnancies and protect themselves for long span relations. Moreover, in another study, Hispanic male adolescents who had no formal education on condom use had lower odds of using it whereas African-American male adolescents and those with positive attitudes about condom use had greater odds (Manlove, Ikramullah, & Terry-Humen, 2008).

2.4 Social Pressures (subjective norms) that affects Adolescents’ Utilisation of Sexual and Reproductive Health Services.

Adolescents’ behaviour is normally influenced by the approval or disapproval of significant others in their lives. An adolescent who believes that significant others approve of utilisation of SRH services may have intentions to utilise the services and vice versa. A study revealed that, social stigma is the most common barrier young people face when seeking for contraceptive or STI services (Biddlecom, Munthali, Singh, & Woog, 2007). Other studies have highlighted the same barrier and much more (Dehne & Riedner, 2001; Amuyunzu-Nyamongo, Biddlecom, Ouedraogo, & Woog, 2005). The social pressures adolescents face partly justifies why adolescents’ utilisation of SRH services is not optimum. In Burkina Faso, Ouedraogo, Woog, and Ouedraogo (2007) analysed in-depth interviews with adults about their perceptions of SRH problems of adolescents. It was discovered that adults were supportive of adolescents accessing SRH information but less accepted that adolescents should utilise SRH services. A conclusion was made in another study that positive changes in community level and social factors play a significant role in improving utilisation of SRH services among adolescents (Mmari & Magnani, 2003). Bam et al. (2015) found friends and peer group influence as a major motivator to utilise SRH services.
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Feleke, Koye, Demssie, and Mengesha (2013) aimed to assess factors affecting SRH services utilisation. It was discovered that mothers who are educated are more open to discussing SRH issues especially family planning with their children. Such mothers are also accommodating in dealing with challenges faced by their wards concerning SRH service utilisation. Moreover, this research reported that discussion of the service with peer groups, sexual partners, relatives and teachers was significantly associated with SRH service utilisation especially family planning. This can be explained by the fact that discussing services with diverse kind of people gives adolescents the opportunity to build comprehensive knowledge about service utilisation and swap information and experiences. The quantitative design which was used was suitable for such research. However, social desirability bias might have resulted in underreporting SRH service utilisation.

Ayehu, Kassaw and Hailu (2016) found out the level of young people SRH services utilisation and its associated factors in Awabel district, Northwest Ethiopia. SRH services were more likely to be utilised by the young people who had discussions with their parents on issues of SRH, as compared to those who did not have such privileges. This could be that the young ones become more knowledgeable and gain awareness of SRH services through open discussions with their parents. Hence, it may serve as a motivation to them in utilising the service. An observation was made on the utilisation of the SRH services for the young people, and it was noted that the rate of utilisation of the services was higher and associated more with them that had participated in peer education on issues about SRH and ever had sexual intercourse. Continuous engagement in SRH peer education by the young people was perceived to give them a better understanding of the services, hence a possibility to increase their need for the service. It was therefore concluded that to avoid risky sexual activities by these sexually active young
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people; there is a need for them to acquire information and counselling services for them. A study carried out in Mekele also bespok a positive effect on the awareness of contraceptive use by female students who had discussions on SRH services with their family and peers (Melaku, Berhane, Kinsman, & Reda, 2014).

When society rules out the likelihood of unmarried women having gynaecological diseases, their need for such services and information on the services are unmet. Sometimes, families do not consider it necessary to provide any information on this subject to women who are not married. This is evident in a study by Mohammadi, Kohan, Mostafavi, Gholami (2016) to explore the concept of stigma in the context of SRH service utilisation by unmarried women. It was noted in this study that unmarried women had a fear of being stigmatised by significant others because they (significant others) do not approve of utilisation of SRH services among such population.

For instance, in Isfahan, most females depend on their families for SRH services because they stay with their families until they are married. Due to this stereotypical way of thinking and fears of unmarried women, they do not want to utilise SRH services when they are having gynaecological issues as noted by the researchers. In some countries like South Asian countries, where premarital sexual relationship is prohibited (Wellings et al., 2006) and virginal status is highly esteemed, it has influenced the provision of SRH services (Sychareun, 2004). Akinyi (2009) also recounted in a qualitative study that religion is significantly associated with utilisation of SRH services. This is because he realised from his study that some religions disallow adolescents from utilising youth friendly SRH services. He also found that most ethnic groups prohibit premarital sex and youth were punished for utilising family planning services. Other studies have confirmed the results of these studies that when significant others do not
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approve of utilisation of SRH services, it puts fear in the acclaimed unqualified users (Biddlecom et al., 2007; DeJong & El-Khoury, 2006). The qualitative design which was used was the best in generating in-depth knowledge about experiences. However, the high dependency of the study on a specific cultural context limits generalisation. In a setting where there are no prohibitions on premarital sexual activities, different findings may be detected. Moreover, the population which was studied included all women in their reproductive age. However, focusing on adolescents alone will also help promote their use of the services by the findings that will be generated. This calls for another qualitative study in a different cultural setting like Ghana to generate more knowledge on adolescents’ utilisation of SRH services.

A qualitative study by Kennedy et al. (2013) revealed that, in Vanuatu, social norms and taboos regarding adolescent SRH behaviour were factors that significantly prevented adolescents from utilising SRH services. These contributed to disapproval from parents and community gatekeepers. Including parents and other gatekeepers in such a study would have yielded information useful to identify possible targets for intervention.

Gebreselassie et al. (2015) reported from their quantitative cross-sectional study that the chances of SRH especially family planning service utilisation were three times higher among adolescents who had discussed with their sexual partners than their counterparts who had not. They recounted that adolescents who had deliberated on SRH service utilisation were two times more likely to utilise the service for VCT with peers than their colleagues. Those who had discussed SRH services utilisation with health workers were more likely to make use of the service four times more than their friends. This shows that social pressures play a role in adolescents’ utilisation of SRH services. In general, it was found that most of the adolescents were utilising SRH services mostly because their significant others approved of it.
Notwithstanding, other factors like educational level also facilitated the utilisation. Adolescents’ experiences with subjective norms will yield more information. The study made use of adolescents from 15 to 19 years which is very characteristic of the adolescent population because at this age they can better communicate their challenges well. A similar finding was yielded in a qualitative study that healthcare providers and opinion leaders approved of family planning which facilitated utilisation (Enuameh et al., 2015).

2.5 Perceptions of abilities to Utilise Sexual and Reproductive Health Services

Perceived control is determined by control beliefs concerning presence and absence of facilitators and barriers to behavioural performance, weighed by their perceived power or the impact of each control factor to facilitate or inhibit the behaviour (Ajzen, 2006). The available resources and opportunities to the adolescents must to some extent order the likelihood of utilisation of sexual and reproductive health services.

Marcell, Morgan, Sanders, Lunardi, Pilgrim, Jennings, and Dittus (2017) researched mid-Atlantic City in the US to explore perceptions of facilitators/barriers to the use of SRH services among an urban sample of African-American and Hispanic young men aged 15 to 24 years. At the structural level, participants’ concerns were factors such as confidentiality, long visits and cost of services. At the social level, the impact on the reputation of these men resulting from the stigma of being seen by inhabitants of the community as they patronise the SRH services was of much concern. Factors at the personal level included fears and anxieties that came with testing and self-risk assessments. With regards to issues of male adolescent-provider relationships, adolescents described their desire to want a choice in the provider they see, respect from the provider for their body during examinations, and their (adolescents’) need for a higher level of self-confidence in asking/answering questions. In comparing with older males in the sample of
the study, these needs of the adolescent males are not as heightened as to the older males. These needs could most probably be attributed to the developmental stage of the adolescent males and their masculine convention of seeing same gender providers. The contributory factor to the lack of self-confidence in males on talking about sexual health can be attributed to the lack of preparation of these males for SRH-related visits. This can be associated historically with the cultural context of SRH. The study was exploratory and did not test the association of factors identified with the use of SRH services. It could be that the issues young men in the study thought to be important to their use of SRH services may affect their future use of services. However, it could also be that prior use of SRH services shaped their views. The use of focus group discussion helped the participants to discuss the perceived facilitators and barriers to the use of SRH services.

Tamang, Raynes-Greenow, McGeechan and Black (2017) investigated the knowledge, experience and utilisation of SRH services among Nepalese youth living in the Kathmandu Valley. It was a mixed method study which used young men and women aged 15 to 24 years. The study did not record any hindrance to SRH care as pertaining to the lack of access to its services. Key barriers such as a sense of fear and shame are the few contrasting factors to the accessibility of the SRH services, although the services were available. Similarly, in previous studies, impacted sociocultural taboos, fewer number of youth friendly services available, a sense of shame and fear springing from parents and the society at large, behaviour and attitudes exhibited by professionals in the health field, just to mention but a few, were the main hindrances to SRH care as gathered from previous studies (Regmi, 2009; Regmi, Simkhada & Teijlingen, 2008). However, there was the possibility of acquiring less legitimate information from the youth as some may have concealed personal and sensitive information due to the face-to-face nature of
conducting interviews. Moreover, there may have been a possibility of some form of bias from the young women due to the unwillingness of some of them to reveal pre-marital and unprotected sexual relations.

Subashi (2014) conducted a study among adolescents (14-19 years) using focused group discussions. He found that uneducated adolescents went to traditional healers when they had STIs. They were unlikely to seek for orthodox treatment because of high cost, negative attitude of providers, slow service and perceived lack of confidentiality. This means that the adolescents had no control over the perceived barriers and so could not utilise SRH services. The use of the qualitative method helped to yield rich in-depth knowledge.

Marrone, Abdul-Rahman, De Coninck, and Johansson (2014) pointed out that, place of residence and marital status predicted contraceptive use among sexually active adolescents in Ghana. Wealth index lost its value in the multivariable analysis in this same study. The wealth index defined in the study was a compound indicator of all income and assets of individual household members but not adolescents. The possibility that the results would have been found is high if they were centred on individual wealth. Although adolescents may be from rich homes, they do not have control over how the income is used. In Serbia, a study found that adolescents who perceived that their family was rich had a lesser tendency of using contraceptives. However, the ones with high weekly disposable income were found to have a high tendency of using contraceptives (Vukovic & Bjegovic, 2007). A further qualitative study to help give a detailed explanation to the trends of contraceptive use, as well as the individual experience, is significant.

There is a clear indication that poverty affects access to contraception. Contraceptive use is unequal within countries and differs by place of residence, education and ethnicity as well as
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by wealth (Malarcher, 2010). Greene and Merrick (2005) give evidence that globally, the unmet need for contraception is highest among poorer women.

Lim et al. (2012) also researched on “Adolescents’ views on barriers to health care”. The researcher used a qualitative design with focus group discussion to gather data from participants. They found out that, most adolescents reported experiencing barriers to making an appointment. Moreover, participants complained of long waiting times before being seen by service providers. Another key barrier identified was knowledge and perceptions about consent and confidentiality. The best approach to get in-depth knowledge of the adolescents’ experiences of utilising the services is a qualitative method and that was what was used in the research.

To add to the above hindrances, in some places, aside the low health seeking behaviour of adolescents, the resources are not available for the adolescents. There is no access to SRH information and the existing health services are adult-centred. Moreover, service providers are not well trained to address adolescents’ SRH needs as reported by Ayehu, Kassaw, and Hailu (2016) in a review of earlier reports. Omobuwa, Asekun-Olarinmoye, and Olajide (2012) explored the perceived reproductive health problems among in-school adolescents in Ile-Ife, Nigeria. Their perceived behavioural control determined their intentions to utilise the SRH services. They had little or no access to youth friendly services even though they had a preference for government hospitals for seeking services.

Sometimes health services are packaged in a way that adolescents do not want to access even if they can. In some places, adolescents have to go and wait for a long time at where people they are familiar with can see them (WHO, 2012). It was reported another time that adolescents from rich background might find health services friendly but those living and working on streets may see it otherwise.
Chilinda et al. (2014) found that lack of youth friendly SRH services left many adolescents feeling ill-equipped to access SRH services which were the same as found in other studies (Koster, Kemp, & Offei, 2001; Khalaf, Mogli, & Froelicher, 2010). Adolescent boys did not utilise the service because there were no male service providers to attend to them.

**2.6 Intentions to utilise Sexual and Reproductive Health Services**

Intention to use family planning is a significant pointer of the possible need for SRH services among adolescents. Abubakari et al. (2015) conducted a study to explore contraceptive use intentions and preferences among adolescents in the Kintampo district of Ghana. This was a cross-sectional survey which used a questionnaire as the data collection tool. In general, 54.3% of adolescents were willing to use contraceptives, but the younger adolescents were least willing to either currently use contraceptives or intended to use it in the future. The demographic health survey of Ghana and Nigeria in 2008 reported that 46% and 55% correspondingly of non-users of contraceptives who were married as at that time did not intend to use any method of contraception in the future (National Population Commission & ICF Macro, 2009). However, in the study under review, older adolescents intended to use contraceptives if they were married than the younger ones. For the adolescents who did not intend to use contraceptives in the future, the associated reasons were cost, fear of side effects and opposition to family planning. Socio-cultural and religious background played a role in predicting intention to contraceptive use as more adolescents with no education were not sure of their intention to use contraceptives as compared to those with some level of education. Furthermore, adolescents in rural communities were not certain of their intention to use contraceptives as compared to those in the urban areas. As compared to other religions, Muslim adolescents were not certain of their intention to use contraceptives in the future. The researchers were not able to interview males on all questions.
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which were used in the study and so the findings are limited to females. Moreover, the focus was only on contraceptives use ignoring the rest of the preventive SRH services.

Bam et al. (2015) in their study to assess Nepali adolescents’ perceived SRH service needs and factors influencing their utilisation found out that a small percentage of adolescents (37%) intend to utilise the SRH services in the future. Compared to 9.2% who utilised services, 15% had ever had a need for adolescent sexual and reproductive health services. Adolescent SRH service utilisation in this study was lower than that of adolescents studied in Tanzania (Abajobir & Seme, 2014) and Vanuatu (Kennedy et al., 2013). Moreover, a gap existed between those who sensed the need of SRH services and those who made use of the services. This is an indication that barriers stopped some participants from utilising services they sensed they needed. The quantitative design used does not allow for further probing into some areas which need further qualitative description. Furthermore, the study was carried out in three government intermediate schools which mean that the findings may not be generalisable to the overall population of adolescents in Nepali and beyond.

Abdul-Rahman et al. (2011) used data from the 2003 and 2008 Ghana Demographic and Health Survey to assess changes in contraceptive use among female adolescents (15-19 years old) who are sexually active. It was exhibited that between the year 2003 to 2008 there was a trivial decline in the number of non-users who intended to use contraceptives in the future. It indicates that adolescents are willing to utilise SRH services for contraception to avoid unplanned pregnancies. It was discovered that the reasons why some adolescents did not intend to use contraceptives were concerns on side effects and opposition from significant others. This complements what Agyei, Biritwum, Ashitey and Hill (2000) found in their studies. This shows that subjective norms can predict adolescents’ intentions to utilise SRH services. The reason why
adolescents had no intentions of utilising SRH services, especially contraceptives, reflect fallacies about modern contraceptives. It could also be that their concerns are not being well addressed by health care workers. It can also be that the stated high knowledge of contraception among adolescents is just appreciation of the existence of some contraceptives.

Agha (2010) conducted a study to find the intentions to use contraceptives in Pakistan. He found that men and women’s intentions to utilise SRH services for family planning methods are influenced by different psychosocial factors. He concluded that attitudes of men towards family planning services had an impact on intentions. Men who were able to deliberate on family planning issues with their wives were more likely to intend to utilise family planning services. This shows that the decision to use condom by males is a joint decision. Comparing this to some previous studies in Pakistan, Agha (2010) found that wives who are not receptive to discussing family planning utilisation issues with their husbands stop the men from intending to use family planning unlike the earlier studies. The strength of this study is the involvement of men and showing their responsibilities in SRH service utilisation. The study gathered data from married women and men and most cultures approve the use of family planning among such population. Using adolescents may yield different results.

In a mixed method study to assess intention to use long acting and permanent contraceptive methods (LAPMs) and identify associated factors among currently married women in Adigrat town, Gebremariam and Addissie (2014) reported that the intention to use LAPMs was 48.4%. This outcome was higher than what was found in a study in Goba town, Ethiopia (Takele, Degu, & Yitayal, 2012). The inconsistency can be explained by the difference in the setting and access to services. The intentions to use contraceptive services for LAPMs were low.
although most of the participants did not want to have a child within the next two years. About 59% of the respondents intended to use at least one LAPMs in the following year. The fraction of women with intentions to use LAPMs reduces with increasing ideal preferred number of children. This can also be explained by the fear of their turn of fertility after using LAPMs. Preference for more children significantly predicted intentions to contraceptive use (Agha, 2010). Other factors are educational level of partners, knowledge of LAPMs and status of occupation. This shows that the SRH service providers during counselling have to examine the reproductive intention of women and enlighten them on the available family planning methods. The study employed a mixed method which helped to triangulate the quantitative results with the qualitative findings. However, since it is a cross-sectional study, it will be difficult to establish cause and effect relationship.

Kang and Moneyham (2008) conducted a study to examine the intention, knowledge and attitude of college students regarding the use of emergency contraceptive pills and condoms in 16 Korean colleges. They found that intentions to use emergency contraceptives and condoms correlated positively with attitudes. Gender disparities existed, in that female students had higher intention of using emergency contraceptives and condoms than male students (Kang & Moneyham, 2008). This is not shocking because women feel liable for contraceptive use and are mostly affected by the consequences of unplanned pregnancies. In earlier studies, intentions to use emergency contraceptive pills varied between the populations of study.

It is necessary to assess disparities in intention to use SRH services across cultures and populations to clarify those factors that determine intentions. In some studies, for instance, the intentions to use emergency contraceptive pills showed disparities in study populations. Over 60% of males and females in samples of United States populations (Sawyer & Thompson, 2003)
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and 64.4% of postpartum women with low-income (Jackson, Schwarz, Freedman & Darney, 2003) intended using emergency contraceptive pills. Contrary to this, Ball, Marafie, and Abahussain (2006) in Kuwaiti found that less than 10% of women intended to use emergency contraceptive pills. This is why it is important to study different populations and cultures as findings may differ from one to the other. Such information is significant to building interventions to promote SRH services across cultures and populations. This is why this study deemed it necessary to find out the utilisation of SRH services among adolescents at Asante Akyem North District.

2.7 Summary of literature Review

Literature has been reviewed on the utilisation of SRH services among adolescents aided by the constructs in the TPB model. It included an overview of utilisation of SRH services, attitudes towards services, perceived social pressures, perceived behavioural control and intentions to utilise SRH services. The literature showed that attitude, subjective norms and behavioural control influence adolescent’s intentions to utilise services. Most of these studies used a quantitative approach to generate responses. However, some adolescents may have real challenges which can be yielded through qualitative interviews. Most of these studies too were conducted in other countries but revealed that responses differ across countries and cultures. Moreover, some of the studies were not on a specific adolescent group and sometimes included youth from 20 to 24 years of age. This study, therefore, used a qualitative approach and explored the utilisation of SRH services among adolescents. The next chapter gives a detailed description of the methodology that was used.
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section gives a detailed account of the type of study conducted, and it includes the research design, research setting, target population, sample size and sampling technique. Other areas include the method of data collection, data collection tool, data management, data analysis, rigour and ethical considerations.

3.1 Research Design

According to Polit and Beck (2013), a research design is the total plan for getting answers to the questions being studied. This study employed the interpretive descriptive approach which is an example of qualitative research described by Thorne (2008). It is a smaller scale qualitative inquiry of a clinical phenomenon that uses inductive analytic approaches such as informed questioning and reflective or critical examination to gain understanding into a phenomenon. This method was designed by a nurse researcher to address nursing problems, and to generate knowledge for the nursing profession (Thorne 2008). This approach was used because it allows flexibility in the collection of an array of experiences from a number of participants in a study. The design helped the researcher to explore the perspective of adolescents on the utilisation of SRH service and to generate knowledge relevant for the clinical context of sexual and reproductive health of adolescents.

3.2 Research Setting

The research was conducted at Agogo Asante Akyem North District in the Ashanti region of Ghana. Agogo, which is the district capital, is about 55km from Kumasi (the regional capital)
by road and 232 km from Accra (the national capital). It is about 18km from Konongo (the municipal capital). The district is located in the eastern part of the Ashanti Region. It shares boundaries with the Sekyere Kumawu District in the north, Kwahu East in the east, Asante Akim South District in the south and the Sekyere East District in the west. It covers a land area of 1,126 square kilometres constituting 4.6% of the region’s land area (24,389 square kilometres). The total population of the district was 69,186 in 2010. The district has a more populous rural sector (53.5%) than the urban sector (46.5%). The total number of adolescents (10-19 years) is 16,068 which is 23% of the total population. Out of this, the number of male adolescents is 8,263 (51.4%), and the number of female adolescents is 7,775 (48.4%) of the total adolescent population. Adolescents aged 15 to 19 years accounted for 7,410 (46.1%) of the total adolescent population.

The inhabitants are mostly Akans and the language that is mostly spoken in the district is Asante Twi. However, due to the influx of immigrants, there are people from all over the country and foreigners living in this town. Out of the population, 11 years and above, 79.2% are literate, and 20.8% are non-literate. The private informal is the largest employer in the district, employing overwhelming 90.1% of employed persons. About 60% are engaged as skilled agricultural, forestry and fishery workers while 16.8% are service and sales workers out of the employed population. The district experiences wet semi-equatorial climate and temperature is found to be uniformly high all year round with a mean annual temperature of 26°C. The first rainy season is from May to July and the second from September to November. The dry harmattan season occurs between December and March and is associated with drought conditions. Christianity is the major religious body in the district and constitutes 79.6% followed by Islam which is 10.2% and Traditionalist, 1.2% and others, 0.7%. About 8.2% do not belong to
any religion. The district has many educational institutions such as basic education, senior high and tertiary institutions. There are four health facilities in the district: Agogo Presbyterian Hospital, which is the second biggest hospital in the Ashanti region, Juansa health centre, Ananekurom and Nyampenase health centres. The Agogo Presbyterian Hospital provides advanced speciality medical care. The 250-bed capacity hospital offers emergency, inpatient and outpatient medical services. The Juansa, Ananekurom and Nyampenase health centres are government owned and provide only general services (Ghana Statistical Service, 2012).

![District map of Asante Akyem North District](image)

**Figure 3.1: District map of Asante Akyem North District**

### 3.3 Target Population

The target population for the study was both male and female adolescents who were currently residing in the Asante Akyem North District where the research was conducted.
3.3.1 Inclusion Criteria

The sample was made up of adolescents from age 15 to 19 years who were in school or out of school and had utilised the SRH services. This age range was selected because at those ages, the adolescents were considered relatively mature and better able to articulate their experiences. Adolescents who could speak English or “Twi” languages were recruited for the study because the researcher speaks and understands these languages well.

3.3.2 Exclusion Criteria

Married adolescents or those who were cohabiting with their partners were not included because after marriage the stigma attached to adolescents’ utilisation of SRH services especially family planning reduces. Eligible adolescents whose legal guardians did not provide consent were excluded even if they were willing to be part of the study and vice versa.

3.4 Sample Size and Sampling Technique

Sampling is the method of selecting a part of a group with the aim of collecting complete information from the representative part (Khan, 2012). There are two main forms of sampling techniques which are probability and non-probability sampling. The sampling technique which was used in the study was purposive which is a non-probability sampling method. The sample that was chosen shared the same characteristics and had experienced the phenomenon which was investigated (Maree, 2010), therefore, members of the population did not have an equal chance of being selected (Khan, 2012). A sample size of 15 was used. However, the sample size was dependent on when saturation was reached. Such a sample was appropriate for the study which was aimed at gaining in-depth data. Moreover, an interpretive description can be used in a sample of almost any size (Thorne, 2008). The most significant thing was to get in-depth data about the phenomenon studied. The participants were purposely recruited from the various health
facilities in the district. Those who gave consent were selected and further arrangements were made with them for the in-depth interview.

3.5 Data Gathering Tool

Interview and observation can be used to gather data in a qualitative interview (Burns & Grove, 2001). The interview guide is a data collecting tool for gathering data through a set of open ended questions asked in a definite order (De Vos, Fouche & Delport, 2005). In this particular study, an individual semi-structured interview guide (Appendix A) was used to gather data from the participants. This allowed participants to freely express their views and allowed the researcher to make clarifications using probes by diverting a bit from the guide (Kusi, 2012). The construction of the interview guide was aided by the Theory of Planned Behaviour and the research objectives. The interview guide had two sections I and II. Section I consisted of the demographic information of participants, and Section II was the open ended questions for the interview which focused on the issues associated with participants’ utilisation of SRHS. However, follow-up questions were asked based on the responses from the participants to seek clarifications.

3.6 Piloting the Instrument

Piloting is done to ensure the efficacy of the research instrument to gather responses and help modify the instrument before administering to the main participants (Khan, 2012). In this study, the semi-structured interview questions were piloted at the Asante Akyem Central district which has similar characteristics to Asante Akyem North. The data collected from this pilot study were not included in the research findings, however the outcome was considered before commencement of the main study. Some questions were reframed which helped the participants
to understand and describe their experiences. The piloting also helped the researcher to develop
his interview skills.

3.7 Data Gathering Technique
An introductory letter from the school of Nursing (see Appendix H) University of Ghana, Legon
and ethical clearance letter from the Institutional Review Board of the Noguchi Memorial
Institute for Medical Research (see Appendix G) were sent to the various health facilities to seek
permission to conduct the study. After the permission was granted, the researcher visited the
Reproductive Health Units of the various facilities to make further arrangements to select
participants for the study. The objectives of the study and all other details were explained to the
participants to help them make an informed decision regarding their participation in the study or
otherwise. Participants were purposively selected from the various health facilities in the district.
Individual interviews were conducted. The interviews took about 40 to 60 minutes depending on
the particular interviewee. A convenient date, time and venue were scheduled with the
participants. The interview was audio-recorded with permission from participants and
transcribed verbatim for analysis. Furthermore, field notes were taken to capture mannerisms
which could not be recorded by the audio recorder. Interview questions were constructed in a
way that helped elicit information on SRH service utilisation by adolescents. Some of the
questions were accompanied with probes to elicit in-depth information. Participants were
individually interviewed, and there were follow up interviews for two (2) of the participants to
further clarify the information given earlier.
3.8 Data Management

After each interview, the recorded data was labelled with a unique identifier and then transferred to a computer. A back up copy was kept on a compact disc which was securely stored. The recorded data was transcribed verbatim immediately after each interview. The data that was gathered has been kept in the researcher’s custody. The supervisors and the researcher are the only people who have access to it. The demographic data has been separated from the rest so that no relationship or link can be made between them. The transcripts will be kept for about five years in the office of the researcher’s supervisor following the study after which the data will be destroyed.

3.9 Data Analysis

Data analysis is a stage where the researcher puts into words the shared information of the participants. According to Carpenter and Speziale (2007), qualitative data analysis involves listening carefully to narratives, sharing descriptions and understanding what has been said in an order that will maintain the highest degree of integrity. Thematic content analysis was used to analyse data in this research. The recordings were transcribed verbatim. Braun and Clarke (2006) identified six phases in thematic analysis, and the analysis of the data in this research followed that order. The researcher familiarised himself with the data and paid attention to little details. Initial codes were then generated by organising data into meaningful units. The generated codes were combined to form themes. The themes were reviewed and broken down into sub themes. Field notes were also reviewed and added to the information obtained. Tentative conclusions were drawn from the identified categories and the themes to depict the adolescents’ utilisation of SRH services. The themes were defined and named, and then the report was produced.
3.10 Rigour

In qualitative research, rigour ensures trustworthiness and quality in the research process and findings. The main aim of maintaining rigour is to exactly represent participants’ experiences. To ensure methodological coherence and trustworthiness in this research, Lincoln and Guba (1985) guidelines were used. They include credibility, transferability, dependability, and confirmability.

**Credibility:** This is about how congruent your findings are with reality. The researcher ensured this by developing and asking appropriate questions, learning about the setting, questioning iteratively and member checking. The questions were pre-tested in a setting with similar characteristics to the setting of the study. The researcher also made sure that the people who were interviewed were the people who had experienced the phenomenon which was investigated. Member checking was conducted by verifying the responses with the participants after the interview which ensured that their stories had been well documented before conclusions were drawn. Peer debriefing was done with those interested in adolescent health services such as community health nurses.

**Transferability:** This is the extent to which the findings of a research are applicable to other settings. However, the main purpose of qualitative research is not to generalise. The researcher ensured that sufficient contextual information about the research setting was provided to help the reader to make deductions. Sufficient description of the phenomenon under investigation was given to allow readers to have a better understanding of it to help them compare the instances of the phenomenon that was described in this research with those the readers will see to emerge in their situations. Accurate records were kept of all interviews and interactions with participants, as the careful recording of data was crucial to the study. The researcher considered at all times, strict
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attention to details, adhering to procedures through consistency and accuracy throughout the research process.

**Dependability:** this determines whether the study can or cannot be replicated by another researcher (Lincoln & Guba, 1985). This was maintained by providing a detailed account of the processes involved in gathering data. In-depth accounts were given to provide an opportunity for others to know that the rigours of research were followed. Quotations from the data were included in the final report. The researcher used an audit trail to enhance the dependability of the study. It involved tracking and recording all decisions which could influence the study so an outside individual can examine the data.

**Confirmability:** this ensures that findings and ideas are views of informants. It guarantees that the sense of the data collected is not changed by the knowledge, prejudices and the researcher’s experience (Kusi, 2012). The researcher ensured this principle by clarifying all information with the participants. Specifically, the researcher took back the transcripts to the participants, told them the contents to ascertain whether what he captured during the interviews was what the participants actually said.

3.11 Ethical Considerations

All research comes with some ethical and moral challenges which must be identified and addressed before any research is carried out (Rogers, 2008). This is aimed at maximising benefit and reducing harm.

To ensure this, an ethical clearance was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana, Legon (Appendix G). After approval, an introductory letter was collected from the School of Nursing, University
of Ghana, Legon to seek permission from the District Health director (Appendix H), the managers and the in-charge of the Public Health unit of the Agogo Presbyterian Hospital (Appendix I). The information sheet was given to participants to read, and for those who could not read, it was translated to Asante Twi language, so that they could understand and choose to either participate or decline. Those who agreed to participate after reading the information sheet were made to sign a consent form (Appendix D). In the case of participants who were less than 18 years and were staying with their parents, parental or guardian consent was sought (Appendix E) and child assent (Appendix F) was given to them (adolescents below 18 years) to sign. They were assured of anonymity and privacy. This was done by not using the names of participants. Moreover, the demographic data was separated from the rest of the data. Participants were assured that they have the right to participate or refuse to participate or to decline once started and this will not result in any penalty in the service you are entitled to. Participants were informed that they will not receive any direct benefit for participating but the findings of the study will be used to counsel other adolescents.
CHAPTER FOUR

FINDINGS

4.0 Introduction

This chapter presents the findings of the study which explored the utilisation of sexual and reproductive health services among adolescents at Asante Akyem North district. The chapter highlights the demographic characteristics of participants since these are useful in interpreting the data. This is followed by a description of the findings supported by choicest anonymous verbatim quotes. These findings were derived from interviews with 15 participants as well as non-verbal information written as field notes during the interviews. The field notes elucidated the data obtained from the interviews. Six major themes emerged from the data. Specifically, four of the themes were directly related to the Theory of Planned Behaviour (TPB) while two themes emerged from the data.

4.1 Demographic Characteristics of Participants

Fifteen adolescents who have utilised SRH services in the Asante Akyem North district were interviewed. The adolescents were recruited from the public health units of the Agogo Presbyterian Hospital, Juansa Government hospital, Ananekurom and Nyampenase health centres and interviewed at the venues of their choice. The numbers recruited from the health facilities lists were seven (7), four (4), two (2) and two (2) respectively. The profiles of the participants are shown in table 3 (Appendix B). The participants’ ages ranged from fifteen (15) to nineteen (19) years; nine (9) were from fifteen (15) to seventeen (17) years of age and six (6) were from eighteen (18) to nineteen (19) years of age. Twelve (12) females and three (3) male adolescents participated in the study. The participants belonged to the Akan, Busanga, Dagomba, Ga and Kokomba ethnic groups and most of them could speak English and “Twi” together with
their own indigenous languages. Ten (10) of the participants were Akans, one (1) Busanaga, one (1) Dagomba, one (1) Ga and two (2) Kokombas. Their level of education ranged from Primary to Senior High schools, and one (1) was at the tertiary level. Thirteen (13) of the participants were students, and two (2) were out of school but were learning dressmaking and hairdressing. Most (12) of the participants were staying with their parents, and three (3) of them were staying with other relatives. Ten (10) of the participants were Christians, three (3) belonged to the Islamic religion, and two (2) belonged to the traditional religion.

4.2 Organization of Themes

The themes that emerged from this study were consistent with the constructs of the TPB such as attitudes of adolescents towards SRH services, subjective norms or social pressures that affect adolescents’ use of SRH services, facilitators/barriers to utilise SRH services and behavioural intentions of adolescents towards utilisation of SRH services. However, two themes emerged in addition to the constructs of the TPB which were: state of adolescents before use of SRH services and perceptions about SRH services. Sub-themes were identified and categorised appropriately under the six major themes after indexing (coding) of the data and categorising them based on identified patterns among them. These are highlighted in Table 2 and described in the ensuing sections.
Table 4.1 Themes and Sub-themes

<table>
<thead>
<tr>
<th>Objective</th>
<th>Major themes</th>
<th>Sub-themes</th>
</tr>
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| Attitudes of Adolescents towards the use of SRH services | Attitudes of Adolescents towards SRH services | • Positive attitudes  
• Negative attitudes |
| Subjective norms | Social pressures that affect adolescents’ use of SRH services | • Attitudes of Parents/Relatives,  
• Attitudes of Friends,  
• Attitudes of the community members/Stigma/Gossips  
• Attitudes of Nurses  
• Motivation to comply |
| Perceived behavioural control | Facilitators/barriers | • Access  
• Quality of care issues |
| Intentions to utilise SRH services | Intentions to utilise SRH services | • Willingness to use SRH services  
• Unwillingness to use SRH services  
• Uncertainty |
| | State of adolescents before use of SRH services | • Morality  
• Sentiments  
• Rationalisation |
| | Perceptions about SRH services | • Activities at the SRH centre  
• Sources of information on SRH services and issues,  
• Perceptions of adolescents concerning services  
• Expectations/suggestions made by the adolescents concerning SRH services |

Source: interview data

4.3 Attitudes of Adolescents towards the use of SRH Services

In response to the first research question, which sought to identify the attitudes of adolescents towards utilisation of SRH services, two sub-themes emerged from the data that was collected for the study. The theme covered the participants’ favourable or unfavourable evaluation of the utilisation of SRH services which involved a consideration of the outcomes of
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the use of SRH services. There was an array of comments from all the participants which showed both good and bad outcome evaluation of utilisation of SRH services. The two sub-themes that emerged were positive attitudes and negative attitudes.

4.3.1 Positive Attitudes

This covers the degree to which the utilisation of SRH services was favourably appraised by the participants. Most of the participants believed that utilising SRH services is good in the sense that they had real sexual and reproductive health challenges and therefore deemed it necessary to utilise the services. The adolescents, therefore, evaluated that if they were able to utilise the services, these challenges would be addressed. Some of the participants were of the view that utilisation of SRH services was good; because when one reaches the stage of adolescence, he or she starts developing secondary sexual characteristics for which they will need counselling and education from the SRH service providers on how to keep themselves healthy. Adolescents also believed that at this stage, there is the likelihood of engaging in premarital sexual activities and therefore found it necessary to utilise SRH services to offset the untoward consequences of their youthful behaviours. Two participants shared their sentiments:

“Okay, mostly I think the teenagers and adolescents need these services more...because we are now upcoming, we do not know much about sex, we have now entered into it, so we need more of their services since sometimes we enter into premarital sex and the outcome might be negative...maybe teenage pregnancy might come about.”

PB, age 15 years

“Okay...I think adolescents should be patronising the facility...because we are growing, boys will have wet dreams, girls will get their menses, some of us have started having sex; so if we go there they will counsel us; for those who have now had their menses, the nurses will educate them on how to keep themselves clean and those of us who have been having sex, they will educate us either to stop or to protect ourselves, and they will counsel us on STIs.”

PD, age 16 years
It also emerged that some of the participants had positive attitudes towards utilisation of the services because of the range of services rendered at the facilities. Utilisation of the SRH services provided an opportunity for them to share with their friends what they had learned from the health facilities. One of the participants noted:

“It is good because as I said earlier on, it is not only for family planning, they do counselling and health talks and also carry out tests on STIs. If the adolescents go there, they will get more and even come and teach their friends about it. So adolescents going there is good because it is not only for family planning. When I see other adolescents going there, my thoughts are that they have started having sex and they do not want to get pregnant that is why they are going there.”

PA, age 17 years

It was evident from the study that participants positively appraised the use of SRH services because of the benefits gained from the usage. The participants highlighted the education they received when they utilised services, the prevention of unwanted pregnancies and the consequences that follow, STIs prevention and treatment. Some participants were also confident in the use of SRH services because of the benefits gained from their previous utilisation. One participant shared this observation:

“I see it to be a protective measure for adolescents.... especially females. If you do not want to get pregnant, and you cannot stay away from sex, you just go and access it. It (contraceptives) keeps adolescents safe from unwanted pregnancies. I have been there for four times, and the family planning they do has prevented me from getting pregnant. As an adolescent, when you get pregnant you will not be able to go to school again and will be tagged as a “nobody” or failure in the family. When you give birth, you will not be able to cater for your child. Also,you can have health complications such STI...your health will be affected.”

PF, Age 17 years

Another participant shared the same benefits with enthusiasm. She appeared to show a positive attitude toward the utilisation of SRH services:
"It benefits...the number of people that go there can even tell you that it is beneficial. You will not become pregnant, and if you get any STI too, you can go for treatment. I have not had any STI before, but it has helped me to prevent pregnancy and I have gained much information on sexual matters."

PL, Age 16 years

A considerable number of the participants were willing to take their friends to the facilities for them to access the services because of how beneficial it had been to them. One of such participants expressed her willingness as follows:

"But it is a very good thing... a very good idea. I always encourage my friends to visit those places because I have learnt a lot from them. There are some things I would not know for instance, the cervical screening. I thought it was only when you are sick that you can go there for the screening. So it is good for adolescents. It should have been for adolescents alone...we need more help."

PC, Age 19 years

Most of the participants believed that the nurses are best informants when it comes to SRH services because they have been trained to do so. This notion encouraged them to seek for expert services. In one’s view, the nurses who have more information about the services have left their towns to provide services to them as a mandate in return for remuneration.

"The nurses have more information about it (SRH services). At the village here, how many have gone to school that can give us accurate information on something like this? They will just tell you based on their knowledge but when you go to the nurses, they have been trained and they know. They come from good places, but it is because of us that they are here, so we have to make use of them. They are paid too (giggled)."

PI, age 19 years

Another participant happily emphasised that she preferred information from the nurses to her mother because the former were skillful in expert advice:

"I would like to receive it (SRH information) from the nurses...because they are more educated on it and are freer with people... like relating to us. They have been taught on how to go about such things with adolescents but with parents; for my mum for instance, I do not think she will be the best person to assist me with that. I feel she will talk and talk and talk. She will beat about the bush but for the nurse, she will just go straight to the point."

PB, age 15 years
The positive attitudes of a few of the participants towards SRH services were also influenced by their prospects. A few adolescents accessed services for pregnancy prevention because of their prospects. It was found that adolescents had future expectations for their lives. They wanted to achieve these life goals and so saw pregnancy as an impediment. They, therefore, decided to prevent pregnancy at this stage by utilising SRH services for contraceptives. This was evident in the statement below:

“I also decided to go there and do the family planning. I do not want any pregnancy so far as I am pursuing my education. I do not want to end my education here...I want to become somebody in the future.”

PF, age 17 years

Participants disclosed that they were sexually active and were in sexual relationships and as such were worried about getting pregnant and the consequences of the unwanted pregnancies as well as contracting STIs. Some thought of how their parents would treat them if they should get pregnant or impregnate a lady. These fears motivated them to utilise the SRH services. It appeared they have positive attitudes towards utilisation based on these fears. Two participants made the following observations:

“Look at someone like me...if I should impregnate a lady, what can I do for her? I cannot take care of her and the baby, we will all drop out from school, and we will not be able to take care of the child. As for this girl, her parents will even take me to the police station. I will not even try!”

PM, age 18 years

Another participant reiterated and emphasised that her sexual partner was sexually active and likes to have sex more often. She shared this:

“My boyfriend... he likes sex too much. Sometimes if you do not want to do it... he will start crying on you, and he is not the one going to get pregnant, so sometimes I will be thinking...what if I become pregnant because most of the times too, we have unprotected sex so I am afraid that I might get STIs or something. I had issues too with my menstrual cycle asI have said earlier and that is why I went there.”

PD, age 16 years
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In all, most of the participants had positive attitude towards services mainly because of the benefits they derived from the use of the services. The next section describes the extent to which the utilisation of SRH services was unfavourably appraised by the participants.

4.3.2 Negative Attitudes

Even though most participants had good attitudes towards the use of SRH services, some expressed negative attitudes as they believed that the services were not meant for adolescents. The reasons that adolescents gave for their unfavourable appraisal of the utilisation of SRH services included the necessity to focus on their education as well as offer assistance to their parents and not involving themselves in sexual activities. Participants also perceived that these services are meant for married people, but the adolescents are allowed to utilise them to achieve population goals and not solely set up for them. One of the adolescents expressed her views as such:

“It is meant for adults because they have reached that stage of giving birth but not teenagers or adolescents... this is because as we all know, as a teenager you are supposed to focus on your education. You have to be studying and helping your parents instead of sleeping around with men. We, adolescents, are allowed there just because they want to reduce the birth rate, but the services are not meant for us. So it is only for married women who have given birth who can go and utilise it so that it can help them.”

PF, age 17 years

A few of the participants reiterated that since the female participants are the ones who get pregnant, they are supposed to go for the services. The males will only have to go there when the female partner is not ready to utilise the services. A participant said:

“Sometimes because it is the ladies who get pregnant, we leave everything on them...like they should go for the injection so that they will not get pregnant. So if your girlfriend decides to take it upon herself to do that what will you go there again for? There will be no need...so our going there depends on the girls.”

PN, age 17 years
Another participant vehemently added the importance of condom use and how it was easy to procure it:

“You know it is the ladies who keep going, once I know how to wear condom, what else do I need to go and do? However, when there is a problem, I will not stay home, I will go for treatment, but I know the condom can protect us from STIs so if it protects, then I do not know when I will be there again. As for the condom, you can get it from any pharmacy shop. I will not go to a drug store closer to where I stay. Moreover, when I go too I will tell them a certain guy has sent me there so that they will not think I have become a bad boy.”

PM, age 18 years

This participant only sees the need to go for SRH services in the advent of a problem. His knowledge of the use of a condom, as well as easy procurement of condoms from the pharmacy, make him prefer to go to the pharmacy. Meanwhile, he disclosed his intention to hide his use of condoms to avoid stigmatisation.

This section has described the findings on the attitudes of adolescents towards utilisation of SRH service. The next section describes the findings on subjective norms, another major theme that emerged from the data and closely related to the constructs of the TPB was subjective norms. The finding that follows is based on the theme.

4.4 Social Pressures (Subjective Norms)

To answer the second research question; “what social pressures affect adolescents’ utilisation of sexual and reproductive health services?”, the theme, subjective norms emerged. This is the perceived social pressure to utilise or not to utilise SRH services. This explained the expectations and attitudes of significant others who would want the adolescent to utilise or not to utilise the SRH services and the adolescents’ motivation to comply with such expectations. The opinions of significant others concerning adolescents’ utilisation of SRH services contributed either positively or negatively to adolescents’ use of the services. The findings of the study
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revealed that most significant others did not approve of adolescents’ utilisation of SRH services as perceived by the adolescents. However, most of the adolescents were largely influenced by the nurses and their friends to use the services. Five sub-themes were identified under this theme. These were: attitudes of parents/relatives, attitudes of friends, attitudes of the community members/stigma/gossips, attitudes of nurses and motivation to comply.

All these had some influence on adolescents’ use of the SRH services. Those whose significant others approved of adolescents’ use of services were able to utilise SRH services without any negative sentiments; however, those whose significant others did not approve had negative sentiments but only used the services because of other motivating factors.

4.4.1 Attitudes of Parents and Relatives towards Adolescents’ use of SRH Services

This is the way parents and or relatives favourably or unfavourably appraised adolescents’ use of SRH services. The participants considered their parents as people who were important in their decision to use or not to use SRH services. This was perceived as a form of pressure that influenced how they used the SRH services.

It was identified that positive parental attitudes towards adolescents’ utilisation of SRH services positively influenced adolescents’ use of the services. Some participants believed that once their parents agreed, they did not have to consider the approval or disapproval of others. The parental support allayed fears and anxieties associated with the use of SRH services. She shared:
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“Because my parents are in support, I am happy...I can go without fears or anxiety. I feel okay because some people have to hide before they go but I can go there because if you see me going there, who are you going to report me to? I do not go to church so you cannot report me to any of the elders in the church or mosque...you cannot report me to my parents because they are aware. So I can go there at anytime that suits me.”

PI, age 19 years

This participant shared that he did not have to fear the repercussions of anybody because she had the support of her parents.

Another participant was largely influenced by her mother and sister to utilise the service. Although the participant was not willing because of what she thought other significant others would say, she obliged to comply because her mother and sister kept on putting pressure on her to utilise the services:

“That is my sister and my mum as I already said. In fact, they were scaring me that because I am sexually active... if I do not take care I will get STIs or become pregnant and I cannot continue my education. They were giving me pressure...in fact, they encouraged me and it has helped me. I initially did not want to go because I had this perception that people will spread bad rumours about me.”

PJ, age 16 years

A few of the participants informed their parents about their sexual relationships, and this made it possible for them to utilise SRH services. This was one participant’s response:

“As I said earlier, we were in J.H.S 2 when I became intimate with a certain girl in the class. So I asked my mum how people get pregnant. Moreover, she was like... ‘ei! you have a girl? So she started advising me that if I do not want to get any girl pregnant or get STIs then I should abstain till I get married. But she also told me about protective measures like using condom. So I decided to go there to check what they will also say.”

PO, age 19 years
Participants shared their views concerning parents’ approval of adolescents’ use of SRH services. Participants believed that the approval of their parents would foster their use of services as the statements below portray:

“It will be good if they approve of adolescents’ use of the place. It is necessary. Whenever they agree with you and you go there, you do not feel shy, and there is no fear in you...you do not panic, you even have the vim, and whenever entering there you are bold because you know your parents support you.”

PL, age 16 years

Although some parents agreed to their wards’ use of the services, the interviews demonstrated that most of the adolescents did not inform their parents before utilising the services because they believed that their parents would not allow them to access the services. This was because their parents considered them to be too young to have sex, let alone talk about protection. Another reason why adolescents did not inform their parents and relatives before use of services was that their parents were responsible for their upkeep and as such did not expect them (adolescents) to be having sex and going for protection by utilising SRH services. In the statements that follow, two participants shared their parents’ perceptions about adolescents’ use of SRH services.

“As for my parents if I tell them they will not allow me to do it. They will say I am too young to have sex and so I should not even think of doing family planning. You know that no parent wants the child to be involved in sex at this age. My mother will even beat me; she will ask why I did not tell her before I went there.”

PK, age 17 years

Another participant added that her father takes care of her and as such does not expect her to have a boyfriend at her age. She said:

“I know if I tell him too he will not allow me because he has said that once he is using his money to cater for me to learn the dressmaking, he does not expect me to be moving with any boyfriend...not to talk of having sex and then going for protection.”

PG, age 19 years
Most of the participants reported that if their parents found out that they were utilising SRH services, they would put up measures to stop them. One emphasised:

“If my parents find out, they might set a spy there to inform them the time I come there, and that will hinder me from going there. They would not like that I go there and spoil their name.”

PC, age 19 years

The above participant feared that due to stigmatisation or labelling, her parents would go to all lengths to prevent her from utilising SRH services.

Another participant noted that if the parents found out about her decision to utilise SRH services, they would react by beating her and ejecting her from the house. The participant thought she would be treated as such because of the religious background of the parents, especially the father. She expressed with a low tone:

“Eeeei...hmm...for my mum I can cool her down but my father...he is hot tempered so if he finds out...he will beat me mercilessly and sack me from the house because he will see me as a sinner and he will say that I have disgraced him. People will say how can he control the affairs of the church but cannot control his child, so he will be disappointed, and he will just sack me from the house.... for that one I am rest assured.”

PD, age 16 years

In all, it was noted that most of the adolescents had not informed their parents of their use of the services because of the perceived attitudes of their parents towards their use of the services.

4.4.2 Attitudes of Friends

This is about how friends of the participants have a positive or negative evaluation of adolescents’ use of the SRH services. It was found that most of the participants were influenced by their peers to utilise SRH services. Participants went for the services because their friends
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shared how the services had benefited them. Participants also said that their friends were aware of their sexual relationships so they advised them against pregnancies and that led to their utilisation of the services. Some were accompanied by their friends to the facility as shown in the statement below:

“As I said, it is my friend who took me there. Since we are doing the same thing (sexually active), it has influenced all of us to attend. When my friend went and told me that it has helped her I also went. At first, I went there with my friend and then when we went there, she took me inside then took me to the nurse and she left me to stand outside.”

PA, age 17 years

Another participant added that the friend had to keep pressuring her to utilise before she did. She said it this way:

“She told me that she has been going there for them to educate her since she does not want any pregnancy because if she gets pregnant the mother will be disgraced and she herself so since she does not want any disgrace she has been visiting the place. One day she told me to ‘ermm’...follow her to the place but I did not ...I told her I cannot go there. She continuously influenced me so I followed her to the place.”

PE, age 18 years

Despite the fact that most of the participants were encouraged by their friends to utilise the SRH services, a few were discouraged by their friends. Some friends did not want to continue their friendship with participants because they utilised SRH services. This was apparent in a participant’s shared experiences:

“Some of my friends think now I am a bad person among them so they try not to associate with me. Yes...at first I was not utilising the services... so we were in school the other time and we saw that a friend had gone for the service. People were saying all sorts of things about the friend that...she has been having sex. That is why she has been going for this service, so nobody was willing to socialise with the girl again.”

PF, age 17 years
The next section presents the findings on the attitudes of the community members towards adolescents’ use of the SRH services.

4.4.3 Attitudes of Community Members/Stigma/Gossips

The community members constitute the rest of the people in the community aside the other discussed significant others. According to the participants, some of the community members accept adolescents’ use of the services because they do not want the adolescents to become pregnant. Participants perceived that those who accepted their use of services were mostly the educated ones. Two participants’ shared views were:

“Some of them accept, others do not accept. Those who accept it do so because they do not want us to be getting pregnant like that at that age.”

PI, age 19 years

Another participant also reiterated that the elite supports their use of the services whiles the uneducated people do not. She said her thoughts:

“The well educated people in the society will say it is good because they are giving you advice, your parents cannot give you such an advice so it is better if you go there.”

PB, age 15 years

Most of the participants in the study thought most community members do not approve of their (adolescents) use of the SRH services because they think it will expose them to premarital sexual activities. The participants also thought that the adults wanted them to grow and become adults before they could engage in sex as shown in the statement below:

“Just that the adults want us to grow before we engage in sex so if they see you going there, they will know you have started having sex and you are going to protect yourself from becoming pregnant. Some say it is not good because they think when we do the family planning we will be promiscuous and be having sex with men whilst our parents are asleep and they do not like it that way.”

PH, age 17 years
Some adults (traders) around the health facilities where SRH services are provided gossip about adolescents who use the facility and reportedly label them as bad. According to the participants, those women have the perception that the facility is for married and older people and not for adolescents. These gossips appeared to deter the adolescents from use of the facilities for the intended purposes. Some of the participants narrated their experiences:

“They gossip especially the women...they will be like eei.... this girl too what is she coming to do here? This small girl what is she here for? The women who are selling around the place do gossip because they think it is for married and older people but not for the people of my age. Sometimes what they say comes out...they will call you and ask you what you are going to do there but as for me I once told them I was going to look for somebody.”

PA, age 17 years

A 16-year-old participant also shared that she had to stop going for the service on a particular day because of the attitude of a woman towards her. She said:

“The other time I remember it was a break time so I was going to the facility and when I was about to enter, a certain woman, she looked at me up and down I had not even yet greeted her ooh...so I did not even go there again and I went back. The way they will eye you, sometimes they will gossip, it is really bad. They have really been gossiping...they say I am bad.”

PD, age 16 years

None of the participants informed any religious leader about their use of SRH services. Some did not want their various religious denominational leaders as well as members of their denominations to see them because they said they always preached about sexual abstinence until marriage. A number of participants shared their concerns about how their religious leaders would react towards them if they got to know of their use of the services. Adolescents thought the religious leaders would say they had become unholy. The statements that follow show the thoughts of some adolescents regarding their use of SRH services and possible reactions from religious leaders:
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“For the religious leaders, they will see me as …. (chuckled) I do not know how to put it...as a sinner.... like I am unholy...like as young as I am, I am doing all these (sexual activities) then if I grow up what will I do? Hmm.”

PD, age 16 years

Another participant looking worried emphasised that religious leaders will never advise the unmarried to engage in sex let alone going for the services:

“As for religion, you know that no church will teach us to go and have sex at our age.... but we are not able to control ourselves sometimes. So for them they will not advise those of us who are not married to be going for family planning. It gives them the idea that we are having sex...meanwhile they preach against it.”

PC, age 19 years

On cultural considerations, most of the participants did not know about their culture in relation to adolescents’ utilisation of SRH services. Adolescents shared their thoughts on the issue since they did not know much about their culture. Some felt restricted because of the perceptions of the community. One voiced that:

“Like I said, I do not know much about our culture... but I do not think the leaders will permit teenagers to go for such services. In the community, although they do not have any laid down rule as in.... adolescents should not go there, they do not want us to be having sex at this time, not to talk of protecting ourselves against pregnancy. If you say you are going to do family planning, I think they will say what family do you have that you are going to plan? (giggled). ‘Ahaha’.....so you see it restricts us.”

PC, age 19 years

Having looked at the attitudes of significant others towards adolescents’ use of SRH services, the attitudes of nurses, who are the service providers in the facilities are presented in the ensuing section.
4.4.4 Attitudes of Nurses

The nurses are the health professionals who render SRH services to the adolescents. Their attitudes towards adolescents’ use of the services encouraged or discouraged the adolescents. Since all the participants had used SRH services before, they all shared their experiences regarding the nurses.

Almost all the participants had experiences of positive staff attitudes. Positive attitudes refer to the good treatment the nurses gave to the adolescents when they utilised the services. Some participants thought that the nurses would react negatively towards them, seeing that they were adolescents, but this did not happen. The nurses were patient and gave participants the opportunity to ask questions for clarification. One participant noted:

“With my encounter with them, when I went there, they were cool. They counselled me...I had many questions, so I thought they would even get angry and sack me but they were patient and explained everything and they said anytime I have questions I can come. It was my first time...I did not know what they would say or do to me. A 16-year-old girl....hmm...so I was thinking as small as I am they will be angry and sack me but that was not the case.”

PD, age 16 years

Most of the participants emphasised that the reason why they had constantly and frequently utilised the services was partly because of the nurses’ positive attitudes towards them.

“Oh, if they were not nice to me I would not have gone to the place for ten times. I would have picked a car to Agogo to do it. They are good; they have time for us...they educate me despite the fact that I have been there for many times. So I am okay with their attitude; they will not frown at all.”

PI, age 19 years

Even though most of the adolescents were content and satisfied with the nurses’ attitudes towards them, a few shared their experiences of the negative attitudes of some nurses. Negative attitudes were the bad treatment the nurses gave to the adolescents when they visited the facility.
Some nurses were not friendly to the adolescents and some discussed the issues of the adolescents in their absence. A seriously looking participant shared:

“I was there one day and one girl came to the place for family planning, some rod thing ....the jadelle...they inserted.... when she left, I heard the nurse telling her other colleagues that the girl is 18 years and she has come for family planning so that will probably prevent me from visiting the hospital for such services. I felt bad for her. She did not hear because they did not say it while she was around. I felt bad because I was thinking about myself that when I leave the same will be done at my back.”

PO, age 19 years

A few of the participants complained about the negative attitudes of nurses at the SRH facilities describing such attitudes as deterrents to adolescents’ use of the facilities as well as unprofessional behaviour.

4.4.5 Motivation to Comply

This was the degree to which adolescents decided to comply with their significant others’ expectations of them regarding their utilisation of SRH services. The findings of the current study showed that most adolescents utilised the services based on the influence of mostly their friends and the nurses who went to their schools. A few were influenced by their parents to utilise these services. Most of them complied with what was expected of them by these significant others (friends and nurses) to use the services. However, others had not informed most of their significant others such as parents, community members which included their opinion leaders and religious leaders because of what they thought such people expect of them which in turn would stop them from utilising the services. Such adolescents were however motivated to use services by the fear of having unwanted pregnancies and or STIs which they do not desire. These fears influenced their attitudes towards utilisation of SRH services which has already been presented above.
A participant said:

“At first, I cared about their gossips, but I have made up my mind that it is not because of them that I will not go there so right now even if they talk...I have not heard!”

**PD, age 16 years**

This participant previously cared about the thoughts of others concerning adolescents’ use of the SRH services but has now decided to go no matter what they will say.

It was also noted that they thought more deeply about the benefits rather than what others would say. Some of the participants verbalised that they were too old to depend on others for their decision to utilise SRH services. Two participants shared these thought provoking sentiments:

“If you follow them, they may tell you not to go but you know what you are doing and you have to go there for protection. Although you are afraid, you have to take a bold step because of your future. Your parents may get angry when they see but you know what is better for you. Sometimes, if you follow them, you will later regret... so no matter what, I will go for the services because it helps me.”

**PL, age 16 years**

Another participant shared her sentiments on the same issue and burst into laughter at the end. She said that once she was legally recognised in the country to have a choice, she could decide what she wants to do. She appeared not to fear what others will say but the benefits she will gain.

“But 19 years I am not young... I vote to decide who should do this or that in the country so I can also decide what to do. I do not want to get pregnant now... that is why I go there. Some people even marry at this village before 19 years, so I have even done well. So nobody can say I should not go there. Some people at my age have two children so what if they get to age 30? (laughed).”

**PI, age 19 years**
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Having presented the findings on the social pressures that influenced adolescents’ utilisation of SRH services, the next section focused on the factors that facilitated or hindered adolescents’ effective use of such services.

4.5 Facilitators/barriers (Perceived behavioural control)

To answer the third research question, on “what are the perceptions of adolescents concerning their abilities to utilise sexual and reproductive health services?”, the theme that emerged was perceived behavioural control (facilitators/barriers). This was the adolescents’ belief about the presence of factors that might facilitate or impede the utilisation of SRH services. It was found that these factors were relative; a factor which facilitated a participant’s utilisation could act as a perceived barrier to another. Factors such as distance from a client’s house to the facility, location of the facility, social and financial access were identified. Some quality of care issues which included: working hours, waiting time, the cost of services, the range of services, availability of drugs and other logistics and provision of services were also identified. These factors made it easier for some adolescents to access SRH services while to others, they were challenges which reportedly could deter them from further use of the services. Two sub-themes emerged from this theme. These were: access and quality of care issues.

4.5.1 Access

This refers to the opportunities, right or ability and the means by which adolescents utilised SRH services. The concept has been further categorised into social, geographical and financial access based on the findings of the study.
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i. Social Access

This is about whether adolescents have the right to and are allowed by society to make use of SRH services. Participants shared that the facility is accessible to adolescents because they see other adolescents using the place apart from themselves and have not been stopped from going there. A participant stated:

“The place is made accessible to adolescents. I am not the only one who goes there. As for the girls who are of my age, I know a lot of them who have made the place their second school (giggles)...they go there but nobody has been sacked or cautioned that, do not come here again.”

PM, age 18 years

However, some participants shared that some adolescents do not like going there although it is accessible to them because they are afraid of what the community members will say when they see them. Participants were also apprehensive about what their parents would do to them when they found out about their utilisation of SRH services. Participants added that more adults used the facility than the adolescents, so it appeared the services were meant for only the adults:

“Adolescents can go there but they do not like going there because they are afraid of what people will say and they are afraid of what their parents will do to them when they find out because the grownups go there more than we the adolescents. Sometimes when I go there, I see only two of my age group, the rest of them, they are my mother’s age group and I am there with them.”

PD, age 16 years

ii. Geographical Access

Geographical access involves the distance from the adolescents’ residence to the facility and the location of the facility. The findings of the study revealed that the distance from
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participants’ residence to the location of the health facility were problems to and at the same time enablers to others depending on where the person lives and the person’s preferences.

Location of Facilities

Among the four facilities used for the study, it was noted that the participants from Juansa and Nyampenase were comfortable with the location of their facilities. Participants said that the facilities for the SRH services were at the main hospital and not separated from it, so most people were not able to identify the reason why they went there. This can be seen in the statement below:

“I like where it is. It is at the hospital and until you enter the specific place they may not know where you are going. Hmm...People may see you but not much. You just have to concentrate on what you are doing.”

PL, age 16 years

The findings indicated that the adolescent participants preferred not to be seen when going for SRH services. Participants chose to do so privately. Those who used the two named facilities were satisfied with the location and integration of SRH services with general health services.

However, at Ananekurom, it was identified that the facility for SRH services is near the market and adolescents were not likely to go there on the market days when many people come around for marketing. A participant responded:

“Oh, when you get to Ananekurom it (the SRH facility) is at where the market is. When you go there on a market day, you will meet a whole lot of people there because they come from the villages around for market and some take advantage of that to do the family planning...the adults. Someone told me so I did not go there on a market day.”

PG, age 19 years
At Agogo, few of the participants were comfortable with the location of the SRH facility. Participants indicated other activities take place at the same facility they have SRH services, and that will make it difficult for people outside to detect what they are going there for:

“The location to me is okay...because they render other services there; the rehabilitation centre and the mental health centre, so it will be difficult for people outside to detect what you are going to do. Some of the nurses live in that house so it may be that you are going there to visit someone or to look for someone.”

PF, age 17 years

However, most of the participants were not comfortable with the location of the facility at Agogo. Some felt shy to go there because of the other institutions close to the place where they go for the services they need and the people that sell around the place. Thus, although a few participants were comfortable with the location because of the other activities that take place at the same facility, others were not comfortable with it and suggested that the SRH services should be at the main hospital:

“But the place is an open place. It should have been inside the main hospital so that we can enter as if we are sick and we are going for treatment. All the same, this place too, people take their babies for weighing there and the mentally challenged people also go there for treatment. However, everybody knows that at my age I am not going for weighing, and I am not mentally challenged too, so they will know that I am going for reproductive health service.”

PC, age 19 years

Another participant worriedly added and suggested that the SRH department should be attached to the main hospital. She shared:

“You see...as I said, it is behind a bank and there is a school also there and there are some people selling there. So personally, I feel shy because many people are around. There is also a child welfare clinic at the same place so there are sometimes a lot of people around and that makes me shy. Moreover, it is outside the hospital.... if it is inside the hospital they will know that maybe you are going for medical treatment. So as for the place, they should move it to the hospital because it stops people from attending.”

PA, age 17 years
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Distance

The findings showed that few of the participants stayed closer to the facility and that enabled them to visit the facility anytime they wanted to visit. This was evident in what one participant shared:

“For me, where I stay is closer to the facility so I do not have any problem. Anytime I want to go there; I can just walk in ... I can easily go.”

PF, age 17 years

For a few others, they could not access the services regularly because of the distance from their residence to the facility. One of them noted:

“I am not able to go there regularly because of the distance. In fact, it is very far from where I am staying.”

PM, age 18 years

A few of the participants also shared that although the distance from their residence to the place of service is far, they were motivated to use the services by the benefits they would derive from accessing them:

“Oh although it is far, it is okay for me. The distance is not an issue ... I cannot take care of a baby now but in the future so I do not have to give birth now. So I have to do all that I can to make sure that I do not get pregnant.”

PI, age 19 years

iii. Financial Access

This is the financial means by which adolescents make use of SRH services. Participants shared their financial means of accessing the services based on the transportation from their place of residence to the place of service which was related to the distance and also the cost of the services they go for. It was evident that participants who had financial support from their
parents had no problems with finances for transportation or the cost of services. It was also identified that some participants felt the cost of services was affordable compared to the costs involved in the consequences of unwanted pregnancy. This was clear in some participants’ responses shown below:

“It is affordable. It is affordable because once you go there you are attended to. It does not matter like...whether you are insured or you do not have. Once you go there you are attended to. And once they attend to you, you have to pay something. And for me, my mum took me there so she paid.”

PB, age 15 years

Another participant emphatically added that the cost of prevention is lower than the cost associated with bearing the consequences of unwanted pregnancies. She stated that:

“It is very very affordable. My mother gives me money. However, if you have to pay yourself, when you impregnate a lady and you want to abort, the amount you will spend on abortion is very expensive...so the amount we pay for the prevention I think should even be high so that people can appreciate it. However, it is very cheap...GH¢1.00 or so.”

PO, age 19 years

However, a few of the participants reported that the services are not affordable and that impeded the frequency with which they accessed the services at the unit. Thus, they suggested that the National Health Insurance Scheme (NHIS) should cover the SRH services. One emphatically said that:

“It is not affordable. The first time that I went, they collected GH¢8.00 and the second time they collected GH¢1.00. However, we have NHIS... it should be able to cover all. That is why I skip some of the appointments.”

PA, age 17 years

A few of them expressed that if the services are made free, more adolescents may utilise the services. Concerning the distance and the costs involved in transportation, it was noticed that
based on where a participant resides the cost may be high for the person and as such may impede service utilisation:

“I think it is expensive and if they make it free of charge they may get people than they are seeing. Maybe when the person is going to school, the person is given GH¢2.00 and the person use that GH¢1.00 for the service, she cannot use GH¢1.00 for food...it cannot satisfy the person. From where I stay to the place, going there and coming back is GH¢2.00 so I have to board a car. It is not a problem for me but others will not come because they may stay far which may take that person about GH¢5.00 to get to the place so I think it is a problem. I know a friend like that.”

PE, age 18 years

Another facilitator/barrier to adolescents’ use of SRH services which was found was quality of care issues. This has been presented in the next section.

4.5.2 Quality of Care Issues

These were the health service related factors that enabled, impeded or could impede the utilisation of SRH services among adolescents. The identified factors from the data were staff attitudes and cost of services; these have been presented. The remaining factors were working hours, waiting time, the range of services, availability of drugs and other logistics and provision of services. These factors either facilitated or made it difficult for adolescents to access services.

i. Working Hours

This refers to the hours within which services are made available to clients. The SRH services units of the four health facilities in the Asante Akyem North district work from Mondays to Fridays. The staffs start work by 8:00am and close at 3:00pm. Participants shared their experiences concerning the working hours with a few of them being comfortable with it and many of them not being comfortable with it. The working hours either facilitated or impeded their utilisation of services based on the participants’ preferences and conditions at school,
workplace or home depending on where the participants may leave to use the services. A few participants shared that they were comfortable with the working hours:

“They have a time they start and a time they close. I think they should maintain their time because, in the night, it is not every parent that will allow their child to go out in the night.”

PB, age 15 years

Most participants had reservations with the working hours and preferred it was extended to the evenings and weekends to ensure privacy and flexibility in relation to their school hours. This can be found in statement below:

“They do not come on weekends but most of the times we are free on weekends because we do not go to school. In the evening, we can hide in the dark and go but they do not work in the evenings. There are a lot of people I know who could have gone there if they had extended the time to the evening. For them, their parents will never agree for them to go there but in the evening they can hide and go. If they can extend their time it will help others.”

PJ, age 16 years

ii. Waiting Time

This is the time participants spend at the facilities to wait until they are attended to when they go for the SRH services. It was found out that the waiting time largely depended on the time the participant in question got there. There were times that participants met a lot of people there and they had to wait and there were times that as soon as they got to the facility, they were served because there was either no one was ahead of them or not many people before them. Those who got to the facility and met none or a few people ahead of them were pleased with the waiting time but those who got there and found many people ahead of them in a queue were not pleased. The statements below portray their sentiments:
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“That one to me it depends on the time you get there because if you go there early you will be served early. I go to school and use my break time to go there. And when I go, I am seen quickly and I come back to school without wasting time.”

PC, age 19 years

A participant who was worried about the waiting time said added that the long waiting hours was due to the number of people that utilise the services.

“We wait for long, sometimes because people really go there, the grownups they really go there and the staffs too are not ‘chaw’ (many). And the women too sometimes they talk too much; even they include reasons why they are not there; so it makes us keep long sometimes. Sometimes 10 to 15 minutes or 20 minutes you will still be there. And consider me, an adolescent sitting down for 20 minutes, imagine oo...you know my fears...already I do not want anybody to see me. When you wait long too you will see people there and what if someone knows you? But then sometimes too as soon as you get there you are served.”

PD, age 16 years

The participant’s statements highlight the long waiting times adolescents seeking SRH services have to put up with. The ratio of service providers to clients was also mentioned and the major concern of the adolescents’ privacy and confidentiality was added. The participant, like many others wishes not to be seen as a client seeking services for they think that they are young and unqualified and that the services are meant for adults only.

Overall, it was noted that most participants wished they were served as soon as they got there so that the adults will not come and meet them there since they do not want them to see them. It was also noticed that some participants felt unsecured in the presence of the adult users.

iii. Range of Services

This refers to the services the SRH units of the facilities covered. The participants said the facilities have everything they think they needed to be served with because they had not been referred anywhere or asked to buy things from elsewhere.
A 19-year-old participant said:

“They do everything there. They have everything there. Everything that a centre should have. They have everything that you want ...you do not have to go and buy something outside. That is why it is affordable because going there you would not have to come back and buy something before you go back to them.”

PC, age 19 years

iv. Availability of Drugs and other Logistics

All the participants said they think the facilities have drugs and other items to serve them because they have not been asked to buy a drug or other items from elsewhere.

“They will not tell you that today we do not have cotton or the injection...the syringes are not enough it is left with two so go to the drug store and buy some. No, they have everything.”

PA, age 17 years

Another participant emphasised that going to the facilities will not be useful if the facilities lacked certain items. He said:

“If we have to buy certain things from outside then who will even go there? We do not buy anything from outside. They have everything there...more condoms.”

PN, age 17 years

v. Provision of Services

This covers how the participants perceived the services that were rendered to them. Almost all the participants were comfortable with how services were provided at the various facilities. One of the participants made the following observations:

“I like everything at the place. The place is neat and they give you a good place to sit. We do not hear what we tell them outside and none of my friends have complained. One day I saw one of the nurses in town, I thought she would be able to recognise me but she could not so I think they do not disclose us because they cannot even remember our faces, not to talk of our names and what we said. I do not think anything will stop me from coming. I like how they receive me and talk to me.”

PK, age 17 years
The participants highlighted the cleanliness of the facility and commendable sitting arrangements. Other quality issues came to the fore as factors that would enhance utilisation. Privacy and confidentiality were key factors in the narration.

Although the participants were comfortable with how services were provided at the facilities, most of them were heavily displeased with the fact that adolescents and adults used the same facility for SRH services. Some of the participants mentioned that adolescents use the same place with the adults and that could be the only reason why they may not utilise the services any more.

“Their services...I am comfortable with it. It is only the teenagers going together with the adults...that is my problem. In fact if I will stop going there, it will be because of this. I think they should separate the teenagers from the adults. When you are mixed...when you are going you will feel shy and there may be fears in you that when someone sees you this person is going to tell your parents. But when you are separated that here is for adults and here is for the teenagers, when you go there you see your colleagues so you do not fear anything and you do go there with vim and vigour.”

PE, age 18 years

Another participant added that if she sees a familiar person there she would run away and come back later:

“The place is good... nurses are confidential. I thought they will tell people about us about what we tell them when we go there but then even their fellow nurses they do not tell them. As for me when I enter I talk small small (smiled) so that nobody will hear what I am telling the nurses. But ‘hmmm’...the sitting arrangement...we mix with the adults, it is not good. I wish we have a special place for the adolescents only and a special place for the adults only to sit; when we are mixed like that, it is uncomfortable for us! As for me as soon as I see that I know someone there I just run back and go later.”

PH, age 17 years
Both participants shared major concerns about not having separate clinic sessions for adolescents and adults. Mixing adolescents and adults in a single clinic session appeared to be a deterrent to utilisation of SRH services by adolescents in the study.

Of all the participants interviewed in the study only one expressed the divergent view of adolescents using the same facilities with adults simultaneously. He thought it should be allowed so the adults will ultimately accept that adolescents also have need for SRH services.

“I do not have any problem with the adolescents receiving services from the same place the adults receive. I think when it continues, with time the adults will come to accept that we are their partners in that business (laughed).”

PO, age 19 years

In all, most participants faced a lot of challenges when accessing services. Another theme that emerged was intentions of the adolescents to use SRH services in future. This has been presented in the ensuing section.

4.6 Intentions of Adolescents towards Utilisation of SRH services

To answer the fourth research question namely “What are the intentions of adolescents towards utilising SRH services?”, the theme that was developed was intentions of adolescents towards the use of SRH services. This reflected the indication of the adolescents’ readiness or willingness to use SRH services in future. The findings of the study revealed that some adolescents had planned either to use or not to use the SRH services in the future. A few were not able to tell whether they would use the facility another time. Three sub-themes emerged: willingness to use SRH services, unwillingness to use SRH services and uncertainty. These are presented in the next section.
4.6.1 Willingness to Utilise SRH Services

Most participants spoke about their willingness to use the SRH services in the future. It was noted that some participants were willing to use the services at another time because of the benefits they have had from using the services. Many of the participants also adjoined that they will go for the services at another time because of how services were provided in the facilities, the follow up appointments they had to keep as well as the prospects of some of the participants.

In all, the focus was largely on pregnancy prevention. These are exemplified in the following shared experiences of the participants:

“Yeah, I will go there. I have used the services and it helped me. So since it has helped me I will go there again. I am not ready to stop going there. The problems I took there have been solved...I have not become pregnant. They keep my information secret. The fact that I will not get pregnant will keep me going.”

PA, age 17 years

To this participant, once she had benefited from the services in diverse ways, she was willing to utilise the services anytime she had to.

PC, a 19-year-old participant reiterated and emphasised that apart from her using the facility in the future, she had intentions of leading other adolescents there.

“I will go there again even if not myself I will lead people there because of what I have gained from it. The family planning, I am doing...the contraceptives will make me go there because I have appointments with them and I will still be going there. I do not want to give birth now but in the future.”

PC, age 19 years

Another participant added that she would look for SRH facilities anywhere she would go aside her current town of residence.

“I will be going there over and over until I graduate from senior high school and leave this town. Even if I leave and go to another place I will locate where they are at that place. Because it will prevent me from becoming pregnant.”

PH, age 17 years
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A few of the participants said that when they grow and marry, they will still utilise the services especially the family planning services because they would not like to give birth to many children and would also like to space births.

4.6.2 Unwillingness to Utilise SRH Services

A few of the participants were not willing to utilise the SRH services in the future because some said they had what they wanted. Others also said, since their sexual partners were willing to utilise the facilities, there will be no need for them to also go to the facilities. They added that the distance was a challenge:

“If the need be, I will go. But as it is now I will not be there again. I have had what I went there for and I can get a condom from a shop so it is okay.”

PM, age 18 years

Another participant shared the reasons why he was not willing to utilise SRH services in future:

“Oh, I will only go there if I need to know something or maybe if I want to get condoms from there. Apart from that I will not be going there rough rough like that. They will even say I am very bad if I do that...so I will be there once a while but my girlfriend too goes there so it is like I handed over to her to be going there. This is because if she is going there I do not see any reason why I also have to be going there. At least, I know that I do not have HIV and she also knows that she does not have any HIV. Condoms too can be bought from a drug store...the place is very far...that is another issue.”

PN, age 17 years

Apart from citing the distance to the facility as a challenge, the participant shared that his frequent visits to the facility for service would make him be considered as a bad boy. For this reason, he felt he needed to regulate his visits so that he goes to the facility only when he needed their services but not routinely.

One of the participants was not willing to go there any more, not only because he had had what he wanted but because of a previous experience which he had in utilising the services:
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“I do not think I will go there again. I said I have gotten to know what I wanted to know and I told you what I experienced the last time I went there. I was there and one girl came to the place for family planning, when she left I heard the nurse telling her other colleagues that the girl is 18 years and she has come for jadelle so that will probably prevent me from going for such services.”

PO, age 19 years

This participant overhead a nurse discussing with colleagues what an adolescent come to do at the facility and the behaviour of the nurses had discouraged him from utilising the services in future.

4.6.3 Uncertainty

A few of the participants were not sure as to whether they would utilise the services in future for various reasons. Some hoped that they will be able to stop having sex so they would stop going for contraceptives. However, the expressed that if they are not able to stop having sex, then they would go for the services:

“Like I said...previously I said I do not intend to use the service again. However, if I am to lose control and have sex, I will go back but if not, the next time I would go in for the service is maybe when I get married ...I will go in for family planning...yeah family planning, since I do not know much about it. I pray that I do not lose control and have sex during this stage.”

PB, age 15 years

A few of the participants also were not sure of utilising the services in future because of the fact that adolescents use the same place with the adults and also because of other people’s perception about their decision to use SRH services. One participant shared:

“Mmhhmm...the combination of the adult and the teenagers, I may not go there again. It is 50 50...yes it is 50 50; I may go or I may not. Because I do not feel comfortable with that combination and then...how people think about me whenever I am going there...I may not go there. And the probability is high that I will not go there. One factor is the fact that we the adolescents and the adults use the same place. And my boyfriend may even leave this town soon to go and stay with his uncle in Accra so that I will not be having any sex again...and I will stop going there.”

PJ, age 16 years
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To this participant, when the boyfriend leaves the town, she will not have sex and there will not be any need to go for protection. However, she was not sure whether or not she would be able to abstain from sex.

Another participant narrated and added shyness as part of the reasons why he was not certain as to whether he would use the services in future:

“I may say no and at the same time yes. However, I will also consider my situation so I am not that sure of my going again. If they still combine the adults and the adolescents together, the shyness is still there and where the facility is sited is a challenge. It depends on whether I will be able to control myself or not.”

PL, age 16 years

This adolescent further shared her dislikes for mixing with adults when seeking SRH services. She also mentioned having problems with self-control regarding sexual activities.

Apart from the objectives which were in line with the constructs of the TPB, other themes emerged from the data analysis. The following sections present the findings on those themes.

4.7 State of Adolescents before Utilising SRH Services

This section covers the condition of adolescents before they accessed the services. It was found from the study that, after the adolescents had intended to use SRH services, they had some sentiments. They considered the issues of morality and also tried to justify why they had to use SRH services despite all odds. The experiences shared by the participants revealed that although they perceived that the services were good for them, and had the belief that utilising these services will help them to overcome certain SRH challenges, and had intended to use SRH services, they still had to consider some factors. Three sub-themes emerged from the analysis of the data that was gathered from the participants. These were: morality, sentiments and rationalisation.
4.7.1 Morality

During the analysis of data collected for this study, it was found that some adolescents considered moral issues before they utilised SRH services. These moral issues sprang from their religious standards. Some felt guilty because they thought others will see them as bad people given their religious affiliations and their activities. However, following these feelings they justified themselves using the benefits they would gain from utilising the services.

“Sometimes...not even sometimes but almost every day I feel guilty going there because of what people will think about me but I really do not think my guilty conscience will stop me from going there because I benefit from it. I feel guilty because of my background. You see...I am a Christian. We have been taught in church to abstain from sex till we marry. Here am I, not married...having a boyfriend... ‘eerm’ sex, hmmm...so you see I feel guilty.”

PC, age 19 years

One participant also added guilt feelings associated with the use of SRH services:

“Like...when you are entering you think you may meet someone you know there so the person may see you as a bad person. So you may feel like not going or stay behind. When you get to the entrance, you still ask yourself should I go or should I come back?” Because if they see you they will give you that bad girl looks.”

PE, age 18 years

It appeared the vast majority of participants worried about being seen using the facility and how those who saw them would think of them. They were not happy about the bad thoughts others will harbour about them but due to the fact that they were sexually active and did not want unplanned pregnancies, the benefits from the SRH services served as impetus for using the facilities.

A participant thought that it was not necessary for her to utilise SRH services especially the family planning services because she perceived it as something bad for teenagers but good for adults.
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“Mmm...(chuckled) I was thinking it is not necessary for me to be going there because I was seeing it to be a bad thing for the teenagers and a good thing for the adults. For the adults, the family planning may help them to know the number of children they want to give birth to and as for me since I am not ready to give birth I do not know anything good about it for me to go there.”

PE, age 18 years

4.7.2 Sentiments

These were the thoughts participants had before utilising the SRH services based on their feelings or emotions. The sentiments identified in the study were shyness, rejection and fear.

Most of the participants felt shy because of the location of the facility and the people around and how they thought the people would see them and have some bad thoughts about them. Some of them also felt shy because they use the same facility with the adults. One of them expressed:

“Mmmm...I feel shy going there because seeing someone of my mother’s age and joining a queue with that person, ‘hmm’ it may be that... ‘hmm’...there may be certain questions you want to ask the nurses and you may think that the person will hear what you are asking the nurse so you may feel uncomfortable asking questions.”

PE, age 18 years

Other participants were worried and could not relax because they were highly concerned about how the people around would look at them.

“I mean you cannot relax! I was worried...very worried because of how the people around will look at you. ‘Hmm’...until you leave the environment, there is tension!”

PH, age 17 years

Few of the participants thought they would be rejected when they go to use the SRH services, especially before their first use of the services. One thought it could be that people of her age were not accepted; she did not know what would happen there since she had not been to the facility before.

“At first, you feel like you will be rejected if you go there. Hmmm...because if you are going there for the first time you will not know what they will think about you but when you go there at first you will know that it is not as you thought. So I feel shy and feel like I will be rejected and I know people will be like: what is this lady
also coming to do here? Hmmm...it was my first time, so I was asking myself a whole lot. What if they do not want people of my age there? What if one of them knows my mother? And sometimes when you are going somewhere for the first time, you do not know what will happen...it is like going for an interview...you do not know what they will ask you.”

PA, age 17 years

This participant asked herself a lot of questions before using the services. She was much concerned about others perceptions towards her use of the services.

A few of the participants had genuine fears. Participants were afraid of the results of the HIV test because they have been having unprotected sex. In this instance, the participants were not worried about what others would think about them. Instead, they were worried about the outcome of the HIV test. One of them shared their thoughts:

“So then I went to do HIV test and Sir it was not easy...whilst you are waiting for the results, everything in you will be boiling. So when I was going, I was afraid that I may test positive.”

PM, age 18 years

The fear about the HIV results appeared to be intense as one participant described it as “being between life and death”. A male participant emphasised:

“I went there to check my HIV status...you do not know what the results will be...you are just going. It is life and death oo...what if after the test they tell you that you have HIV? Ei...so I was a bit afraid...because I did not know what the outcome will be. Well, it was negative but I was afraid because I have been having unprotected sex. I was not that concerned about the gossips of others but I was thinking about the results.”

PN, age 17 years

The look on the faces of these two participants showed how they were gripped with fear before utilising the services for HIV testing.

One participant felt uncomfortable anytime she had to utilise SRH services but she overcame that by going with a friend.
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“Anytime I have to go there I feel uncomfortable but in order for me to feel okay, I go with a friend.”

PB, age 15 years

4.7.3 Rationalisation

The participants after having these sentiments and considering moral issues then find justifications why they had to utilise the services. Participants used the benefits they believed they would gain from utilising the SRH services to justify why they had to utilise these services. It was identified that utilisation of services among adolescents was perceived by them as a difficult and an uncomfortable task as they feared being seen by familiar people who they thought might report them to their parents. However, they considered the fact that they wanted to prevent unwanted pregnancies and their consequences and went ahead to utilise the services.

One participants’ expressions below shed light on their thoughts:

“Sometimes it is when I am in school and get a chance that I pass there. Even the mere fact that I am in uniform going there is a very big case but because of what I am gaining from them I think I have to put those things aside and utilise the service because I am gaining so much from it. But going there is not easy, it is very difficult going there because my sister goes to school at the school closer to the place so if my sister should see me and report me to them that I have been visiting that place it will be a very big issue for me but sometimes you have to forget about them. It is an uncomfortable thing!”

PC, age 19 years

This participant exclaimed that utilising the services is not comfortable because of the challenges she faced anytime she had to go for the services.

PK, another participant in the study appeared to be uncomfortable and thought that they would be stigmatised and reported to their parents. However, their focus on pregnancy prevention motivated their use of the services.
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“I was afraid that if I have sex with my boyfriend I will be pregnant, so that is why I went for the service. So anytime I have to go, I think about it but if I do not go and I get pregnant I will not be happy. Everybody will look at me and say oh so you were having sex. I do not even know how my parents will react. I cannot take care of the child and my guy too cannot because sometimes I even have to give him money. My life will end there...I will not be able to move with my friends again.”

PK, age 17 years

One participant compared what she had been told about contraceptives with what she has observed from those who are using contraceptives. Consequently, participants had to go for the services because of the consequences of teenage pregnancy. She said:

“I think about what I have heard about the contraceptives...then I will panic all of a sudden...then I will say but those who have done it have not reduced weight...then I will be okay. So it continued like this until I finally decided that if I do not go and get pregnant, I cannot bear that one too.”

PG, age 19 years

The next section highlights the activities or components of the SRH services as perceived by the participants; what is done at the service centres and what they think should be added to what was available at the time of the study.

4.8 Perceptions on SRH Services

The participants of the study were adolescents who had utilised SRH services before and because of that they all shared what they thought the services were about and what is done at the service centres. It was observed that, a number of the participants thought SRH services were all about family planning although most of them knew of other activities which took place at the various centres. It was also observed that almost all the participants made use of the family planning services and a few used other services such as sex education, counselling, cervical screening and HIV testing. Four sub-themes emerged during the analysis of the data that was gathered from the participants. These were: activities at the SRH centre, sources of information...
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on SRH services and issues, perceptions of adolescents concerning services and expectations/suggestions made by the adolescents concerning the SRH services.

4.8.1 Activities at the SRH Centre

The participants shared what they knew made up SRH services and the services they knew were rendered at the various centres. It was identified that most participants knew the services included counselling, advice, education on sex and sex-related diseases, family planning, health screening and examinations. Some participants shared the following concerning what the centres do:

“They offer advice to young people and teenagers...they give counselling to them and all of that. They also help in family planning. They also educate the people who come there about sexuality.”

PB, age 15 years

Another participant added health screening to what had been found already.

“Okay....what I know about it is that they render services like counselling and then they educate the adults on family planning in case you have given birth plenty and you want to stop, you can go there. They also do health screening and also teach about STIs.”

PD, age 16 years

It appeared these participants knew the components of SRH services from their shared knowledge on it. In all, most of them mentioned family planning which appeared to be the most known component.

Some adolescents added that apart from what the nurses do at the SRH centres, they also come to their schools for school health during which they provide teaching on sex and inform them of the services available at the SRH service centres. One said:

“Mmmm...here too they do the family planning. They go to schools to announce what they do to the students.....they even came to our school to talk about family planning.”

PK, age 17 years
4.8.2 Sources of Information on SRH Services

This covers where participants got information on SRH matters including services. It was found that, participants received information on SRH matters and services from their friends, community health nurses, social media, parents especially mothers, schools and the mass media.

Most of the adolescents got information from their friends and also from the nurses who went to the various schools for health education. A few participants obtained SRH information from their teachers:

“Some of the nurses came to our school to tell us about the services they render. They said that we have to protect ourselves so that we will not impregnate the girls. My friends also told me about it. Some of my friends have been there and others have just heard about it. In school too, we are taught...they teach us on issues concerning adolescents. But I went there because of what the nurses said.”

PM, age 18 years

Still on the sources of information, PJ emphasised and added that she heard it from the social and mass media. She responded:

“I can say from the social media, then from my parents especially my mum...because I am closer to my mum. On the internet; I always search and read more about it. The nurses also have been coming to our school to talk about it. I also heard it on television and radio”

PJ, age 16 years

A few of the participants mentioned that although they had information on SRH services from friends before the nurses came, they could rely more on the nurses’ information than that from their friends because sometimes information from friends were not reliable. A participant said:

“I first heard it from a friend but I really did not take interest in it until I heard from the nurses and the people who work there advertising it to us. They went round like making us know that they have such services around. So when I heard it from them I was okay then it is something that can help because sometimes if you take advice from your friend you will end up in a mess. Once I heard it from them (the nurses) it was something I could rely on.”

PC, age 19 years
4.8.3 Perceptions of Adolescents concerning SRH Services

Participants had thoughts concerning the SRH services. They had thoughts on who the services are meant for and what the services are meant to do.

i. Perceptions of Adolescents on who can access Services

It was found that participants had perceptions on who can access SRH services. Some of them said the services are meant for both the married and the unmarried and gave an age range for use as indicated in the narrative below:

“The services are meant for married and unmarried couples. Once you are from age 15 to 45 years, you can go there because by age 15 someone can be in sexual relationship...but even if not in a relationship you can still go there because their services are not only meant for family planning. They do health talk. Mmm...if one is below 15 years too and would like to go fine...he or she can go. But after 45 years some people are in menopause so they may not go there for family planning...but well...maybe for counselling or other things.”

PA, age 17 years

Most of the participants said that the services are meant for everyone including adolescents and adults because they perceived that all people have SRH needs. Participants thought that in their town, the community members have made it look like the SRH services are meant for adults only because the adults patronise it more than the adolescents since they want to reduce their birth rates. One participant said:

“To me, it is meant for everyone because we all have sexual and reproductive health matters; we all have something we do not understand; and it is not meant for a group of people. It is meant for everyone because like I said we all have sexual and reproductive matters and it is not everybody you can share with...if you tell him or her she will say you have something to do or...but it is meant for everyone...yes everyone can go there. Men, women, old women, everyone, children can go there if only they have something to discuss with them.”

PC, age 19 years
Another participant added that:

“*These services are meant for everyone. Both adolescents and adults, but like I said earlier this community, they have made it to look like it is only grown-ups who should go there because they like giving birth plenty; but we the adolescents, most of us have high libido and some of us too we cannot keep our legs closed (giggled)...I mean we have sex.*”

**PD, age 16 years**

This 16-year-old participant considered that the services are meant for adolescents as well as adults even though the community members reportedly consider it as being for adults only. The participant also underscored that adolescents are highly sexually active and urgently need the services. To her, adults tend to use the services for family planning needs.

A few of the participants exhibited fallacies about men and the use of family planning. They considered family planning to be solely for women in the fertile age. This is because the participants perceived that it is women who carry babies till term and undergo the delivery process. Meanwhile, with other SRH services, they perceived that the services were beneficial to adults and adolescents, married and unmarried. Participants expressed that the usefulness of the services was skewed to women. One participant shared her thoughts:

“*When I go, I do not see guys there. After all, guys do not give birth... they do not get pregnant. Moreover, I do not think that place is for males...it is for females. Males cannot go there for family planning. If anything, we the ladies can listen and tell them. So I think it is for the adults and the young women like me who cannot abstain from sex.*”

**PI, age 19 years**

One participant stressed that all women can access the services because they can get pregnant or have SRH problems but the males can only access services for STI treatment. She said she did not think it was necessary for the males to go for the family planning services and had not seen a male accessing the services before:
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“All women who can get pregnant or have any reproductive health problems can go there for service. The guys can go there when they have STIs because the family planning...I do not think it is necessary for a guy to go there...because since I started going there I have not seen any male going there before.”

PL, age 16 years

Another participant who believed both males and females can utilise the services added:

“Everybody can go...males can go and females can also go. But females really go there because it helps the females. It could be that they do not want to give birth early or it is not time for them to give birth so they go there to protect themselves so that they will not get pregnant.”

PM, age 18 years

This participant observed that even though both males and females can go for the services, more females go there than the males because in his view the services help the females more.

ii. Perceptions of Adolescents on the Purpose of Services

Participants had perceptions on what the SRH services are meant to do. Most of the participants thought the services are there to help reduce teenage pregnancies and the birth rate. A few perceived that the services were made available to prevent STIs and also teenage pregnancies with the provision of contraceptives. Most of the participants added that the services are not only to prevent teenage pregnancies but to help the adults who are giving birth to space their children. Two participants vehemently said:

“Their purpose is to help reduce the birth rate and to give birth to the number of children they can take care of. We adolescents for instance, when we give birth, we cannot take care of the children at this age. So when we come here they help us to prevent pregnancies. The adults too, some have already given birth to many children so if they become pregnant again they cannot take care of the children so they can come here for contraceptives so that they can space births.”

PK, age 17 years
Another participant added STIs prevention as another reason why the services are provided. He said:

“It (SRH services) is there to help us so that the girls will not get pregnant and the guys will not also impregnate the girls. So that we will not also transmit various diseases to others. It is there to teach us so that we can abstain from sex.”

PN, age 17 years

To these two participants, the services have been established for both adolescents and adults for prevention of pregnancies and STIs as well as reducing the birth rate.

4.8.4 Expectations of Adolescents Concerning SRH Services

It was found from the data gathered that participants had some expectations concerning SRH services and as such gave some suggestions on how adolescents want SRH services for the adolescents to be packaged.

Some participants suggested that, there should be posters on the walls of the various health facilities and pamphlets they can read should be made available to them. One added that the nurses should give out their contact numbers to them so that adolescents can discuss certain things with them on phone without going to the facility as it is done in some places.

“There should be posters. Some of the posters will show us how the diseases are transmitted.”

PL, age 16 years

PN added that pamphlets and contact numbers of the nurses should be made available to them (adolescents).

“But if they can also give us some pamphlets so that we will read them. Some places too I heard they give their numbers out so that you can call to discuss certain things with them without going there. I did not ask them but I think they have to give it to us.”

PN, age 17 years
Furthermore, few of the participants suggested that the nurses should move from house to house to advice the adolescents to utilise the services because of the benefits. Others added that there should be public education in churches, schools and the communities about the services offered at the SRH centres so that people will get to know what the services entail, what they are meant for and who can utilise the services. Some thought that it will help the adolescents to utilise the services without thinking about what others will say about them and their use of SRH services:

“Oh me I will say that, if they go to our churches, our schools, our communities, house to house to advise them and tell them about their services and what it is meant for...and that it is not only meant for married people as they think;...and also let their children come there, it will be fine. They will get to know that it is not mainly for family planning but they do other services; everybody will be comfortable going there.”

PA, age 17 years

This participant wanted the general public to be educated on SRH services and what it is meant to do for which she believed will facilitate their use of the services.

4.9 Summary of Findings

The findings showed the attitude of adolescents towards utilisation of SRH services, the social pressures that affect adolescents’ utilisation of SRH services, the adolescents’ perceptions of their abilities to utilise SRH services and their behavioural intentions to utilise SRH services. These findings were in line with the constructs of the TPB. Other findings that were identified through content analysis included state of adolescents before use of SRH services, and perceptions of adolescents on SRH services. The sub-themes that were identified provided a detailed description of participants’ experiences with regards to the utilisation of SRH services.
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The study revealed that most of the participants had positive attitudes towards utilisation of SRH services because of their SRH needs, benefits they derived from the services, the range of services rendered and their need for expert care. It was however noted that a few participants had negative attitudes towards utilisation of SRH services because they thought services were meant for married people and only females because it is only females who get pregnant.

Subjective norms largely influenced participants’ utilisation of SRH services. Most of them were influenced by their friends to utilise SRH services. However, the community in which the adolescents found themselves largely had negative attitudes towards adolescents’ use of the services. It was also discovered that most adolescents had not informed their parents and relatives as well as community members and their religious leaders about their use of SRH services with the exception of the nurses and some friends because participants thought they would not agree to their use of the services if they got to know.

Facilitators and barriers to adolescents’ use of services were identified as adolescents shared their experiences before, during and after the use of services. Overall, most of them had intentions of utilising the services at another time, a few were not willing to utilise the services any more and a few were uncertain as to whether they will use the services any more. It was also realised that participants had negative sentiments like fears and feeling of shyness and considered a lot of factors such as moral issues before utilising services. In general, adolescents had factors that motivated them to utilise SRH services as they rationalised by weighing benefits over odds. Participants had perceptions about SRH services such as who and what they think services are meant for as well as how they want SRH services to be packaged. The participants made suggestions on how they want SRH services to be packaged to attract other adolescents to utilise the services.
CHAPTER FIVE
DISCUSSION OF FINDINGS

5.0 Introduction

This chapter discusses the findings of the study on the utilisation of SRH services among adolescents in Asante Akyem North district, in relation to the wider literature in order to relate findings to the context of nursing knowledge. The purpose of the was to explore the utilisation of SRH services among adolescents at the Asante Akyem North district. The research had the following objectives:

- to identify the attitudes of adolescents towards utilisation of sexual and reproductive health services,
- to explore the perceived social pressures (subjective norms) that affect adolescents’ utilisation of sexual and reproductive health services,
- to describe adolescents’ perceptions of their abilities to utilise sexual and reproductive health services,
- to identify the adolescents’ intentions to utilise sexual and reproductive health Services.

The discussion begins with the demographic data of participants and successively followed by the major themes in the study which were organised by the theory of planned behaviour. Six major themes emerged from a content analysis of the data gathered from the participants. An array of matching sub-themes was identified. In the subsequent sections, the themes and their respective sub-themes are discussed in relation to the reviewed literature.
5.1 Attitudes of Adolescents towards the use of SRH Services

The findings indicate that adolescents’ utilisation of SRH services is influenced by both positive and negative attitudes.

5.1.1 Positive Attitudes

Most of the adolescents demonstrated positive attitudes towards utilisation of sexual and reproductive health services in the current study. Some of the adolescents utilised the services because they believed that it will help them overcome their sexual and reproductive health challenges or needs. They had needs for counselling and education from the sexual and reproductive health service providers because they had started developing secondary sexual characteristics. The study findings here is in agreement with that of Lesedi, Hoque and Ntuli-Ngcobo (2011) in Botswana who observed that adolescents positively appraised sexual and reproductive health services and believed that such services are of utmost significance for their development. The researchers observed that, adolescents’ positive appraisal of SRH services was due to the fact that in Botswana, all persons of reproductive age have the basic right to decide for themselves how many children to have and when to have them irrespective of age or marital status.

Participants in the Botswana study also indicated that they would recommend the SRH services to others. This is congruent with the findings of the current study as adolescents were willing to take their friends to the facility for them to access the services because of how beneficial it has been to them. Those who have utilised SRH services have had their needs met since they started utilising the services and did not only shared their experiences with their friends but also recommended it to them.
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In the current study, most participants wanted to prevent pregnancy so they utilised contraceptive services and reported that they had not become pregnant. This finding may be due to the fact that getting pregnant in Ghana at that stage is usually associated with forfeiting one’s dreams and goals in life. In a way therefore, the adolescents’ positive attitude towards utilisation of SRH services was to safeguard their wellbeing.

In the current study, the adolescents also believed that at this stage, where they are sexually active, there is the likelihood of engaging in premarital sexual activities and found it necessary to utilise SRH services for contraceptives. Similar outcomes have been observed in Mozambique where adolescents positively appraised the utilisation of the youth-friendly health services provided within public health facilities because the services meet their needs pertaining to contraception (Hainsworth, Zilhao, Badiani, Gregorio, & Jamisse, 2010). It was also noted from the current study that some adolescents had frequently used the services because they believed that their needs were being met. Another study in Kenya by Godia, Olenja, Hofman and Van Den Broek (2014) had a similar finding. In their study, young girls utilising family planning clinics reported that the services met their needs, suggesting that, when adolescents’ needs are met, there is the probability of influencing further use of the services.

Apart from needs, the current study showed that some adolescents had a positive attitude towards utilisation of the services because of the range of services rendered at the facilities and the benefits they derived from it. Participants considered the services as a package which was good for their sexual and reproductive health. Among others, emphasis was placed on the education they received when they utilised services, prevention of unwanted pregnancies and the consequences that follow, STIs prevention and treatment. They found the services useful because it was able to meet their expectations. This was in line with the study findings of Dako-Gyeke
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and Ntewusu (2012) in Tamale metropolis of Northern Ghana which showed that adolescents utilised the promotive, preventive and curative services provided by the adolescent health corner and found the services useful for their sexual and reproductive health. These indicate the perceived usefulness of the services offered at the SRH units and may suggest the need to have similar units in other areas in Ghana to serve the populace.

The current study again found that adolescents were confident in the use of SRH services and positively appraised it because of the benefits they gained from their previous utilisation. This latter finding is however in contrast to that of Tegegn, Yazachew, and Gelaw (2008) in their study in Jimma town, Southwest Ethiopia which revealed that previous utilisation of reproductive health services showed less attitude index towards the services. This might be as a result of health providers’ judgmental attitudes and lack of confidentiality as well as other health service related factors such as waiting time, privacy and confidentiality, and working hours.

Motuma (2012), on utilisation of youth-friendly SRH services and associated factors in Harare, Ethiopia found that most of the youth had positive attitude towards services. This is not different from the findings of this study. Adolescents in the current study believed that the nurses are the best informants when it comes to SRH services because they have been trained to do so. They therefore sought for their expert services in preference to the information from other sources. This is a good attitude as it is likely to result in the utilisation of SRH services. If adolescents should rely on friends or other traditional sources for information and treatment of STIs, they may not get the right information and treatment. Their reliance on the nurses to provide them with expert services could also be attributed to the fact that most of them said the nurses treated them with respect; the nurses also showed professionalism by maintaining privacy and confidentiality so they perceived that the nurses would not spread what they shared with
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them. This is consistent with the study findings of WHO (2009) which showed that the majority of adolescents had positive attitudes towards services provided within the public health system. The adolescents said they were cared for with respect and there was maintenance of confidentiality. This implies that training health professionals to show non-judgmental attitudes towards adolescents may increase the utilisation rate. Therefore, health professionals should be wary of the attitudes they show to all their patients.

A few of the male adolescents in the current study positively accepted SRH services because they believed that getting a girl of their age pregnant is a threat to their lives. One of them was afraid of being imprisoned or being forced to marry the young girl. This finding is similar to the finding of a study by Nalwadda, Mirembe, Byamugisha and Faxelid, (2010) who discovered that adolescents’ attitude towards SRH services, especially contraceptives was because of fear of imprisonment and imposed marriage in case of impregnating a girl of their age. This suggests that adolescents’ utilisation of SRH services is dependent on personal motivating factors. They wanted to use contraceptives to avoid unwanted pregnancies and protect themselves in their relationships since they were sexually active.

Findings on adolescents’ attitudes towards the use of SRH services remain divisive because although most of the participants in this study had positive attitudes towards the use of the services, a few others had negative attitudes towards the services which also corroborates findings from other studies.

5.1.2 Negative Attitudes

Even though most participants had positive attitudes towards the use of SRH services, some adolescents in the current study expressed negative attitudes as they believed that the
services were not meant for adolescents. However, these adolescents have all utilised the services before and they might have said this based on their experiences with previous utilisation.

According to Berhane, Berhane and Fantahun (2005) most of the adolescents who suffered reproductive health illness in the last three months prior to their study did not seek treatment as the adolescents did not find the existing services accessible and acceptable. This is an indication of their negative attitudes towards sexual and reproductive health services and this may be related to what they perceive to be acceptable or not. In the current study, only a few adolescents had negative attitudes towards the SRH services. The adolescents in this study who had negative attitudes towards the services perceived that the services were meant for adults since most of the time, when they went to the facility to utilise services they met many adults who have also gone to utilise the same services from the same facilities. This perception could have contributed to the description of the services at the SRH as unacceptable for adolescents. Thus, having the perception that the services have been developed for adults may make the adolescents shy away from the services and avoid their use altogether. Despite this assertion, further studies are needed in understanding how positive attitudes may buffer the negative attitudes observed in order to increase service utilisation.

The male adolescents in the current study expressed that if their female counterparts will utilise the services, there is no need for them to go for the services. The males thought once they knew how to wear condoms, there was no need to use any of the SRH services. Another reason why the male adolescents thought it was the duty of the female adolescents to utilise the services was because it is women who carry pregnancy until delivery. The only time they thought it necessary for a male to go to the health facility is when a problem occurs such as having STI
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symptoms and going for treatment. These may possibly be some of the reasons why most males do not utilise SRH services. These may offer directions in understanding the differing needs of males in the utilisation process as it appears that they are more interested in avoiding pregnancy and as such their focus is mainly on how to use the condom. This finding is congruent with the findings by Kotecha et al. (2009) that female counterparts have more tendencies to using SRH services than their male counterparts. Godia, Olenja, Hofman and Van Den Broek (2014) also agree with these disparities between male and female adolescents. They found that young people’s views of the sexual and reproductive health services available are not uniform and showed disparities between males and females. In their study, young girls utilising family planning clinics and antenatal care services had a positive appraisal of the use unlike young boys. In contrast, Bilal, Spigt, Dinant and Blanco (2015) recently found that the utilisation of SRH services is higher among male adolescents and lower among senior high students and the basic reason for utilising the services was to receive information. In the current study, most of the adolescents thought the reason for utilising services was for contraceptives although a few also went for information.

Possibly, that accounts for the difference between this current finding and what resulted from the study by Bilal, Spigt, Dinant, and Blanco (2015). Another finding which was contrary to the current study was the study’s finding was the study finding by Gebremichael and Chaka (2015) who reported that most male adolescents had positive attitudes towards SRH services than the female adolescents. This was probably because voluntary counselling and testing and condoms were the two mostly used SRH components in Ambo, Ethiopia. In the current study, the few males that had used the services before expressed that there was no need to go to the facilities for services once they can use condoms and can easily procure it from pharmacies.
It is therefore imperative for the community health nurses to educate the general public on their services and the components of the SRH services for the adolescents to gain much knowledge on it. This may possibly change their attitudes towards the use of SRH services.

Apart from the attitudes of adolescents influencing their intentions towards utilisation of SRH services, subjective norms which are the social pressures for adolescents to use or not to use services were also discovered in the study. This is discussed in the next section.

5.2 Perceived Social Pressures (Subjective Norms) that affect Adolescents’ Utilisation of Sexual and Reproductive Health Services

The discussion in this section reflects adolescents’ perceptions of the social pressures that affect their utilisation of SRH services.

5.2.1 Attitudes of Parents/Relatives

This is the way parents and/or relatives favourably or unfavourably appraised adolescents’ use of SRH services. The participants considered their parents as people who were important regarding their decision to use or not to use SRH services. This was perceived as a form of pressure that influenced how they used the SRH services. It was identified that positive parental attitudes towards adolescents’ utilisation of SRH services positively influenced adolescents’ use of the services and vice versa.

Most adolescents in the current study were not able to discuss sexual matters and had not discussed their utilisation of SRH services with their parents. They thought that when their parents got to know about their use of SRH services, they will lose trust and confidence in them. They believed that their parents would not allow them to access the services if they informed
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them. Another reason why adolescents did not discuss matters relating to their utilisation of SRH services with their parents was because their parents were responsible for their upkeep and so did not expect them (adolescents) to be having sex let alone going for protection by utilising SRH services. This corroborates the study findings of Wilson (2014) which showed that although adolescents recognised their parents as an important source of social support, most of them were not able to discuss sexual matters and their use of contraceptives with them.

Adolescents in other studies were not able to discuss sexual matters and their use of SRH services with their parents (Tejineh et al., 2015; Hutchinson et al., 2012). Parent-adolescent relationships and the discussion of sexual matters is characterised with trust and distrust. According to adolescents in the current study, parents were not willing to discuss such matters with them because they (parents) think that such discussions will expose the adolescents to promiscuity. This finding may be an indication that issues pertaining to sex are considered private and not topics for discussion in Ghanaian homes. The effects of this can however be serious as adolescents may obtain such information elsewhere which may have adverse impact on their sexual lives. As parents are considered by participants in the current study as significant in their decision making, there is the need to encourage parents to openly discuss sexual issues with their children. This may help adolescents to understand the stance of their parents.

In this study, although most of the adolescents did not discuss their utilisation of SRH services with their parents, a few did and were motivated by their parents to go to the facility to access services. These adolescents were able to utilise the services without any financial barriers. They were also able to access services without anxieties because of the approval of their parents. The parental support they had allayed the fears and anxieties associated with the use of SRH services. This was not different from what Ayehu, Kassaw and Hailu (2016) found in their study.
in Awabel district, Northwest Ethiopia. They noted that compared to those who were not able to discuss SRH issues with their parents, SRH services were more likely to be used by those who had discussions with their parents. This could be that adolescents become aware of SRH services through discussions with their parents. Moreover, since parents have authority over their children, their consent and approval may facilitate utilisation of the SRH services. A study conducted in Mekele in northern Ethiopia also found a positive effect on contraceptive use by those who had discussed SRH services with their family (Melaku, Berhane, Kinsman, & Reda, 2014). This shows that adolescents’ utilisation of SRH services is most likely to be enhanced by parental involvement. It also underscores the fact that parents need to take an active role in openly discussing such issues with their children.

Apart from the influence of parents on adolescents’ use of SRH services, adolescents were also influenced by their friends to utilise SRH services. The discussion on this follows.

5.2.2 Attitudes of Friends

This is about how friends of the participants have a positive or negative evaluation of adolescents’ use of the SRH services. Adolescents relate to their peers more informally and as such discuss many issues, including sexual matters with them. According to Ayalew, Mengistie and Semahegn (2014), their study found that the majority of students preferred to discuss SRH matters and services with their friends and not their parents. Another study by Warenius et al. (2006) in Godar showed that discussion about SRH services with different people was objectively and significantly associated with utilisation of SRH services. Similarly, in this study, it was found out that most of the participants were influenced by their peers to utilise SRH services. They went for the services because their friends shared how the services had benefited
them. They also said that their friends were aware of their sexual relationships so they advised them against pregnancies and that led to their utilisation of the services. A similar finding was reported by Gebreselassie, et al. (2015) which indicated that discussion with friends about family planning and voluntary counselling and testing were significantly associated with utilisation of SRH services. In their study, adolescents who had discussed with their sexual partners were four times more likely to use the services. This shows that discussion with friends provide adolescents the opportunity to exchange information that helps them to have more understanding about SRH services which may most probably contribute to adolescents’ use of the services. This indicates the significant role of friends and the immense impact they can have on their peers. However, if parents decide to discuss openly with their children on sexual matters, the influence of peers may be minimised.

In the current study, most of the adolescents were motivated by their friends to utilise SRH services. Others were accompanied by their friends to the facilities to ease the tension that reportedly accompany adolescents’ utilisation of the services. The findings are in line with those of Bam et al. (2015) which showed that friends and peer group influence was a major motivator to the utilisation of SRH services.

Despite the fact that most of the participants were encouraged by their friends to utilise the SRH services, a few were discouraged by their friends. Some friends did not want to continue their friendship with participants because they utilised SRH services. This was because of the perceptions of the friends of these participants concerning SRH services. Their friends saw it as an unholy act and an unacceptable thing for an adolescent to do.
5.2.3 **Attitudes of the Community Members/Stigma/Gossips**

The community members constitute the rest of the people in the community aside the other discussed significant others. One of the important predictors of the health care seeking behaviour of adolescents is community support. There is some evidence that youth-friendly SRH services are more useful with community interventions (Kesterton & de Mello, 2010). According to the participants, some of the community members accept adolescents’ use of the services because they do not want the adolescents to become pregnant. However, most of the community members as perceived by the adolescents were not in support of adolescents’ use of the SRH services. As a result, adolescents in this study were concerned about being seen by people in the community as they utilised SRH services. This finding was not different from what Marcell, Morgan, Sanders, Lunardi, Pilgrim, Jennings and Dittus (2017) observed in their study. A similar finding was reported by Khan and Richards (2014) in Grenada. This means that adolescents use of SRH services possibly depend on the approval and acceptance of the community in which they live. This being the case, educating the community about the benefits of adolescents’ use of the facility will be useful.

Some participants in this study thought most community members did not approve of their (adolescents) use of the SRH services because they (community members) think it will expose them (adolescents) to premarital sexual activities. According to the participants in the current study, the community members saw them as children and so wanted them to grow and become adults before they could engage in sex and utilise SRH services as well. The adults had the perception that the facility is for married and older people and not for adolescents. This perception may be the reason why some participants felt the services were not designed for them but for adults. Such gossips stopped some of the participants from going to use the SRH services.
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This finding is in agreement with that of Chilinda, Hourahane, Pindani, Chitsulo, and Maluwa, (2014) which showed that adolescents were tagged as children whenever they wanted to utilise SRH services. This denotes that the issue of discrimination should not be ignored when providing SRH services to adolescents. Adolescents should also not be discriminated against. SRH services should be packaged to meet the needs of adolescents. Mixing adolescents and adults in one place for the same SRH services may lead to the adolescents not utilising the SRH services. This need of adolescents should be considered and taken into account when planning services.

The findings of the present study show that some adults gossip about adolescents who use the facility and reportedly label them as bad. These gossips appeared to deter the adolescents from the use of the facilities for the intended purposes. This observation is in agreement with the findings of Biddlecom, Munthali, Singh, and Woog (2007) which indicated that participants faced social stigma in accessing SRH services. These gossips and stigma may partly account for why the need for adolescents to access SRH services is not best met. For instance, adults did not really accept young people’s use of SRH services in Burkina Faso as Ouedraogo, Woog and Ouedraogo (2007) reported.

Cultural norms have been viewed by others as a significant element that continues to impact the behaviour of the youth with regards to SRH matters (Chege, 2005; Kaler, 2004). In a study by Kennedy et al. (2013) socio-cultural norms and taboos were noted to be significantly associated with adolescents access to care. On cultural considerations in the current study, most of the participants did not know about their culture in relation to adolescents’ utilisation of SRH services. They shared their thoughts on the issue since they did not know much about their
culture. Some felt restricted because of the perceptions of the community but reported that they do not think their culture will allow young people of their age to use SRH services.

None of the participants informed any religious leader about their use of SRH services. Some did not want their various religious denominational leaders as well as members of their denominations to see them using the facilities because they said they always preached about sexual abstinence until marriage. They thought the religious leaders would say they had become unholy. Tamang, Raynes-Greenow, McGeechan and Black (2017) posited that the vast difference between knowledge and practice possibly reflect the religious environment that limits open discussion of sexual issues especially for adolescents. Religion has been found to be a significant determinant of SRH seeking behaviour of adolescents (Prusty & Unisa, 2013). That is possibly why adolescents in the current study decided not to let their religious leaders or congregations know about their use of SRH services as they believed they will restrict them.

Having looked at the attitudes of significant others towards adolescents’ use of SRH services, the attitudes of nurses, the service providers in the facilities are discussed in the ensuing section.

5.2.4 Attitudes of Nurses

The nurses are the health professionals who render SRH services to the adolescents. The attitude of the nurse as the provider may influence the adolescents in their use of SRH services. Adolescents considered the attitudes and skills of the service provider as a defining characteristic in what they consider as youth friendly service (Kennedy et al., 2013). Muula, Lusinje, Phiri and Majawa (2015) established that poor or negative attitudes of health workers contribute to low utilisation of SRH services by adolescents. A study by Tangmunkongvorakul et al. (2012) found that service providers were judgmental and this attitude was a strong disincentive to adolescents.
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seeking care. Contrary to the above findings, the current study found that almost all the participants had experiences of positive staff attitudes. A few of the participants thought that the nurses would react negatively towards them, seeing that they were adolescents, but this did not happen. Some participants emphasised that the reason why they had constantly and frequently utilised the services was partly because of the nurses’ positive attitudes towards them. This could be attributed to the fact that in Ghana, a lot has been done in making SRH services youth friendly. This finding is in line with that of Tilahun, Mengistie, Egata and Reda (2012), as they found that most of the nurses had positive attitudes towards adolescents’ use of the services. However, the service providers in their study were more willing to provide contraception to adolescents who were married and had begun childbearing than those who were single and had not given birth. In the current study, the adolescents used were unmarried and had not started childbearing, yet the nurses’ welcomed them and treated them with professionalism.

Even though most of the adolescents were content and satisfied with the nurses’ attitudes towards them, a few of the participants complained about the negative attitudes of nurses at the SRH facilities such as being unwelcoming and not holding their issues confidential. Adolescents described such attitudes as deterrents to adolescents’ use of the facilities as well as unprofessional behaviour. However, in other studies, the attitudes of providers were the major challenge reported by the adolescents (Agampodi, Agampodi, & Piyaseeli, 2008; Alli, Maharaj, & Vawda, 2013). Anecdotal evidence has also shown that some health workers refused to serve adolescents who utilised family planning services (Abdul-Rahman, Marrone, & Johansson, 2011). There is a need to make services attractive to the youth by enquiring from them how they want services to be packaged to meet their needs. This may facilitate utilisation of SRH services and possibly reduce the outcomes of non-use of services.
5.2.5 Motivation to Comply

This was the degree to which adolescents decided to comply with their significant others’ expectations. The findings of the current study showed that most adolescents utilised the services by the influence of mostly their friends and the nurses who went to their schools for health education purposes. A few were influenced by their parents to utilise these services. Most of them complied with what was expected of them by these significant others (friends and nurses) to use the services. However, others had not informed most of their significant others such as parents, community members which included their opinion leaders and religious leaders of their use of services because of what they thought such people expect of them which they believed would stop them from utilising the services. These adolescents were however motivated by the fear of having unwanted pregnancies and STIs which they did not desire. These fears influenced their attitudes towards utilisation of SRH services which has already been discussed. It appeared this point has not been explored in literature.

Having discussed the perceived social pressures that affect adolescents’ use of SRH services, the facilitators and barriers to adolescents’ use of SRH services which was another major finding are discussed next.

5.2.5 Facilitators/ Barriers (Perceived Behavioural Control)

This was the adolescents’ belief about the presence of factors that might facilitate or impede the utilisation of SRH services. It was found out that these factors were relative; a factor which facilitated a participant’s utilisation could act as a perceived barrier to another.
5.3.1 Access

This refers to the opportunities, right or ability and the means by which adolescents utilised SRH services. The concept has been further categorised into social, geographical and financial access based on the findings of the study.

Social access is about whether adolescents generally have the right to and are allowed by society to make use of SRH services. Participants shared that the facility is accessible to adolescents because they see other adolescents using the place apart from themselves and have not been stopped from going there. This was consistent with a study by Tamang, Raynes-Greenow, McGeechan and Black (2017) in Nepal which found that adolescents had access to SRH services. This means that adolescents are not excluded from those who can legally use SRH services. However, contrary to the current study, Berhane et al. (2005) pointed out that adolescents in their study did not find the SRH fully accessible. This could be that there were some forms of restrictions which could be socio-cultural in nature. Over, the years, much has been done in making SRH services youth friendly. This could be an explanation for the observed differences.

Geographical access involves the distance from the adolescents’ residence to the facility and the location of the facility. The findings of the study revealed that the distance from participants’ residence to the location of the health facility was problematic for some adolescents and at the same time enablers to others depending on where the person lives and the person’s preferences.

Tegegn and Gelaw (2009) reported that adolescents found the services fully accessible geographically. However, the findings of the current study do not corroborate theirs. The current
study found that the location of services was a challenge to the majority of the participants and some added that they believed that was why some friends of theirs were not able to utilise the services. It is possible that when services are extended to other locations, it may facilitate the use. The findings showed that a few of the participants stayed closer to the facility and that enabled them to visit the facility anytime they wanted to visit. This finding supported that of Bam et al. (2015) as they found that distance was a barrier and that a shorter distance to a healthcare facility eased SRH service utilisation. Once more, in their study, the majority of students preferred SRH services within the emergency health services department. This is consistent with the findings of the current study which found that most of the participants preferred SRH services integrated with general health services for the fear of being seen and noted by others. This also corroborates the findings of the study by Berhane et al. (2005) who found that a considerable fraction of adolescents preferred services within the general services as they viewed that it will be hard for people who are familiar with them to detect the reason why they utilised the health services.

Participants shared the financial costs of accessing the services based on the transportation from their place of residence to the place of service delivery. This was related to the distance and also the cost of the services they went for. It was evident that participants who had financial support from their parents had no problems with finances for transportation or the cost of services. Thus, when parents agree to adolescents’ use of SRH services, it may minimise the financial constraints of adolescents thereby increasing the rate at which they utilise the services. It was also identified that some participants felt the cost of services was affordable compared to the costs involved in the consequences of unwanted pregnancy. In all, the majority of the participants had no problem with finances in relation to service utilisation. This supports
the finding by Obong and Zani (2014) who found that the majority of participants said services were affordable. However, this finding was not consistent with other findings where adolescents in those studies reported financial constraints as a major barrier regarding access to SRH services (Tylee, Haller, Graham, Churchill & Sanci, 2007). Research has indicated that people from rich backgrounds may find SRH friendly than others from poor background (WHO, 2012).

However, a few of the participants in the current study reported that the services are not affordable and that impeded the frequency with which they accessed the services at the unit. Thus, they suggested that the National Health Insurance Scheme (NHIS) should cover the SRH services. Others expressed that if the services are made free, more adolescents may utilise them. Concerning the distance and the costs involved in transportation, it was noticed that based on where a participant resides, the cost may be high for the person and as such may impede service utilisation. A similar finding was reported by Johnson, Nshom, Nye and Cohall (2010) that monetary costs and lack of insurance were clear barriers to adolescents’ use of services. There is an obvious indication that financial barriers affect access to SRH services especially, contraceptives. Malarcher (2010) noted that contraceptive use is uneven within countries and differs by wealth and place of residence. Greene and Merrick (2005) found that globally, the unmet need for contraception is highest among poorer women.

The health service related factors which facilitated or hindered adolescents’ utilisation of SRH services is discussed in the next section.

5.3.2 Quality of Care Issues

These were the health service related factors that enabled, impeded or could impede the utilisation of SRH services among adolescents. The identified factors from the data were staff
attitudes and cost of services; these have been discussed already. The remaining factors were working hours, waiting time, range of services, availability of drugs and other logistics and provision of services. These factors either facilitated or made it difficult for adolescents to access services.

Working hours refer to the hours within which services are made available to clients. Most participants had reservations about the working hours and preferred it was extended to the evenings and weekends to ensure privacy and flexibility in relation to their school hours because most of them were students. This supports the finding by Lesedi et al. (2011) who found that the working hours were not suitable for the youth because most of them were students. Therefore, no matter how well services are designed, the time should be appropriate for the users to facilitate high patronage.

The waiting time is the time participants spend at the facilities to wait until they are attended to when they go for the SRH services. It was found out that the waiting time largely depended on the time the participant in question got there. Those who got to the facility and met none or a few people ahead of them were pleased with the waiting time but those who got there and found many people ahead of them in a queue were not pleased. Overall, it was noted that most participants wished they were served as soon as they get there so that the adults will not come and meet them there since the participants did not want the adults to see them. WHO (2012), similarly reported that in some places adolescents had to wait for a long time at where they could be seen by familiar people before they were served for which they (adolescents) were not comfortable with. Thus, adolescents did not want to waste time at the facilities and preferred to be served as soon as they arrived. This calls for an increase in community health nurses and midwives so that adolescents will be served as soon as they report for services. There is a need
for a separate place for them where they will not be concerned about being seen by adults whilst they wait for their turn.

Concerning the range of services and availability of drugs and other logistics, all the participants in the current study were comfortable with the components of services provided and the logistics used to serve them. Some participants added that going to the facilities will not be useful if the facilities lacked certain items. Contrary to this Bam et al. (2015) found that most of the adolescents stated that services could not meet their needs as it did not cover all the components and expectations of adolescents. This implies that SRH services coverage should be widened to cover all that adolescents will need regarding SRH matters in one place so that they will not have to be referred to other units as this can deter them from future use.

The provision of services in this study covers how the participants perceived the services that were rendered to them. Almost all the participants were comfortable with how services were provided at the various facilities. The participants highlighted the cleanliness of the facility and commendable sitting arrangements. Other quality issues came to the fore as factors that would enhance utilisation. Privacy and confidentiality were key factors in their narration. The majority of participants trusted the nurses to keep their matters confidential. This is congruent with the findings by Obong and Zani (2014) where the majority of adolescents believed they could trust the service providers to maintain confidentiality. The finding by Tegegn et al. (2008) was different as adolescents in the study were uncertain of what providers do with their information.

However, adolescents in the current study attributed the lack of confidentiality and privacy to the fact that adolescents and adults used the same facility for SRH services. They were displeased with this arrangement and some stated that this could be the only reason why they
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might not utilise the services in future. Similar to the findings of the current study, Kalo (2006) found that the youth prefer separate services in a private environment at hours convenient to them. This finding also supported the findings by Marcell, Morgan, Sanders, Lunardi, Pilgrim, Jennings and Dittus (2017) and Regmi, Van Teijlingen, Simkhada, and Acharya (2010). However, it should be noted that the confidentiality and privacy related issues in this study were not related to disclosure of information by healthcare providers but the fact that adults were mixed with adolescents in one setting.

Of all the participants interviewed in the study, only one expressed the divergent view of adolescents using the same facilities with adults simultaneously with the view that the adults will ultimately accept that adolescents also have need for SRH services. Adolescents therefore appeared to desire services that are youth friendly and are accessed only by people of their age.

Having discussed the adolescents’ perceptions of their abilities to utilise the services, the next section discusses their intentions to utilise the SRH services.

5.4 Intentions to Utilise SRH Services

This reflected the indication of the adolescents’ readiness or willingness to use SRH services in the future. The findings of the study revealed that some adolescents had planned either to use or not to use the SRH services in the future. A few were not able to tell whether they would use the facility at another time.

5.4.1 Willingness to Utilise SRH Services

Most participants spoke about their willingness to use the SRH services in the future. It was noted that some participants were willing to use the services at another time because of the benefits they have had from using the services. Many of the participants also adjoined that they
will go for the services once again because of how services were provided in the facilities, the follow up appointments they had to keep as well as the prospects of some of the participants. In all, the focus was largely on pregnancy prevention. This finding is similar to Gabremichael and Chaka, (2015) who found that the majority of adolescents had intentions to use SRH services in the future. Tejineh et al. (2015) also found that most of the adolescents had intentions to use SRH services, especially family planning in the future and this is similar to the findings of the current study. This shows that adolescents have a high demand and a need for SRH services.

Contrary to the findings of the current study is the finding by Bam et al. (2015) that most of the adolescents in their study had no intentions of utilising SRH services in the future. This variation may possibly be due to variations across populations and the situation under which the behaviour was occurring (Glanz, Rimer, & Viswanath, 2008). It could be as a result of the presence of factors that impeded service utilisation at Nepali where the study was conducted. However, the fact that the current study found that the majority were willing to utilise SRH services at another time does not mean that there were no barriers. Participants listed a number of barriers and challenges they faced in utilising SRH services. However, their motivation to prevent pregnancy and focus on their dreams for the future was the major reasons for their intentions.

5.4.2 Unwillingness to Utilise SRH Services

A few of the participants were reluctant to utilise the SRH services in the future because some said they have had what they wanted. A few of them said, since their sexual partners were willing to utilise the facilities, there was no need for them to go to the facilities for services. Apart from citing the distance to the facility as a challenge, one participant also cited social
stigma as the reason why she was not willing to use the services any more. One of the participants was reluctant to go to the facility for service at another time, because of the negative attitudes of a nurse towards him in his previous use of the service.

However in the study by Abubakari et al. (2015) the reasons why adolescents had no intentions to use SRH services, especially contraceptives in the future were the costs involved, fear of side effects and opposition to family planning, socio-cultural and religious background. Furthermore, the adolescents in rural communities were not certain of their intention to use contraceptives as compared to those in the urban areas. Compared to other religions, Muslim adolescents were not certain of their intention to use contraceptives in the future.

Therefore, positive changes in social and community-level factors as well as health service related factors will play a major role in adolescents’ use of SRH services.

5.4.3 Uncertainty

In this study, a few of the participants were not sure of whether they would utilise the services in the future for various reasons. Some hoped that they would be able to stop having sex so they would stop going for contraceptives. However, they thought that they needed the services for pregnancy prevention if they were not able to abstain from sex. Other reasons why they were not sure of using SRH services in the future were their dislike for mixing with adults when seeking SRH services and also because of other people’s perception about their decision to use SRH services. It appeared not much has been found on this aspect.
5.5 State of adolescents before use of services

It was found from the study that, after the adolescents had intended to use SRH services, they had some sentiments. They considered the issues of morality and also tried to justify why they had to use SRH services despite all odds.

5.5.1 Morality

During the analysis of data collected for this study, it was found that some adolescents considered moral issues before they utilised SRH services. These moral issues were religion oriented. Some felt guilty because they thought others will see them as bad people given their religious affiliations and their activities. A similar finding was pointed out by Fentahun, Assefa, Alemseged and Ambaw (2012) that religion influences attitudes towards SRH significantly. In their study, students attending religious services had less favourable attitudes and vice versa. Khan and Richards (2014) also found that the key factors that impede adolescents in having knowledge on SRH were religion and thoughts of being stigmatised by their communities and religious congregations.

5.5.2 Sentiments

These were the thoughts participants had before utilising the SRH services based on their feelings or emotions. The sentiments identified in the study were shyness, rejection and fear.

Most of the participants felt shy because of the location of the facility, the people around, how they thought the people would see them the bad thoughts they may have about them. Some of the participants also felt shy because they use the same facility with the adults. The majority of them also feared that the people who saw them would report them to their parents as people
knew each other in the communities. Similarly, in other studies a sense of fear of society and parents and shame relating to their use of SRH services were reported by some adolescents (Regmi, 2009; Regmi, Simkhada & Teijlingen, 2008). In line with the current study, Tegegn and Gelaw (2009) also reported fear of being seen by people who knew them and feeling of embarrassment as concerns of adolescents in utilising SRH services.

In the current study, a few participants thought they would be rejected or sent away when they went to use the SRH services, especially before their first use of the services. When significant others do not approve of adolescents’ utilisation of SRH services it puts fear in the adolescents (DeJong & El-Khoury, 2006; Biddlecom et al., 2007).

A few of the participants had genuine fears. They were afraid of the results of the HIV test because they have been having unprotected sex. This is congruent with the findings of other studies that fears and anxieties accompanied the HIV testing (Khan & Richards, 2014).

5.5.3 Rationalisation

The participants after having these sentiments and considering moral issues then found justifications why they had to utilise the services. They used the benefits they believed they would gain from utilising the SRH services to justify why they had to utilise the services. It was identified that utilisation of services among adolescents was perceived by them as a difficult and an uncomfortable task as they feared being seen by familiar people whom they thought might report them to their parents. However, they considered the fact that they wanted to prevent unwanted pregnancies and their consequences and went ahead to utilise the services. It appeared studies done have not found this.
The next section discusses the activities or components of the SRH services as perceived by the participants; what is done at the service centres and what they think should be added to what was available at the time of the study.

5.6 Perceptions about SRH Services

Discussion of findings on the perceptions of adolescents about the SRH services is done under the respective sub-themes.

5.6.1 Activities at the SRH centre

The participants shared what they knew made up SRH services and the services they knew were rendered at the various centres. It was identified that most participants knew the services included counselling, advice, education on sex and sex related diseases, family planning, health screening and examinations. Almost half of the participants thought SRH services are all about family planning. However, the majority knew about other components apart from family planning. In contrast to the findings of the current study, Gebremichael and Chaka (2015) in a study in Ethiopia found that the majority of adolescents did not know the components of SRH. In their study, they found that most adolescents had not used SRH services because they lacked knowledge on it. This may be due to their level of education or socio-cultural factors that restrict discussions on sex related issues or low utilisation of functional means of communication such as radio, television and others. Knowledge of SRH services is reportedly associated with utilisation of the services (Tegegn & Gelaw, 2009). They found that adolescents who had knowledge on voluntary counselling and testing for HIV/AIDS were three times more likely to have ever used SRH services than adolescents who had no knowledge. Thus, knowledge of the SRH services can positively influence the use of the services. However, it is known that knowledge and practise have a gap between them. This is a debatable issue.
According to most of the adolescents in the current study, apart from what the nurses do at the SRH centres, they also visit schools for school health services during which they provide teaching on sex and inform adolescents of the services available at the SRH service centres. This shows that the nurses have been doing their best to improve adolescents’ utilisation of SRH services. Since it influenced adolescents’ use of the services, the continuation of such strategies will improve adolescents’ use of the services so as to meet their (adolescents) needs. Biddlecom et al. (2007a) opined that sex education in schools is an important means of enhancing the knowledge of adolescents on SRH matters such as prevention of unwanted pregnancies and HIV.

Most of the participants shared that the services were there to help reduce teenage pregnancies and adolescents’ birth rate as well as STIs prevention. Moreover, most of the participants added that the services were not only to prevent teenage pregnancies but to help the adults who were giving birth to space their children. This shows that participants fairly knew what the services were meant for. This might be an impetus for utilising SRH services as other research work have established the link between knowledge and utilisation of SRH services.

The next section discusses participants’ sources of information on SRH issues and the services from.

5.6.2 Sources of Information on SRH Services and Issues

The findings showed that adolescents received information on SRH issues and services from the social media and the mass media. This is congruent with the finding by Enuameh et al. (2015) in Ghana that the well-known sources of information on SRH services were the mass media such as radio, television and social media. Another study in Ghana discovered that the major source of information on SRH matters was the radio (Cleland & Ali, 2006). Other studies
elsewhere have found the same sources of information on SRH services and matters (Tejineh et al., 2015; Kothari, Wang, Head, & Abderrahim, 2012).

Most of the adolescents also heard about SRH issues from friends, the community health nurses, parents (especially mothers) and from schools. The adolescents relied more on the nurses’ information than their friends’. The same sources of information were found in other studies in Ghana (Owusu-Ansah & Mensah, 2014; Marrone et al., 2014). A similar finding was also reported by Abajobir and Seme (2014) that health professionals were the main sources of information followed by the mass media. This signifies that these sources can be used to provide more information on SRH services to adolescents. Since adolescents mostly rely on the information by the nurses, it should be made one of the priorities of nurses to disseminate such information to adolescents.

5.6.3 Perceptions of Adolescents concerning Services

Most of the participants said that the services were meant for everyone including adolescents and adults because they perceived that all people have SRH needs. They considered that the services were meant for adolescents as well as adults even though the community members reportedly considered it as being for adults only. A few of the participants exhibited fallacies about men and the use of family planning. They considered family planning to be solely for women in the fertile age. They did not think it was necessary for the males to go for the family planning services and had not seen a male accessing the services before. This may account for the reason why females utilise SRH services more than males. For instance, in a study by Lesedi et al. (2011) in Botswana more females (59%) had utilised the SRH services than their male counterparts.
5.6.4 Expectations/Suggestions made by the Adolescents concerning SRH Services

Finally, it was found from the data gathered that participants had some expectations concerning SRH services and as such made some suggestions on how they wanted SRH services for the adolescents to be packaged. Some suggested that there should be posters on the walls of the various facilities and pamphlets they could read for themselves. There was a suggestion that the nurses should give out their contact numbers to them (adolescents) so that they could discuss certain things with them on telephones through calls and text messages without going to the facilities as it is done at some places. Perry et al. (2012) similarly found that participants delighted in receiving text messages that provided needed information on their SRH in a simple format. They also stated that the text messages helped them in discussing sexual health issues with their peers. This means that subscribers became informal health educators based on the content of the messages. This may be convenient for the adolescents as it may not pose any financial challenges and will also create a great sense of privacy. Other studies have also found the relevance of text messaging in engaging teenagers about health and promoting utilisation of SRH services (Gold et al., 2011; Cornelius & St Lawrence, 2009).

Participants suggested that there should be public education in churches, schools and the communities about the services offered at the SRH centres so that people will get to know what the services entail, what they are meant for and who can utilise the services. The adolescents believed that it will help them to utilise the services without thinking about what others will say about them and their use of SRH services. The suggestion that there should be sex education in schools supports the study finding of Mkumbo (2013) who found that the vast majority of primary and secondary school students in Tanzania were in support of sex education in schools. This implies that adolescents are willing to use SRH services if their significant others approve
of it. Increasing the coverage of sex education within schools, communities and other places is very important in enhancing knowledge of the society on SRH services which may improve adolescents’ use of services.

5.7 The Usefulness of the Theory of Planned Behaviour in the Study

The study was guided by the Theory of Planned Behaviour which was developed by Icek Ajzen (1991) from the Theory of Reasoned Action to predict human behaviour. The theory has been used in health research to predict human behaviour such as HIV prevention and condom use, addiction related behaviours such as smoking and alcohol use. Literature was reviewed on the application of the model in other studies and this was presented in chapter two. There are other models which could have been used for the study such as the health belief model and Anderson’s model of health service utilisation. However, in exploring the utilisation of SRH services among adolescents, the TPB was preferred because as Sniehotta, Presseau and Araújo-Soares (2014) observed, for the past three decades, the TPB has been the principal framework to guide studies on health-related behaviour.

The researcher observed that, the constructs of the theory namely attitude, subjective norms, and perceived behavioural control were related to each other in that some factors such as knowledge of the behaviour could influence any of these constructs. Furthermore, some of the identified factors that would lead to utilisation of the SRH services could fit in either subjective norms and/or perceived behavioural control. For instance, the attitudes of nurses could be categorised as a health service-related factor under perceived behavioural control in the theory. However, it was identified that ‘the nurse’ was seen by the adolescents as significant other in their decision to use SRH services and so it was considered as a subjective norm.
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It was also noticed that after adolescents had formed intentions to utilise SRH services, they still had to ponder on certain things such as issues of morality and how they would be viewed by others who would see their use of services. They therefore had sentiments such as fear, anxieties and shyness. The adolescents also shared their perceptions on the SRH services and how they thought it could be packaged to meet their needs. The TPB appeared not to have constructs to cover these additional themes. However, the TPB which underpinned this study was effective in guiding the researcher meet the objectives of the study. The themes that emerged outside the constructs of the TPB have contributed an added dimension to the theory.
CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary of the whole research as well as the implications of the findings for nursing education, research and practice. The limitations of the study, conclusion and recommendations have also been made based on the findings of the study.

6.1 Summary of the Study

Adolescence may be defined as a transitional stage from childhood to adulthood (Kwankyey, Amedoe, & Cash-Abbey, 2014). The World Health Organization (2011) categorises adolescence as the period in growth and development of humans that happens between childhood and adulthood, from 10 to 19 years of age. Adolescents encounter a lot of general as well as sexual and reproductive health problems which if not resolved can affect them not only at this stage but in adulthood. In view of this, globally, there is an increased concern about the sexual and reproductive health and adolescents’ development (Omoni, 2009) and Ghana is no exception. The utilisation of sexual and reproductive health services is however a vital component in helping adolescents to avoid diverse sexual and reproductive health problems.

Therefore, the study explored the utilisation of SRH services among adolescents at Asante Akyem North district. It was guided by the theory of planned behaviour. The study employed a qualitative interpretive descriptive design, using a purposive sampling approach. Data collection was aided by an interview guide after ethical approval was obtained from the Institutional Review Board of the Noguchi Memorial Institute of Medical Research. Fifteen participants were recruited for the study and the sample size was based on saturation. The
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Participants were recruited from the public health units of the four health facilities in the district namely: Agogo Presbyterian Hospital, Juansa, Nyampenase and Ananekurom health centres. Interviews were conducted after consent/assent and/or parental consent was obtained from participants and/or their parents. The interviews were based on adolescents’ utilisation of SRH services which were audio-recorded and transcribed verbatim.

Six major themes emerged from the analysis of the data gathered from the participants. The themes were: attitudes of adolescents towards adolescents SRH services, social pressures, facilitators/barriers, intentions to utilise SRH services, state of adolescents before use of services and perceptions about SRH services. The key findings of this study revealed that, the majority of adolescents had positive attitudes towards SRH services utilisation. Most of them were influenced by their friends, parents and nurses to utilise the SRH services. However, on the whole it appeared the significant others do not openly approve of adolescents’ utilisation of SRH services and this had a significant impact on adolescents’ utilisation of the services. Notwithstanding these influences, adolescents expressed their willingness to use SRH services to prevent pregnancies, STIs and to gain knowledge on sexual matters.

The major barriers that adolescents shared in the study included geographical barriers such as long distance and unfavourable location of the services. Other barriers identified were financial barriers and health service related barriers such as the working hours, waiting time, privacy and confidentiality issues which were related to the fact that adolescents used the same facility with the adults. However, a few adolescents had no problems with these factors which in turn facilitated their use of the services.
Most of the adolescents were willing to use the SRH services in the future with a few of them not willing as well as uncertain as to whether they will utilise the services in future.

Aside the objectives of the study which were congruent with the constructs of the TPB, there were other findings generated through content analysis which equally influenced adolescents’ utilisation of the SRH services. These included the state of adolescents before use of services and their knowledge and perceptions concerning the services. It was found that adolescents had sentiments such as fear of the unknown and anxiety about what others will think of their use of the services but they were motivated by the fact that they do not want to become pregnant as they are sexually active. It was also identified that most of the participants had a fair knowledge of the components of the SRH services. All the objectives of the study were achieved.

6.2 Implications

The findings of this study have implications for nursing education, nursing research and nursing practice.

For Nursing Education

From the findings, adolescents reported that the nurses have good attitudes towards their (adolescents) use of SRH services. It is clear that continuing education for nurses is important to maintain and harness competency in working with adolescents. It is thus imperative to improve the curricula for nursing training to expand the content on adolescents and sexual and reproductive health. Sexual and reproductive health nursing can be considered as a specialty area which will help the nurses to acquire skills and competency on how to handle adolescents and other groups of people in matters relating to sexual and reproductive health. Lecturers and tutors
in the various nursing institutions should specially train students to meet the SRH needs of adolescents.

**For Nursing Practice**

Findings of the study revealed that nurses have good attitudes towards adolescents’ use of SRH services. This implies that the nurses are promoting adolescents’ use of the services; hence nurses should keep on treating adolescents as young people who also have sexual needs which demand their attention and the provision of non-judgmental care. An insignificant number of the adolescents shared that they had experienced negative attitudes of some nurses at the facilities. This calls for nurses to bridge the gap between their personal moral values and the needs of the adolescents so that they can discharge their duties as expected in providing equitable services to all who have the right to use the facilities, including adolescents. Therefore, nurses should be friendly, welcoming and non-judgmental.

**For Nursing Research**

This research discovered that the majority of adolescents had positive attitudes towards SRH services and were willing to utilise services in the future. However, they faced barriers anytime they tried to utilise SRH services but were motivated by the benefits of using the services. This indicates that those who have not been able to utilise SRH services might be willing to but do not have control over the factors that hinder adolescents’ use of such services. Further research to involve adolescents who have not utilised the services will be essential since the current study only focused on those who have utilised the services. In future, the current study can also be repeated in other hospitals in Ghana to further explore adolescents’ utilisation
of SRH services. Moreover, a quantitative study to determine the association of gender with the use of SRH services is recommended.

6.3 Limitations

The small sample size of 15 could not be a fair representation of adolescents in the Asante Akyem North district. Another limitation was that the research was carried out on only adolescents who have utilised sexual and reproductive health services and does not cover those who have never utilised the services. Therefore, the challenges of those who have not utilised the SRH services were not covered. Further research can therefore consider using adolescents who have not utilised SRH services.

6.4 Conclusion

Adolescent SRH remains an issue of public health importance thus, it is imperative to note that adolescent sexuality is a reality which should not be ignored. This study has provided valuable information on the utilisation of SRH services among adolescents at Asante Akyem North District and has provided a deeper insight into the attitudes of adolescents towards SRH services, the social pressures that influence adolescents’ use of services and adolescents’ belief of the presence of factors that can facilitate or impede their use of SRH services. Most of them were willing to utilise services in the future against all odds however, a significant minority were not willing and not sure as to whether they will utilise services in future. In addition, state of adolescents before they used SRH services as well as their perceptions and suggestions on how SRH should be packaged were identified. There is therefore the need to further educate the adolescents as well as the general public to remove the stigma that goes with adolescents’ use of SRH services. The findings were congruent with the Theory of Planned Behaviour as data were found for all the constructs of the theory. However, two additional themes emerged which were
also key as they also influenced adolescents’ use of the SRH services. The theory in effect illuminated the areas that adolescents had challenges with access to SRH services so that interventions could be developed to meet the challenges.

6.5 Recommendations

Based on the findings of the study, recommendations were made to Ministry of Health (the Family Health division of Ghana Health Service), the various health facilities in the Asante Akyem North district, and nurses.

**Ministry of Health (The Family Health Division of Ghana Health Service)**

- The department should make policies to strengthen the existing SRH services provided at the general hospitals and clinics to ensure that they are youth friendly by providing private rooms for adolescents to serve them at their own convenient hours.
- They should support healthcare providers through appropriate pre-service and in-service training in adolescent SRH so that they can effectively provide services to adolescents.
- They should support Non-Governmental Organizations (NGOs) that provide SRH services to adolescents to widen their catchment areas.
- Adolescents should be involved in designing and programming as well as reorientation of SRH services so that their views on how they want the services to be packaged will be considered to motivate them to utilise the services.
- Since the social and mass media were identified as sources of information of adolescents, information should be made available to them using these means to help them know more about the SRH services. Those same means can be used to generate community support and to encourage parent-adolescent communication, so as to increase the participation of
significant others thereby creating a supportive environment for adolescents’ use of services.

Agogo Presbyterian Hospital, Juansa, Nyampenase and Ananekurom Health Centres

- The units for providing sexual and reproductive health services should ensure that privacy is maintained when dealing with adolescents.
- The hospitals should separate adolescents from the adults and provide youth-friendly SRH services that meet their needs.
- The health facilities should integrate youth friendly health services into their facilities following the criteria for the youth friendly health services.
- There should be standardised records to monitor the utilisation of SRH services among adolescents so as to identify the trends to allow for improved planning of adolescent sexual and reproductive health services.

Ghana Registered Nurses’ and Midwives’ Association

- Nurses should accept the fact that adolescents are sexually active and they need SRH services to curb unwanted pregnancies, abortions as well as STIs.
- Nurses should keep their skills updated by attending workshops on SRH to adolescents.
- Nurses should reach out to adolescents, their parents, and families via health education to increase the awareness and knowledge on SRH services for adolescents and its importance. It was discovered in the study that the nurses do well in moving from school to school to keep adolescents informed, but the out-of-school adolescents can be reached out to during the community outreaches so that they can also be given the necessary information on the services.
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Utilisation of SRH Services among Adolescents


Utilisation of SRH Services among Adolescents


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Utilisation of SRH Services among Adolescents


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Marcell, A. V., Morgan, A. R., Sanders, R., Lunardi, N., Pilgrim, N. A., Jennings, J. M., ... &


Utilisation of SRH Services among Adolescents


Utilisation of SRH Services among Adolescents


Utilisation of SRH Services among Adolescents


http://apps.who.int/iris/bitstream/10665/44153/1/9789241598354_eng.pdf


APPENDICES

APPENDIX A:

INTERVIEW GUIDE

PART I

BACKGROUND INFORMATION FORM

A. Demographic Information

Code number …………………….

1. Age 15 ( ), 16 ( ), 17 ( ), 18 ( ), 19 ( )

2. Sex …………………………………

3. Number of children …………………….

4. Residence ……………………………….

5. Occupation ……………………………..

5. Tribe …………………………………….

6. Language (s) spoken ………………………….

7. Religion ………………………………………….

PART II

B. Guiding Questions

1. Please kindly tell me about sexual and reproductive health services?

2. What are the sources of obtaining information on sexual and reproductive health services?

3. How do you view sexual and reproductive health service utilisation?

Probes
Utilisation of SRH Services among Adolescents

Approval/disapproval

Positive/Negative

4. What role do you think others can play in making you utilise or not utilise sexual and reproductive health services?

Parents, Peers, Religious leaders, culture etc.

5. How do you think of others approval of the adolescents’ utilisation of sexual and reproductive health services?

Parents, Peers, Religious leaders, culture etc

6. What do you think may make it possible for you to utilise sexual and reproductive health services?

Probes

Logistics, policies, guidelines, facility, service providers, others.

7. What do you think may hinder your ability to utilise sexual and reproductive health service?

Probes

Logistics, policies, time, facility, service providers, others

8. How many times have you utilised sexual and reproductive health services?

9. Why did you utilise sexual and reproductive health services for the first time?

Probes

Why have you been utilising the SRH services after your first attendance?

Or

Why have you not been utilising after your first attendance?
10. Kindly describe your experiences with the utilisation of sexual and reproductive health services?

Probes

Service provider, facility, others perception about you etc

11. Tell me about your intentions to utilise sexual and reproductive health services in the future?

Probes

Why would you like to utilise the services again?

Or

Why would you not like to utilise the services again?

12. How do you want sexual and reproductive health service to be packaged for adolescents?

13. What more would you like to tell me?
## DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sex</th>
<th>Age in years</th>
<th>Tribe</th>
<th>Languages spoken</th>
<th>Level of education</th>
<th>Occupation</th>
<th>Who participants stay with</th>
<th>Religion</th>
<th>Hospital</th>
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<tbody>
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<td>PA</td>
<td>Female</td>
<td>17</td>
<td>Akan</td>
<td>English, Twi</td>
<td>SHS</td>
<td>Student</td>
<td>Parents</td>
<td>Christianity</td>
<td>Agogo Presbyterian Hospital</td>
</tr>
<tr>
<td>PB</td>
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<td>15</td>
<td>Dagomba</td>
<td>English, Twi, Dagomba</td>
<td>JHS</td>
<td>Student</td>
<td>Parents</td>
<td>Christianity</td>
<td>Agogo Presbyterian Hospital</td>
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<tr>
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<td>Akan</td>
<td>English, Twi</td>
<td>SHS</td>
<td>Student</td>
<td>Parents</td>
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<td>Twi</td>
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<tr>
<td>PH</td>
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<td>Akan</td>
<td>Twi</td>
<td>Primary Simstresses</td>
<td>Student</td>
<td>Parents</td>
<td>Traditional</td>
<td>Ananekurom Hospital</td>
</tr>
<tr>
<td>PJ</td>
<td>Female</td>
<td>16</td>
<td>GaAdange</td>
<td>English, Ga, Twi</td>
<td>SHS</td>
<td>Student</td>
<td>Parents</td>
<td>Christianity</td>
<td>Nyampe nase</td>
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### DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS CONT’D

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<th>Religion</th>
<th>Hospital</th>
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<td>English, Twi</td>
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<td>Other relatives</td>
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<td>Other relatives</td>
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<td>Juansa</td>
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<tr>
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<td>Koko mba</td>
<td>English, Twi,</td>
<td>SHS</td>
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<td>SHS</td>
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<td>Other relatives</td>
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### APPENDIX C

**THEMATIC CODE FRAME**

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<tr>
<td>ATTITUDES OF ADOLESCENTS TOWARDS UTILISATION OF SRHS</td>
<td>AOATU</td>
<td>It covers the participants’ favourable or unfavourable evaluation of the utilisation of SRHS which involves a consideration of the outcomes of the use of SRHS.</td>
</tr>
<tr>
<td>1. Positive Attitude</td>
<td>Pa</td>
<td>This covers the degree to which the utilisation of sexual and reproductive health services was favourably appraised by participants.</td>
</tr>
<tr>
<td>2. Negative Attitude</td>
<td>Na</td>
<td>This entails the extent to which the utilisation of sexual and reproductive health services was unfavourably appraised by participants.</td>
</tr>
<tr>
<td>SUBJECTIVE NORMS</td>
<td>SN</td>
<td>This is the perceived social pressure to utilise or not to utilise sexual and reproductive health services.</td>
</tr>
<tr>
<td>1. Attitudes of Parents/Relatives</td>
<td>Aopr</td>
<td>The way parents/relatives favourably or unfavourably appraise adolescents’ use of SRH services.</td>
</tr>
<tr>
<td>2. Attitudes of friends</td>
<td>Aof</td>
<td>The way friends favourably or unfavourably appraise adolescents’ use of SRH services.</td>
</tr>
<tr>
<td>3. Attitudes of the community members</td>
<td>Aotcm</td>
<td>The way the community members favourably or unfavourably appraise adolescents’ use of SRH services.</td>
</tr>
<tr>
<td>4. Attitudes of the nurses</td>
<td>Aotn</td>
<td>The way the nurses favourably or unfavourably appraise adolescents’ use of SRH services.</td>
</tr>
<tr>
<td>5. Motivation to comply</td>
<td>Mtc</td>
<td>This was the degree to which adolescents decided to comply with their significant others’ expectations of them regarding their utilisation of SRH services.</td>
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</table>
### THEMATIC CODE FRAME CONT.

<table>
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<th>THEMES</th>
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<td><strong>PERCEIVED BEHAVIOURAL CONTROL</strong></td>
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<tr>
<td>1. Access</td>
<td>Acc</td>
<td>The ease or difficulty of adolescents to use SRH services</td>
</tr>
<tr>
<td>2. Quality Issues</td>
<td>Qis</td>
<td>Quality of care issues that makes it easy or difficult for adolescents to use SRH services</td>
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<tr>
<td><strong>INTENTIONS FOR USE OF SRH services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Willingness to use SRH services</td>
<td>Wtus</td>
<td>This is the indication of how willing adolescents are to use SRH services in future.</td>
</tr>
<tr>
<td>2. Unwillingness to use SRH services</td>
<td>Utus</td>
<td>This is the indication of the adolescents’ unreadiness to use SRH services in future.</td>
</tr>
<tr>
<td>3. Uncertainty</td>
<td>Uct</td>
<td>Adolescents lacking a definite opinion as to whether or not to use SRH services.</td>
</tr>
<tr>
<td><strong>STATE OF ADOLESCENTS BEFORE USE OF SRHS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Morality</td>
<td>Mor</td>
<td>Adolescents’ deliberating on religious issues before use of SRH services</td>
</tr>
<tr>
<td>2. Sentiments</td>
<td>Stm</td>
<td>These were the thoughts participants had before utilising the SRH services based on their feelings or emotions.</td>
</tr>
<tr>
<td>3. Rationalisation</td>
<td>Rat</td>
<td>Adolescents’ attempt to justify why they should utilise service despite all odds.</td>
</tr>
<tr>
<td>THEMES</td>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PERCEPTIONS ON SRH SERVICES</td>
<td>SRHS</td>
<td>All what adolescents say it is done at the facility, think and expects to be done at the facility.</td>
</tr>
<tr>
<td>1. Activities of the centre</td>
<td>Aotc</td>
<td>All what adolescents say it is done at the centre.</td>
</tr>
<tr>
<td>2. Sources of Information</td>
<td>Soi</td>
<td>Where adolescents get information concerning SRH services from.</td>
</tr>
<tr>
<td>3. Perceptions of adolescents concerning services</td>
<td>Poacs</td>
<td>All what adolescents think the services are about</td>
</tr>
<tr>
<td>4. Expectations of adolescents concerning SRHS</td>
<td>Eoacs</td>
<td>How adolescents want SRH services to be packaged</td>
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</tbody>
</table>
Title: Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North District.

Principal Investigator: Frank Bediako Agyei

Address: School of Nursing, College of Health Sciences, University of Ghana, Legon. P. O. Box LG 43, Legon.

Dear Participant,

You are please invited to participate in a research with the title stated above. You are entreated to read the information below carefully before you agree or disagree to take part.

General Information about Research

The purpose of this study is to explore the utilisation of sexual and reproductive health services among adolescents at Asante Akyem North District. You will be required to answer interview questions in English or Twi which will take you 40 to 60 minutes to go through at a convenient place of your choice. There is no right or wrong answer and you can answer in your own words. This will be audio recorded with your permission and field notes will be taken on event that cannot be recorded. The recordings will be transcribed in exactly the same words as you will use and then analysed. There may be a second interview when necessary. Your name will not be recorded on the tape. A number or a false name will be given to the conversation the researcher will have with you. Those who will be aware of the conversation the researcher will have with you shall be his supervisors. The information shall be kept in the office of the researcher’s supervisor for 5 years after the study and it shall thereafter be destroyed. The findings will be
Utilisation of SRH Services among Adolescents

discussed by comparing it to other related researches and conclusion drawn. The report will be shared with community health nurses who deal with adolescents.

**Possible Risks and Discomforts**

You will not be exposed to any risk in this research. However, because sexual and reproductive health is a sensitive area, it may create emotional discomfort. Therefore, you are encouraged to talk freely about what you will feel comfortable with throughout the interview process.

**Possible Benefits**

You will not receive any direct benefit for participating but the findings of the study will be used to counsel other adolescents. It will also inform health providers especially community health nurses, the Ministry of Health and Ghana Health Service in general to improve the services they render to adolescents.

**Confidentiality**

All the information you will provide will be known exclusively to the researcher and his supervisors. Your name will not be included in any of the information you will give to the researcher except the agreement form. The interview will be done at a place where nobody will be able to identify you. The information you will provide will be kept under lock in the office of the researcher’s supervisor for five years and if the need to use it further arise permission will be sought from you.

**Compensation**

You will not be given any money as compensation for participating in this study. However, you will be given lunch and snack after the interview as an appreciation of your time.
Voluntary Participation and Right to Leave the Research

Please know that your participation in this study is solely voluntary. You have the right to participate or refuse to participate or to decline once started and this will not result in any penalty in the service you are entitled to. You have the right to drop out from the research at any time you desire.

Contacts for Additional Information

Please feel free to ask if you have any question now or in the course of the study. You are assured of an answer at anytime you ask. For further information please contact:

Frank Bediako Agyei,
School of Nursing, University of Ghana, Legon.
Telephone: 0241200480.
E-mail: frankagyei89@gmail.com

Dr. Patience Aniteye,
School of Nursing, College of Health Sciences, University of Ghana
P. O. Box LG 43,
Legon. Tel. No. 0244681352;
Email address: patienceaniteye@yahoo.co.uk

Dr. Daniel Kojo Arhinful,
Noguchi Memorial Institute for Medical Research (NMIRMR), University of Ghana, Legon.
P. O. Box LG 581.
Tel. No. 0244932139, email: darhinful@gmail.com.
Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title: Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_________________________ ____________________________
Date                                                                             Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_________________________ ____________________________
Date                                                                             Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_________________________ ____________________________
Date                                                                             Name Signature of Person Who Obtained Consent
PARENTAL CONSENT FORM

Title: Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North District.

Principal Investigator: Frank Bediako Agyei

Address: School of Nursing, College of Health Sciences, University of Ghana, Legon. P. O. Box LG 43, Legon.

Dear Parent,

Your child is please invited to participate in a research with the title stated above. You are entreated to read the information below carefully before you agree or disagree to allow your child to take part.

General Information about Research

The purpose of this study is to explore the utilisation of sexual and reproductive health services among adolescents at Asante Akyem North District. Your child will be required to answer interview questions in English or Twi which will take you 40 to 60 minutes to go through at a convenient place of your child’s choice. There is no right or wrong answer and your child can answer in his or her own words. This will be audio recorded with your child’s permission and field notes will be taken on event that cannot be recorded. The recordings will be transcribed in exactly the same words as your child will use and then analysed. There may be a second interview when necessary. Your child’s name will not be recorded on the tape. A number or a false name will be given to the conversation the researcher will have with your child. Those who will be aware of the researcher’s conversation with your child shall be his supervisors.
Utilisation of SRH Services among Adolescents

information shall be kept in the researcher’s custody for 5 years after the study and it shall thereafter be destroyed. The findings will be discussed by comparing it to other related researches and conclusion drawn. The report will be shared with community health nurses who deal with adolescents.

**Possible Risks and Discomforts**

Your child will not be exposed to any risk in this research. However, because sexual and reproductive health is a sensitive area, it may create emotional discomfort. Therefore, your child will be encouraged to talk freely about what he or she will feel comfortable with throughout the interview process.

**Possible Benefits**

Your child will not receive any direct benefit for participating but the findings of the study will be used to counsel other adolescents. It will also inform health providers especially community health nurses, the Ministry of Health and Ghana Health Service in general to improve the services they render to adolescents.

**Confidentiality**

All the information your child will provide will be known exclusively to the researcher and his supervisors. Your child’s name will not be included in any of the information he or she will give to the researcher except the agreement form. The interview will be done at a place where nobody will be able to identify your child. The information your child will provide will be kept under lock in the office of the researcher’s supervisor for five years and if the need to use it again arise permission will be sought from your child.
Compensation

Your child will not be given any money as compensation for participating in this study. However, your child will be given lunch and snack after the interview as an appreciation for his or her time.

Voluntary Participation and Right to Leave the Research

Please know that your child’s participation in this study is solely voluntary. Your child has the right to participate or refuses to participate or to decline once started and this will not result in any penalty in the service your child is entitled to. Your child has the right to drop out from the research at any time he or she desires.

Contacts for Additional Information

Please feel free to ask if you or your child have any question now or in the course of the study. You or your child are assured of an answer at anytime you ask. For further information please contact:

Frank Bediako Agyei, School of Nursing, University of Ghana, Legon. Telephone: 0241200480. E-mail: frankagyei89@gmail.com

Dr. Patience Aniteye, School of Nursing, College of Health Sciences, University of Ghana P. O. Box LG 43, Legon. Tel. No. 0244681352; Email address: patienceaniteye@yahoo.co.uk

Dr. Daniel Kojo Arhinful,

Noguchi Memorial Institute for Medical Research (NMIRMR), University of Ghana, Legon.

P. O. Box LG 581.

Tel. No. 0244932139,

email: darhinful@gmail.com
Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your child’s rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title: Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree that my child should participate as a volunteer.

_____________________  _____________________________
Date                                           Name and signature or mark of parent or guardian

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the child’s parent or guardian. All questions were answered and the child’s parent has agreed that his or her child should take part in the research.

_____________________  _____________________________
Date                                           Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____________________  _____________________________
Date                                           Name Signature of Person Who Obtained Consent
APPENDIX F

CHILD ASSENT FORM

Introduction

The researcher’s name is Frank Bediako Agyei from the School of Nursing at University of Ghana, Legon. The researcher is conducting a research study entitled Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North District. The researcher is asking you to take part in this research study because he is trying to learn more about Adolescent Sexual and Reproductive Health Services. This will take about 40 to 60 minutes.

General Information

If you agree to be in this study, you will be asked to answer interview questions on your utilisation of sexual and reproductive health services and it will be audio taped with your permission.

Possible Benefits

You will not receive any direct benefit for participating but the findings of the study will be used to counsel other adolescents. It will also inform health providers especially community health nurses, the Ministry of Health and Ghana Health Service in general to improve the services they render to adolescents.

Possible Risks and Discomforts

You will not be exposed to any risk in this research. However, because sexual and reproductive health is a sensitive area, it may create emotional discomfort. Therefore, you are
Utilisation of SRH Services among Adolescents

eccouraged to talk freely about what you will feel comfortable with throughout the interview process.

**Voluntary Participation and Right to Leave the Research**

You can stop participating at any time if you feel uncomfortable. Please know that your participation in this study is solely voluntary. You have the right to participate or refuse to participate or to decline once started and this will not result in any penalty in the service you are entitled to. You have the right to drop out from the research at any time you desire.

**Confidentiality**

Your information will be kept confidential. No one will be able to know how you responded to the questions and your information will be anonymous.

**Contacts for Additional Information**

You may ask the researcher any questions about this study. You can call the researcher at any time on 0241200480 or talk to him the next time you see him.

Please talk about this study with your parents before you decide whether or not to participate. The researcher will also ask permission from your parents before you are enrolled into the study. Even if your parents say “yes” you can still decide not to participate. Moreover, if your parents do not agree, you will not be allowed to participate even if you are willing.

**Your rights as a Participant**

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your
Utilisation of SRH Services among Adolescents

rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh.

VOLUNTARY AGREEMENT

By making a mark or thumb printing below, it means that you understand and know the issues concerning this research study. If you do not want to participate in this study, please do not sign this assent form. You and your parents will be given a copy of this form after you have signed it.

This assent form which describes the benefits, risks and procedures for the research titled Utilisation of Sexual and Reproductive Health Services among Adolescents at Asante Akyem North District has been read and or explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate.

Child’s Name: …………………………. Researcher’s Name: ……………………………

Child’s Mark/Thumbprint……………………Researcher’s Signature:……………………

Date: …………………………………………………… Date:……………………………
APPENDIX G

ETHICAL CLEARANCE

29th November, 2016

FEDERALWIDE ASSURANCE FWA 00001824
NMIMR-IRB CPN 047/16-17
IRB 00001276
IORG 0000908

On 29th November, 2016, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) conducted expedited review and approved your revised protocol titled:

TITLE OF PROTOCOL: Utilization of sexual and reproductive health services among adolescents at Asante Akyem North District

PRINCIPAL INVESTIGATOR: Frank Bediako Agyei, MPhil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 28th November 2017. You are to submit annual reports for continuing review.

Signature of Chair: ………………………………………
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)
APPENDIX H

INTRODUCTORY LETTER

The District Director
Asante Akyem North District
Agogo Asante Akyem

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Frank Bediako Agyei, an MPhil Year II student of the School of Nursing, University of Ghana, Legon. He is conducting a research on “Utilisation of Sexual and Reproductive Health Services among Adolescents at the Asante Akyem North District.”

I would be grateful if you could offer him assistance.

Thank you.

Yours faithfully,

Dr. Mrs. Patience Anieter
SUPERVISOR

Cc: The Manager
Joana Health Center

The Manager
Nyampenase Health Center

The Manager
Amankrom Health Center
SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON

P. O. Box LG 43
LEGON, GHANA

December 21, 2016

The General Manager
Agogo Presbyterian Hospital
Agogo Asante Akim

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Frank Bediako Agyei, an MPhil Year II student of the School of Nursing, University of Ghana, Legon. He is conducting a research on “Utilisation of Sexual and Reproductive Health Services among Adolescents at the Asante Akim North District.”

I would be grateful if you could offer him assistance.

Thank you.

Yours faithfully,

Dr. Mrs. Patience Aniteye
SUPERVISOR
APPENDIX J

APPROVAL LETTER

Mr. Frank Bediako Agyei
School of Nursing
College Of Health Sciences
University Of Ghana
Legon

Dear Sir,

LETTER OF APPROVAL

I write to acknowledge receipt of your letter dated December 21st 2016. I am pleased to inform you that your request has been granted on a study on "utilization of Sexual and Reproductive Health Services among Adolescents at the Asante Ayem North District".

You are therefore required to submit a final copy of your findings to this Hospital. We wish you luck and declare our support towards the successful completion of the study.

Thank you.

Yours sincerely,

ALEX KESSE NYAMESA
GENERAL MANAGER

Cc: The Medical Administrator, Agogo Presbyterian Hospital, Agogo
Cc: Dr. Mrs. Patience Aniaye (Supervisor)
APPENDIX K

APPROVAL LETTER

In case of reply the number and the date of this letter should be quoted.

My Ref. No: GSB/ASN/DD/H/PG/002

Your Ref No:

E-mail: ddsvwo@gmail.com

Ghana Health Service,
Asante Akim North
P.O. Box GG 133
Agogo

24th January, 2017

THE SUPERVISOR
SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON

RE: PERMISSION TO CONDUCT RESEARCH IN ASANTE AKIM NORTH DISTRICT

With reference to your letter dated 21st December, 2016 seeking approval for Mr. Frank Bediako Agyei, an MPhil Year II student from your school to undertake a research on the topic “Utilization of Sexual and Reproductive Health Services among Adolescents at the Asante Akim North District”, I write to inform you that approval has been granted.

Management would give him the needed support to enable him undertake the research successfully.

Thank you.

REBECCA TENI DOKURUGU
DISTRICT DIRECTOR OF H/SERVICE

University of Ghana  http://ugspace.ug.edu.gh
APPENDIX L

APPROVAL TO USE THE THEORY OF PLANNED BEHAVIOUR

Dear Frank Bediako Agyei,

The theory of planned behavior is in the public domain. No permission is needed to use the theory in research, to construct a TPB questionnaire, or to include an ORIGINAL drawing of the model in a thesis, dissertation, presentation, poster, article, or book. If you would like to reproduce a published drawing of the model, you need to get permission from the publisher who holds the copyright. You may use the drawing on my website (http://people.umass.edu/aizen/tpb.diag.html) for non-commercial purposes, including publication in a journal article, so long as you retain the copyright notice.

Best regards,

Icek Ajzen

Professor Emeritus

University of Massachusetts ñ Amherst

http://www.people.umass.edu/aizen