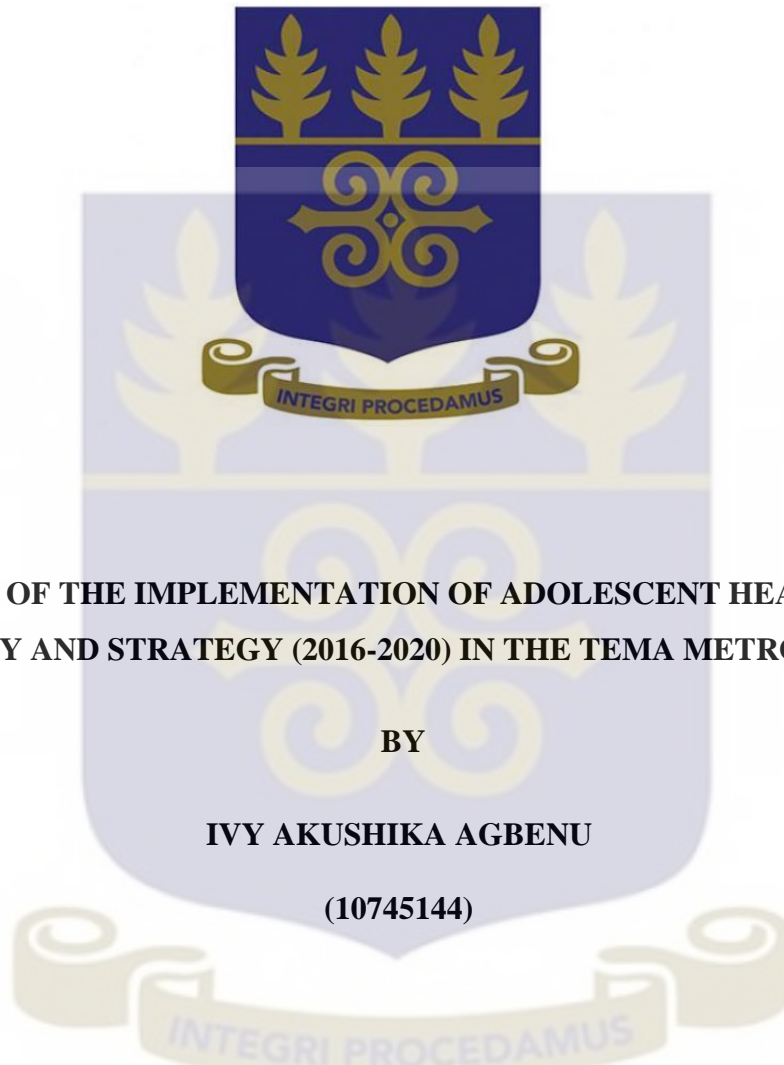


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**EVALUATION OF THE IMPLEMENTATION OF ADOLESCENT HEALTH SERVICE
POLICY AND STRATEGY (2016-2020) IN THE TEMA METROPOLIS**

BY

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(10745144)

**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF
MASTER OF SCIENCE PUBLIC HEALTH MONITORING AND EVALUATION
DEGREE**

JULY 2019

DECLARATION

I, **IVY AKUSHIKA AGBENU**, hereby declare that with the exception of references and quotations from other sources which have all been duly cited, the study on “EVALUATION OF THE IMPLEMENTATION OF ADOLESCENT HEALTH SERVICE POLICY AND STRATEGY (2016-2020) IN THE TEMA METROPOLIS.” is my independent work to the best of my knowledge as a student of the University of Ghana, School of Public Health.

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DEDICATION

This work is dedicated to my lovely parents Mr. Dollar Agbenu and Ms. Rejoice Nyamador for their support and encouragement. To my lovely sisters Joan and Lynn for their prayers.

ACKNOWLEDGEMENT

I am thankful to God Almighty for his guidance, strength and protection throughout the master's programme.

I want to also express my gratitude to my supervisor Dr Genevieve Cecilia Aryeetey for her enormous contributions, patience and time taken to shape this work from conceptualization to the completion of the study. A special thank you also goes to the staff and management of the school of public health, health policy planning and management for their hard work to make the programme a success.

My sincere gratitude goes to the Tema Metropolitan health director, Adolescent Health Service Focal person, directors of Tema General Hospital, Tema Polyclinic, Tema Metropolitan Assembly Maternity and Child Care centre, Manhean Polyclinic, Managers and staffs of AYFHS units in the aforementioned health facilities for the support and the opportunity granted me to conduct the study in their institutions.

I also want to thank Mr. Desmond Dzidzornu Otoo, my personal research assistant for his input into the design, data collection, analysis of findings and long hours of proofreading.

ABSTRACT

Background: Due to the importance of adolescents in the future of a nation, it has become necessary to consider the well-being of adolescents in order to drive national development. Ghana has developed, adopted and implemented initiatives and programmes to protect and promote the reproductive health needs of adolescents-the Adolescent Health Service Policy and Strategy (2016-2020).

Objectives: To conduct a process evaluation on the implementation of the Adolescent Health Service Policy and Strategy and to determine barriers and facilitators influencing the implementation.

Methods: The study employed both qualitative and quantitative approaches to address its objectives. That is cross-sectional survey, focus group discussions, key informant interviews were used to obtain information from Young people and Heads of Adolescent and Youth Friendly units in health facilities in the Tema metropolis. Quantitative results were analysed using the STATA 15 and qualitative data collected were coded and analysed using NVivo 11 to generate themes and patterns.

Results: The study found that young people had adequate access to health information through the internet, schools and hospitals. Service providers have been well trained in various aspects of service provision. There was varying degree of partnership among various stakeholders with few peer educators and community actors' groups in existence. Barriers such as lack of awareness of policy, inadequate staff and financial resources hinder policy implementation with advocacy being a main facilitator.

Conclusion: Although there are barriers hindering the implementation of the Adolescent health Service Policy and Strategy (2016-202), there is adequate access to information, continuous capacity building of staffs and varying degree of partnership among stakeholders.

KEYWORDS: Adolescent, Child, Young People, Young Adult, Youth, Strategy

TABLE OF CONTENTS

DECLARATION.....	i
DEDICATION.....	ii
ACKNOWLEDGEMENT.....	iii
ABSTRACT.....	iv
TABLE OF CONTENTS	vi
LIST OF TABLES	ix
LIST OF FIGURES	x
LIST OF ABBREVIATIONS	xi
CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Background	1
1.2 Problem Statement	5
1.3 Study objectives	7
1.3.1 Main objective	7
1.3.2 Specific objectives.....	7
1.4 Research questions	7
1.5 Justification	8
1.6 Conceptual Framework	9
1.6.1 Narrative of Conceptual Framework	9
CHAPTER TWO	11
LITERATURE REVIEW	11
2.1 Introduction	11
2.2 Concept of adolescence.....	11
2.3 Adolescent health	13
2.4 Adolescent and Youth Friendly Health Services (AYFHS).....	16
2.5 Adolescent Policies and Legal Framework.....	17
2.6 The Adolescent Health Service Policy and Strategy (2016-2020).....	18
CHAPTER THREE	21
METHODS	21
3.1 Introduction	21
3.2 Study design	21
3.3 Study location.....	21

3.4 Study population	24
3.5 Inclusion and exclusion criteria.....	25
3.5.1 Inclusion criteria	25
3.5.2 Exclusion criteria.....	25
3.6 Study variables	25
3.7 Definition of indicators and measurement	27
3.8 Sample size determination	29
3.9 Sampling method/Procedure	29
3.10 Data collection techniques/methods and tool.....	30
3.11 Data quality control/assurance	32
3.12 Data processing and management	33
3.13 Data analysis	34
3.13.1 Qualitative analysis.....	34
3.13.2 Quantitative analysis.....	34
3.14 Ethical considerations	35
CHAPTER FOUR.....	37
RESULTS	37
4.1 Introduction	37
4.2 Socio-demographic characteristics.....	37
4.3 Access to information on health and health Services relevant to adolescents.	40
4.4 Capacity of service providers in the health facilities	44
4.5 Partnership and inter-sectoral collaboration among adolescent and youth groups, relevant institutions and communities.....	48
4.6 Barriers and facilitators influencing implementation of Adolescent Health Service Policy and Strategy.....	51
CHAPTER FIVE	56
DISCUSSION	56
5.1 Access to information on health and health services relevant to adolescents.	56
5.2 Capacity of service providers in the health facilities	58
5.3 Partnership and inter-sectoral collaboration among young people, communities and relevant stakeholders	59
5.4 Barriers and facilitators influencing implementation of adolescent health service policy and strategy	60
5.5 Study limitations	63

CHAPTER SIX	64
CONCLUSION AND RECOMMENDATIONS.....	64
6.1 Conclusion.....	64
6.2 Recommendations	65
REFERENCES.....	67
APPENDICES	72
APPENDIX A: PARTICIPANT INFORMATION SHEETS, CONSENT AND ASSESNT FORMS	72
APPENDIX B: QUESTIONNAIRES AND GUIDES	85
APPENDIX C: CLEARANCE AND SUPPORTING LETTERS.....	96

LIST OF TABLES

Table 1: Indicators and Sources of Measurement.....	27
Table 2: Socio-Demographic Characteristics of Young People.	38
Table 3: Socio-Demographic Characteristics of Service providers.....	39
Table 4: Indicators for Capacity Building of Service Providers.....	45
Table 5: Indicators for Partnership and Collaboration among Actors.	49

LIST OF FIGURES

Figure 1: Conceptual Framework of Implementation of Adolescent Health Service Policy and Strategy 10

Figure 2: A map of the Tema Metropolis 23

Figure 3: Number of SBCC Materials in the Facilities..... 41

Figure 4: Social mobilization Activities Conducted in Schools and Communities According to Facilities..... 41

Figure 5: Fields of Training of Service Providers 45

LIST OF ABBREVIATIONS

ADHD – Adolescent Health and Development

AHSPS - Adolescent Health Service Policy and Strategy

ASRH - Adolescent Sexual and Reproductive Health

AYFHS - Adolescent and Youth Friendly Health Services

CERSGIS - Centre for Remote Sensing and Geographic Information Systems

HIV - Human Immunodeficiency Virus

IEC - Information, Education and Communication

SBCC – Social and Behaviour Change Communication

SDG - Sustainable Development Goals

SRH - Sexual and Reproductive Health

STI - Sexually Transmitted Infections

WHO - World Health Organization

“The new policy” as used in this study means the Adolescent Health Service Policy and Strategy (2016-2020)

CHAPTER ONE INTRODUCTION

1.1 Background

The World Health Organization (WHO) categorizes and defines an “Adolescent” as an individual who falls within the age group of 10-19 years, a “Child” as an individual within 0-17 years of age, “Youth” as 15-24 years of age, “Young Person” as 10-24 years of age and a “Young Adult” as an individual within the ages of 18-24 years (UNICEF, 2011; WHO, 2015). About 18% of the world’s population comprise of adolescents (WHO, 2017). Out of the growing population of about 1.8 billion young people in the world, nearly 90% of these young people live in developing countries. Adolescents in Sub-Saharan Africa make up approximately 23% of the entire population (UNFPA, 2018; UNICEF, 2016a). Generally, despite the healthiest period of life being the period of adolescence and youthful ages, adolescents in Ghana and other countries experience varying health and behavioural problems with alarming mortalities and morbidities due to several factors that are preventable (Patton & Sawyer, 2014; WHO, 2015).

In emerging countries like Northern Africa, Eastern Asia and Western Asia just a maximum of 1% of 15-year olds die before age 25 years. Simultaneously in South Asia, the odds of dying during youthful age are almost two (2) times as high in South Asia, and four (4) times higher in sub-Saharan Africa (UNICEF, 2016b). Adolescent deaths worldwide are mostly due to communicable diseases such as, HIV/AIDS, and other respiratory-tract infections and non-communicable diseases related to road traffic accidents, tobacco usage and other drug abuses, violence, self-injury, and risky sexual behaviours causing early and unplanned pregnancies (Patton et al., 2009). Unhealthy lifestyle and behaviours during adolescence like smoking, unprotected sex, poor eating and exercise habits culminate to premature deaths in their later stages of adulthood (Mcintyre & Williams, 2003; WHO, 2015).

In addition to the increasing woes of adolescents, worldwide fertility rate among adolescent girls remain high at about 47 births per 1000 girls (WHO, 2018). A significant proportion of adolescents in the world are living with HIV and Acquired Immune Deficiency Syndrome (AIDS) continues to be a significant cause of morbidity and mortality among adolescents in the Sub-Saharan African region (WHO, 2015).

In Ghana, nearly 29.3% of the population is made up of young people with 21.9% being Adolescents aged 10-19years. Adolescents have peculiar issues attributed to “sexual and reproductive health, HIV and STIs, nutrition, mental health, substance use, non-communicable diseases, intentional and unintentional injuries, all kinds of violence, inequities, risks and vulnerabilities linked with child marriage, child labour, child trafficking as well as disabilities” (GSS, 2015).

The increasing awareness of the developmental process that takes place in adolescence continues to inform stakeholders in creating and offering specific interventions for sub-groups in this section of the population considering their age, gender specific needs and interests. The wellbeing and development of young people are assets for the progress of the nation as they are major treasures to their immediate relations and society as a whole. Their wellbeing reflects on the social, political and economic growth as they enter the labour force of the country in the future. Some initiatives have been introduced to make quality health services easily accessible to adolescents thus the idea of “Adolescent-Friendly Health Services” (WHO, 2009).

Due to the importance of adolescents in the future of a nation, it has become necessary to consider the well-being of adolescents in order to drive national development (Kleinert & Horton, 2016). In order to cover the gap left behind in the Millennium Development Goals (MDGs) on adolescent health, the third goal of the newly established Sustainable Development Goals (SDGs) seeks to

“ensure healthy lives and promote the well-being of all ages”, which includes adolescents (WHO, 2015).

Several countries have developed and implemented special programmes to meet the increasing needs of adolescents’ health. In response to these international calls and initiatives, government and various stakeholders are taking charge to address challenges to achieving the international target of universal health coverage. Ghana has developed, adopted and implemented initiatives and programmes to protect and promote the reproductive health needs of adolescents (Aninanya et al., 2015; Awusabo-Asare, Abane, & Kumi-Kyereme, 2004). The “Adolescent Health and Development (ADHD) programme” that was introduced in 2001 sought to deliver information relating to adolescent health, make available and accessible the necessary information and services for adolescents (GNA, 2012; GHS, 2016). These services are termed the “Adolescent and Youth Friendly Health Services (AYFHS)”.

Adolescent and Youth Friendly Health Services are services that are equitable, effective, accessible to, acceptable by and appropriate for adolescents and youth. These services sensitively and effectively meet the needs of young people and covers all adolescents (Mcintyre & Williams, 2003). The AYFHS are mostly provided at Adolescent Health Corners (ADH) or Youth Corners newly developed or integrated into existing public health facilities. Youth corners and Adolescent Health (ADH) corners have been established to purposefully provide adolescent health services and play important roles in the health sector. There are several programs and strategies initiated in Ghana to provide quality health services to adolescents in a friendlier environment. Among them is the “Young and Wise” initiative developed jointly by the Planned Parenthood Association of Ghana (PPAG) and the Ghana Social Marketing Foundation (GSMF). This initiative places a focus on reducing risky sexual behaviours, teenage pregnancy and STIs (Hesse & Samba, 2006). To

complement the already existing programmes, another Strategic Plan was established for the period of 2009 to 2015 with the aim to deliver information, services and education in relation to the gender and age of young people.

Despite the numerous interventions by the government of Ghana, the 2017 HIV sentinel survey reported that, a total number of 3,422 new child infections were estimated to have occurred among children 0 to 14 years and 5,557 new infections in 15 to 24-years group. In addition to these, birth rate among adolescents remains high. (Ghana AIDS Commission, 2017). Health services of young people have been shown to lack adequate integration, reduced quality coupled with lack of equity and accessibility and places more emphasis on Sexual and Reproductive Health (SRH) issues including STIs and does not fully encompass the broader picture of adolescent related health problems especially in relation to female adolescents as reported in the January to March 2016 evaluation of the ADHD programme (GHS, 2016). In view of this, a current “Adolescent Health Service Policy and Strategy (2016-2020)” has been launched and being implemented to target programmes that could not be accomplished, and fight against deaths that can be prevented and communicable diseases that exist among young people. The new policy takes into consideration the Sustainable Development Goals (SDGs), Global Accelerated Action of Adolescents (AA-HA!) and the 2015-2030 Global strategy for women’s Children’s and Adolescents’ Health (GHS, 2016). The policy envisages to boost young people’s health by providing fair access to relevant, all inclusive, quality and gender-sensitive adolescent health information and services at an affordable cost. The impact of this will be an appreciation in the health stock of young people in Ghana. Health indicators in the country have improved in current periods, however, at current rate of impact it will be impossible to achieve envisaged objectives and targets set for the “new policy” (GHS, 2016). Adolescent and youth friendly health services under the “new policy” are currently

available in several parts of the country to provide services such as counselling, family planning services, STIs testing and safe motherhood to provide solutions to the many adolescent health issues confronted by the country (GHS, 2016; Hesse & Samba, 2006). Despite these efforts by government and other stakeholders, these challenges still exist and remain problematic irrespective of the many positive achievements made (GHS, 2016).

Since the inception of the “Adolescent Health Service Policy and strategy 2016-2020”, there is no available literature about a process evaluation of the policy and how effectively the strategies are being implemented. It is against this background that, the study aims to evaluate the implementation of the Adolescent Health Service Policy and Strategy, 2016-2020 in the Tema Metropolis.

1.2 Problem Statement

In view of the increasing health and social needs of adolescents and young people in Ghana, government and key stakeholders in health have instituted programmes to make these social and health needs of adolescents a priority (GHS, 2016). A key objective of many collaborations was the integration of adolescent health services into already existent public health facilities and establishment of new adolescent health corners to increase availability, accessibility and utilization of such health services among adolescents (GHS, 2016; Mazur, Brindis, & Decker, 2018).

Ghana has made considerable efforts in enrolling programs and policies within its health system to well address the health needs of adolescents. Several initiatives have been undertaken in Ghana since 1980. In the year 2001, the “National Adolescent Health and Development (ADHD)” programme was launched to serve as a guidance to the enrolment of adolescent programmes. In

relation to this, a strategic plan for the “National Adolescent Health Development (ADHD)” programme (2009-2015) was also introduced to provide a multi-sectoral support to every young person within the confines of Ghana with the necessary information and education. This was with the objective of making adolescents adopt healthy physical, psychological and social lifestyles (GHS, 2015).

Evaluation of the programme revealed that; several positive achievements have been made over the past decade. There was decline in the number of HIV infection among young people and an appreciation in the number of young people who engaged the services of skilled personnel during child birth. Despite these successes, birth rate among adolescents remain high with low degree of integration of adolescent health services, inequity in access and utilization and the synonymy of adolescent health to only sexual and reproductive health, HIV and STIs while neglecting other essential issues to the background (GHS, 2016).

In response to these gaps, a new “Adolescent Health Service Policy and Strategy (2016-2020)” has been established and being implemented to address the remaining issues and other key problems of adolescents. In an attempt to monitor and evaluate the performance of the health system in the delivery of the adolescent friendly health services, a Standards and Tools for monitoring Adolescent and Youth Friendly Health Services (AYFHS) document has been developed and distributed by the GHS in 2012 (GHS, 2016). The standards have been re-echoed in the new policy to accelerate efforts to achieve targets that were not achieved in ADHD (2009-2015). However midway the period (2016-2020), there are no research publications on process evaluation and inadequate supervisory or monitoring and evaluation reports on AYFHS. A midterm process evaluation will not only highlight strengths and weaknesses in the

implementation of the strategies but serve as a timely reminder to accelerate efforts to achieve set targets by the year 2020.

Hence this study seeks to conduct an evaluation of the implementation of the Adolescent health service Policy and Strategy (2016-2020) in the Tema Metropolis. The study focused on three (3) specific strategic objectives of the new policy.

1.3 Study objectives

1.3.1 Main objective

To conduct a process evaluation on the implementation of the Adolescent Health Service Policy and Strategy and to determine barriers and facilitators influencing implementation.

1.3.2 Specific objectives

1. Determine access to information on health and health services relevant to adolescents.
2. Evaluate the capacity of health service providers and support staff in AYFHS.
3. Evaluate the partnership and inter-sectoral collaboration among young people, communities and relevant stakeholders.
4. Determine barriers and facilitators influencing implementation of Adolescent Health Service Policy and Strategy.

1.4 Research questions

1. Do Adolescents have access to relevant information on their health and health services?
2. What is the capacity of health service providers and support staff in the provision of AYFHS?

3. Is there partnership and collaboration among young people, communities and relevant stakeholders?
4. What are the barriers and facilitators influencing implementation of Adolescent Health Service Policy and Strategy?

1.5 Justification

An evaluation of the “National Adolescent Health Service Policy and Strategy (2016-220)” will assist stakeholders to obtain essential information from past and current activities that can serve as the basis for fine-tuning existing programmes and planning of future ones. An efficient and effective process evaluation which is also sometimes referred to as monitoring, would make it possible to ascertain whether the policy and strategies are being implemented as planned per the original objectives and determine the direction and pace of progress achieved so far. The study will also provide insight to other researchers and bring out areas of adolescent health needs to be further researched. It will guide service providers to reorient and tailor the way in which adolescent health services are provided in order to meet adolescent preferences and set targets.

Finally, the study will provide evidence and insight to policy makers on the challenges of implementation of the policy in order to set an agenda for the re-structuring of the policies to achieve universally accepted standards.

1.6 Conceptual Framework

1.6.1 Narrative of Conceptual Framework

The framework for the study is adapted and modified from the triangulation of the Youth development Philosophy and Approach and Conceptual Framework for Adolescent Health. The attainment of Adolescent health, which encompasses the well-being of youth aged 10-24 years old is influenced by challenges. These challenges are presented by the complex but crucial developmental period of adolescence and other disparities due to multiplicity of factors such as age, race, religion, ethnicity, gender, social status, educational status and geographical location. In addressing these challenges, it is very necessary to develop and implement adolescent health policies and strategies that will regulate and guide the access to health information and services relevant to the age and gender to enable young people make informed choices. Adolescent health policies implemented should address the capacity building of service providers and support staff to enable them gain essential knowledge, expertise and affirmative attitude towards providing successful adolescent and youth friendly services at the various levels of healthcare. Success in adolescent health is also achieved when policies and programs foster collaboration among adolescents, youth groups, communities and relevant stakeholders in the provision and utilization of AYPHS. In this regard, young people are seen as partners rather than clients hence creating environments that empower peer educators and some other role players.

Youths that receive the needed support from families, teachers, religious and community leaders, NGOs and other relevant institutions feel respected and have a sense of belonging. Processes of implementation of adolescent health service policy can be influenced by barriers that should be controlled and facilitators that can be capitalized on as they emerge. These in a long run foster an efficient implementation and achievement of policy targets.

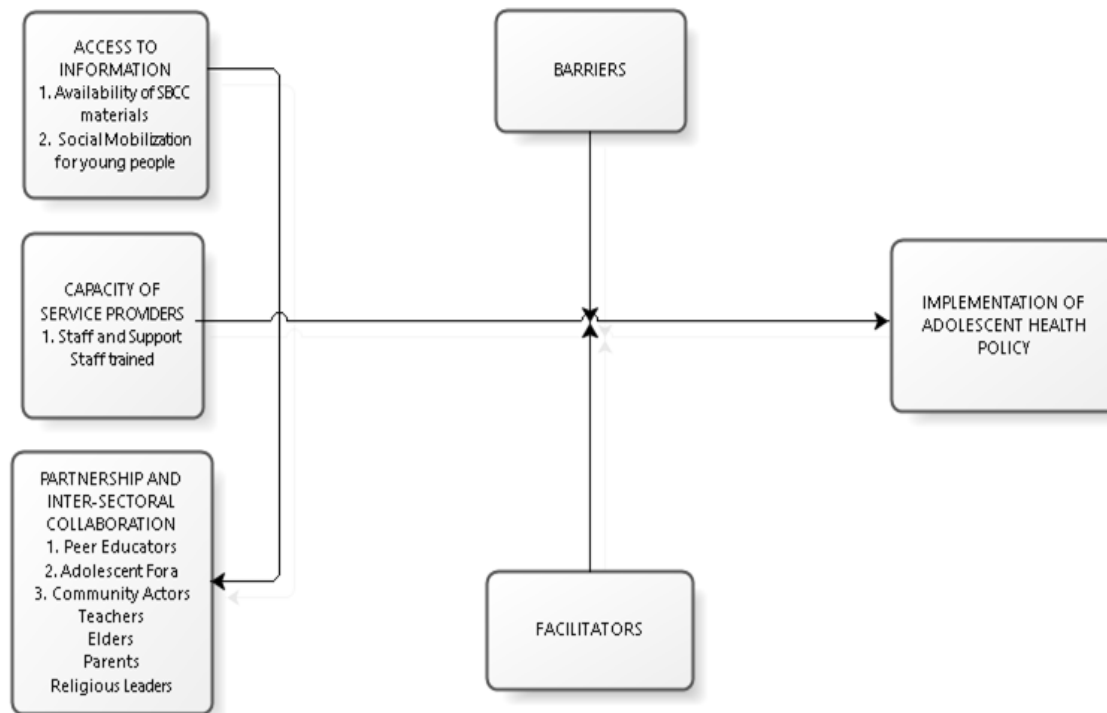


Figure 1: Conceptual Framework of Implementation of Adolescent Health Service Policy and Strategy

Source: Adapted and modified from the triangulation of the Youth development Philosophy and Approach and Conceptual Framework for Adolescent Health (Fine & Large, 2005).

CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

This chapter seeks to present discussions of other scientific studies bordering on Adolescent health Services Policy and Strategy. The emphasis of the discussions will include Concept of Adolescence, Adolescent Health, Adolescent Friendly Health Services, Adolescent Policies and Legal Framework, and the “Adolescent Health Service Policy and Strategy (2016-2020)”.

2.2 Concept of adolescence

United Nations defines an adolescent as an individual within the age of 10-19 years (World Health Organization, 2015). It further elucidates Adolescence as a phase of life with distinct health and developmental needs, rights and a period to gain appreciable knowledge, competency, attributes and abilities that would shape the individual in the assumption of adult roles (Jaworska & MacQueen, 2015; World Health Organization, 2015). Adolescence is recognized as one of the expeditious stages of human development and considered a transition in the development of humans from childhood to adulthood (Sawyer, Azzopardi, Wickremarathne, & Patton, 2018; Shikha, 2015).

The phase of adolescence is characterized by change in age, physical looks, neuro-developmental, social and psychological changes. Universally, age is considered the most widely used and more appropriate factor for assessing biological changes in adolescents (World Health Organization, 2017). Despite the definition as a transition into adulthood, adolescents are not immediately expected to assume adult roles and responsibilities (Eliason, Mortimer, & Vuolo, 2015; Settersten, Ottusch, & Schneider, 2015). Irrespective of the WHO definition of adolescence, the concept of adolescence varies in different contexts. This means the concept of adolescence is not the same

everywhere. Thus, adolescents are a non-homogenous group that vary by age, gender, marital status, class, geography and culture (Curtis, 2015). To capture this notion, Steinberg (2014) as cited by Curtis (2015) defines adolescence as the phase between pubertal onset and the development of social independence.

The United Nations Children's Fund conceptualizes adolescence as a complex concept to define and complicated by differences in individual experiences and cognitive maturation, wide variation in national laws in terms of the minimum age for the participation in activities reserved for adults such as marriage, voting, ownership of properties and consumption of alcohol (UNICEF, 2011). In addition to these, robbing of an individual's adolescence through engagement in activities such as labour and marriage thereby neglecting defined thresholds that separates childhood, adolescence and adulthood complicates the definition of adolescence in many jurisdictions (UNICEF, 2011).

In Ghana, the definition of an adolescent is in synchrony with the United Nation's concept of adolescence as a person between the ages of 10-19years. To compliment this definition, and to guide adolescent and youth reproductive services, "Child" is further defined as from the ages of 0-17years, "Youth" as from 15-24 years; "Young Adult" as from 18-24 years, while "Young Person" as from 10-24 years (GHS, 2016).

In Ghana, most societies advise young people on several pertinent issues such as relationships, sexuality and reproduction at the point of entry into adolescence. Traditionally, other groups of people take young persons through several rituals and activities to signify the initiation of adolescence. Adolescent males and females are socialized differently on their reproductive roles and responsibilities due to the perceived variation in roles (Glover et al., 2003; Kumi-kyereme & Awusabo-asare, 2007). Across most societies and ethnic groups in Ghana, premarital sexual activities are disallowed and childbirth outside wedlock especially during the period of

adolescence is considered undesirable. Young people are encouraged to live chaste lives, during adolescence and avoid marriage till adulthood. In spite of this, some communities continuously practice child and adolescent marriages (Kumi-kyereme & Awusabo-asare, 2007). This breeds ambiguity in the culture about adolescence and premarital sexual relationships and marriages. Due to these conflicts and ambiguity, designing and implementing health promotion programmes that can reach all adolescents equitably tends to be problematic (Kumi-kyereme & Awusabo-asare, 2007).

2.3 Adolescent health

Adolescent health can be defined as the physical, mental and social well-being and not merely the absence of disease or infirmity during the period of adolescence (Salam, 2016). Adolescents face a lot of health issues in Ghana. These issues affect adolescents in different ways. They include;

Early Sexual experience, marriage and childbirth: Over the past decade, exposure to sexual activities and marriage at early stages has remained high. As at 2014, the percentage of female adolescent who had their first sexual activity by the age 15years was 11.8% (GSS, 2015). Approximately 260,000 girls are affected by early marriage in Ghana with 1 in 5 females getting married before their eighteenth (18th) birthday (GSS, 2015). The Northern region records the highest level of childhood and adolescent marriages. This menace is predominant in the rural areas, among the poor and the less educated than among those in urban areas, rich and well educated (GSS, 2015). Early pregnancy and childbirth have also been faced by adolescents over the past decade. About 22% of Ghanaian women (25-49years) in 2014 had explicitly had their first child

delivery before attaining the age of 18 years. These issues predispose adolescents to health risks such as unsafe abortions, maternal mortalities and poverty (GSS, 2015).

Accessibility and utilization of reproductive health services: Although Ghanaian adolescents have adequate knowledge about reproductive health services, the availability, accessibility and utilization of such services have been problematic (GHS, 2016). Adolescent reproductive health services such as counselling services, safe abortion and contraceptives are not widely available to adolescents. In some areas where these services are available, factors such as stigma, law, low advertisement, distance and social status bias by providers prevent adolescents from being able to access such services. Access to and utilization of family planning services by sexually active male and female adolescents has also been low. Data from a health survey in 2014 suggests that only about 6% of adolescents between 15-19years had an exposure to information and access to family planning services (GHS, 2016; GSS, 2015).

Risky Sexual Behaviours, HIV/Sexually Transmitted Infections (STIs): The Ghana Maternal Health Survey 2017 suggests that, a considerable number of adolescents had two or more sexual partners and engage in unsafe sexual practices while 18.8% of adolescents between the age of 15-19years are reported to have ever had an abortion (GSS, 2018). Approximately 510,000 young people were reported to have been newly infected with HIV, in the year 2018 of whom 190,000 were adolescents (UNICEF, 2019). Gonorrhoea, Syphilis, Herpes and Chlamydia infections have also been issues of worry to adolescents especially among those between 15-19years of age (NACP, 2014). Most of these adolescents neglect safe sexual practices and avoid testing for STIs including HIV and tend to live with them unknowingly leading to adverse situations later.

Violence and Injuries: Violence is a common issue in Ghana which has negative impacts on both males and females. Adolescents between the age of 15-19years are the most affected group which predisposes them to mental, psychological health problems. These group commonly go through physical and sexual violence. It is reported that, 64% of males aged 15- 19years were at high risk of physical violence while more than 38% of adolescent females had suffered at least one act of sexual violence (GSS, 2015). Sexual violence is reported to be very common in urban as compared to rural areas while physical violence was commoner in rural areas as compared to urban areas. Adolescents also experience injuries from activities such as physical fighting which are associated with substance misuse and more common in males than in females (GSS, 2015).

Psychological/Mental Health: Adolescents in Ghana face many psychological health issues during the period of adolescence (Quarshie, Osafo, Akotia, & Peprah, 2015). The common problems faced by adolescents include but no limited to depression, anxiety, stress, obsession, panic attacks/disorders, post-traumatic stress disorders, kleptomania and several mood disorders (Ghana Health Service, 2015). A study about adolescent mental health in four (4) African countries reported that, different forms of mental problems affect about 20% of children and adolescents in Ghana with depression being the commonest mental health problem (Kleintjes, Lund, & Flisher, 2010; WHO, 2014).

Other pertinent issues of concern in adolescents include, menstrual hygiene and management, nutrition related issues and obesity, child labour and trafficking, substance abuse and noncommunicable diseases (GSS, 2015; House, Mahon, & Cavill, 2012).

2.4 Adolescent and Youth Friendly Health Services (AYFHS)

Adolescent and Youth Friendly Health Services is defined as the provision of services that are acceptable, accessible, and appropriate for adolescents (WHO, 2012). In addition to this, Ghana Health Service further conceptualizes AFYHS as services designed to specially satisfy the needs of adolescents and youth. The AYFHS services are in different forms such as promotive, preventive, curative and rehabilitative care (GHS, 2013).

The standard for AYFHS by the WHO is that the services provided are affordable, safe, very effective and should satisfy the exact needs of individual adolescent and youth. These people may be satisfied, feel comfortable to return when they have to and suggest such services to their mates (Mcintyre & Williams, 2003).

Despite this global standard, the types of services provided in each country varies. It was concluded at a WHO global consultation meeting that, it was not prudent to develop a core package for all and rather suggested that countries should be empowered to develop their own packages with the standard as a guideline taking into consideration economic, social, epidemiological and cultural constraints (WHO, 2001).

Packages found in the AYFHS provided in Ghana include family planning services/contraceptive services, STI counselling, testing and treatment, HIV/AIDS and its related services, adolescent mental health services, maternal and child health services, safe abortion and post abortion services, management of sexual violence, counselling on and management of nutritional, dietary and eating disorders, general counselling, referrals, and recreational services (GHS, 2012).

2.5 Adolescent Policies and Legal Framework

Adolescent health services in Ghana are regulated by several frameworks in order to set and achieve targets. Despite the preponderance of policies and legal frameworks in Ghana, several challenges continue to exist. These policies function together to promote the quality, availability, accessibility and acceptability of adolescent health services across the country. The country has developed and implemented several initiatives leading to the introduction of the “National Adolescent Health and Development Programme (ADHD)” in 1996, and later followed by a seven-year strategic plan (2009-2015) which was to provide multi-sectoral support to all adolescents and youth in Ghana.

Currently, the ADHD programme is implementing the “Adolescent Health Service Policy and Strategy (2016-2020)” which was informed by the findings from the evaluation of the 2009-2015 strategy (GHS, 2016).

Legal documents that have been used or continue to bind and regulate adolescent health in Ghana (Awusabo-Asare et al., 2004; GHS, 2016) include:

- Article 37(4) of the 1992 Constitution
- Revised National Population Policy, 1994; Act 485
- National Population Council Act, 485, 1994
- Ghana Adolescent Reproductive Health Policy (2000)
- 2nd Edition Reproductive Health Policy and Standards (2003)
- Ghana Youth Policy 1999
- Ghana Health Sector Policy (2008)
- Health Sector Medium Term Development Plan, 2014-2017
- Road Map for Repositioning Family Planning in Ghana (2006-2010)

- Reproductive Health Strategic Plan (2007-2011)
- 1960 Criminal Codes
- Education Act 778, 2008
- Inclusive Education Policy, Ministry of Education, 2013
- 1998 Children's Act, Act 560
- Ghana: Legislation Enacted to Criminalize the Trokosi Tradition of Enslavement (1998)
- Legislation against Female Genital Mutilation (FGM)
- Child and Family Welfare Policy 2015

2.6 The Adolescent Health Service Policy and Strategy (2016-2020)

This policy is a policy framework established as a result of findings from the evaluation of the 2009-2015 strategy. The new policy seeks to create priority areas in adolescent health services.

The key areas considered by the policy include (GHS, 2016):

- Sexual and Reproductive Health;
- All forms of malnutrition, including iron-deficiency anaemia, undernutrition, overweight, and obesity;
- HIV/STI;
- Other communicable diseases, particularly diarrheal diseases, intestinal infections, meningitis, malaria, tuberculosis, and lower respiratory infections;
- Non-Communicable diseases, including haemoglobinopathies, congenital anomalies, leukaemia and other neoplasms, ischaemic heart disease, cerebrovascular disease, asthma, and sense organ diseases;
- Mental Health issues;

- Violence (child maltreatment, partner violence, sexual assault, and violence against lesbian, gay, bisexual, or transgender (LGBT) individuals);
- Intentional and Unintentional Injuries, especially Road Traffic Accidents (RTAs), falls, drowning and fire;
- School health service;
- Gender-related issues which affect the health of adolescents and young people
- Adolescents with disability;
- Risks and Vulnerabilities including child labour, marriage and trafficking.

2.6.1 Vision

Improved health status of adolescents and young people through equitable access to appropriate, comprehensive, gender-sensitive, quality and cost-effective adolescent and youth responsive health information, education and services (GHS, 2016).

2.6.2 Goal

The goal of the Policy is to enhance the health status and quality of life of adolescents and young people in Ghana, to contribute towards realization of their full potential in national development through mainstreaming information and gender-sensitive and responsive health services (GHS, 2016).

2.6.3 Strategic objectives

The Adolescent Health Service policy and strategy has 8 objectives as follows (GHS, 2016):

1. Improve access to information on health and health services relevant to the age and gender specific needs of adolescents and young people to enable them make informed decisions

2. Build capacity of health service providers and support staff to enable them have the required knowledge, skills and a positive attitude towards the provision of effective adolescent and youth responsive services at all levels.
3. Improve access to specified package of health services that are of high quality, gender sensitive, disability-responsive in an appropriate environment at all levels.
4. Develop and advocate for relevant enabling environment including protective health policies, and legislative framework to support the provision of AYHS at all service delivery and management points.
5. Promote partnership and inter-sectoral collaboration among adolescent and youth groups, relevant institutions and communities in the provision and utilization of Adolescent and Youth Responsive Health Service (AYRHS).
6. Develop innovative strategies to address financial barriers for AYRHS.
7. Strengthen Research for evidence-informed policies and interventions in AYRHS.
8. Strengthen management, leadership and support systems for AYRHS.

CHAPTER THREE METHODS

3.1 Introduction

This chapter is designed to highlight on the research methods employed to achieve the study objectives. These include: the study design, study location, sampling population, sampling and sampling design, study variables and indicators, data collection techniques and data analysis.

3.2 Study design

A cross-sectional study that adopted a triangulation of both qualitative and quantitative research methods to provide advantages that in turn overcomes the limitations of both approaches. Mixed methods in evaluation provides understanding of a program and its implementation and triangulation of the views and experiences of beneficiaries, service providers and program managers (Odendaal, Atkins, & Lewin, 2016). This approach gives an in-depth and more detailed insight into the questions under study in order to address the set objectives. The use of Mixed Method is to explore and validate findings using quantitative and qualitative data sources (Wisdom & Creswell, 2013). The use of quantitative approach prevents elements of bias in the gathering and presentation of data. The quantitative approach employed a facility based cross-sectional study method where service providers who consented were given structured questionnaires to complete to answer the objectives of the study. The qualitative research approach on the other hand provides more in-depth and comprehensive information as data is gathered through open-ended questions.

3.3 Study location

The study was conducted in the Tema Metropolis, one of the sixteen (16) administrative districts in the Greater Accra region (figure 1) with three Sub-Metropolitan Councils namely; Tema West,

Tema East and Tema Central. It was created from the erstwhile Tema Municipality in 2007 with the promulgation of Legislative Instrument (LI) 1929. Tema Metropolis lies in the coastal savannah zone situated about 30 kilometres East of Accra, the Capital City of Ghana. The metropolis covers an area of about 87.8 square kilometres with Tema as its administrative capital.

The Tema metropolis has a total population of 292,773 according to the 2010 Population and Housing Census, representing 7.3% of Greater Accra Region's total population with a male and female population of 139,958 (47.8%) and 152,815 (52.2%) respectively with 47.8 percent been males and 52.2 percent females. The age groups 10- 14, 15-19, and 20-24 years represent (9.3%), (9.6%) and (11.1%) respectively (Ghana Statistical Service, 2014).

The Metropolis is entirely urban with a total number of 70,797 households and average household size of 4.1 persons per household with approximately two (2) households living in a house. The proportion of those who have never married are 47.8 percent, followed by 37.8 percent who are married and 5.4 percent living together consensual union. The remaining who are less than one-tenth of the population either widows divorced or separated. The population age 15years and older who are economically active are about 72 percent with 90.4 percent employed and 9.6 percent are unemployed. Ninety one percent of the population 11 years and older are literate by language literacy in either English or Ghanaian language only or both (Ghana Statistical Service, 2014).

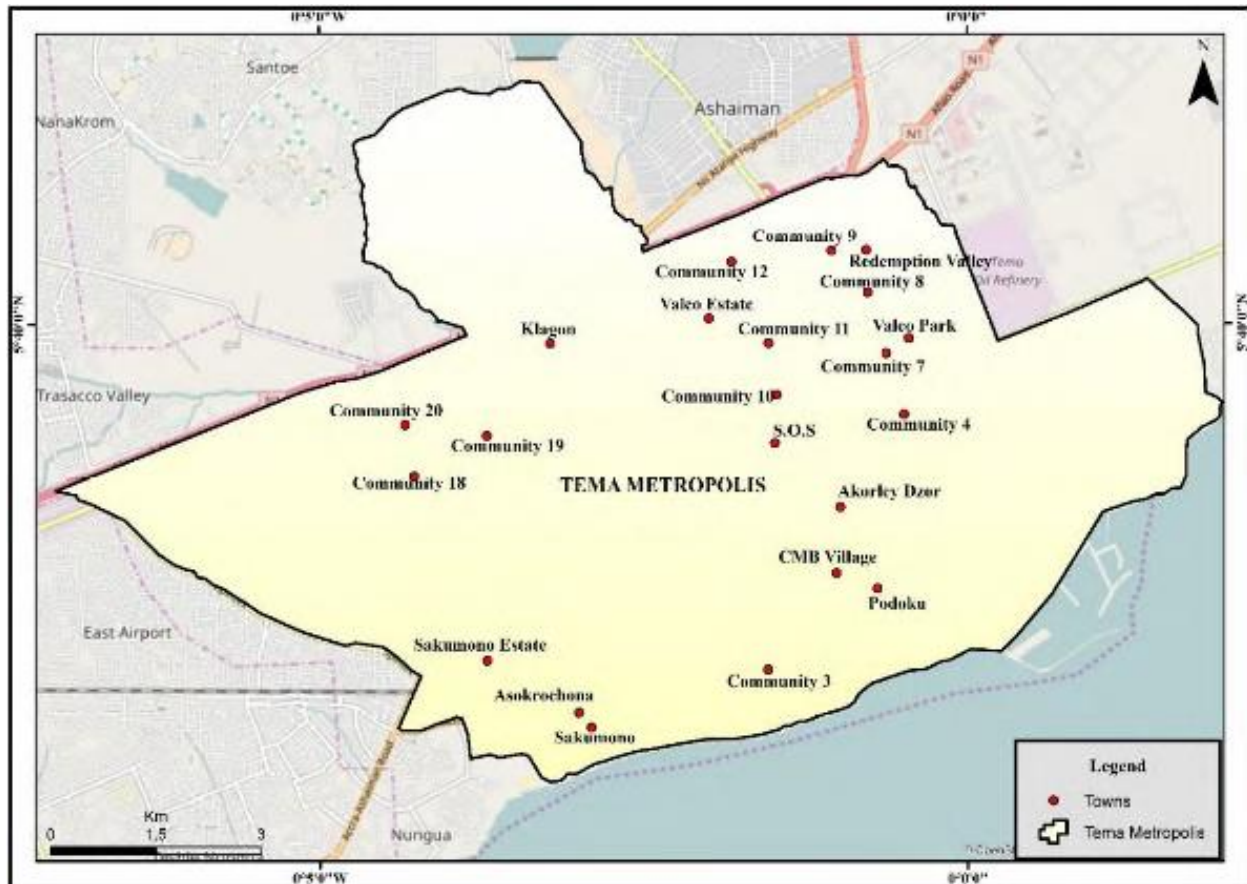


Figure 2: A map of the Tema Metropolis

Source: CERSGIS, University of Ghana, Legon

3.3.1 Health infrastructure and healthcare services

The Metropolitan has both public and private health facilities that render wide range of health services among which the public facilities are the majority 54.2%. Maternal and Child health services, Reproductive and family planning health services are some of the public health services offered in these health facilities (Ghana Statistical Service, 2014). The Tema Metropolitan Health Directorate (TMHD) is responsible for health services in the metropolis and has 3 Sub-Metro that has health management teams also responsible for their catchment areas. The health system runs a three hierarchical system. The first level is mainly the provision of primary health care such as;

treatment of minor ailments, dressing of wounds, health education, counselling and family planning services at CHIPS compounds or community clinics. The next level is the sub-metro level namely health centres and polyclinics that provide more advance and comprehensive form of services to cases that are referred from the CHIPS compounds. The complicated cases that need multidisciplinary attention and more comprehensive care are then referred to the topmost of the hierarchy, the Tema General Hospital (Odoi, 2017).

The metropolitan also has four adolescent health corners and 19 adolescent health clubs, distributed among the communities and second cycle institutions. The four health corners are located in public health facilities namely, Tema General Hospital, Tema Polyclinic, Manhean Health Centre and Tema Metropolitan Assembly (T.M.A.) Maternity and Child Clinic. (Anaba & Abuosi, 2018).

3.4 Study population

For the purposes of the study, and the evaluation of the implementation of Adolescent Health Service Policy and Strategy a framework that takes into cognizance the health of both Adolescents (10-19years) and Young adults(18-24years), this study focused on all young people (10-24years) attending youth corners in the Tema Metropolis. The target population consisted of young people between the ages of 10-24years attending youth corners in the Tema Metropolis, managers and service providers at the Youth Corners and the focal person for Adolescent and Reproductive health at the Tema Metropolitan Health Directorate.

3.5 Inclusion and exclusion criteria

3.5.1 Inclusion criteria

All adolescents and youths between aged 10-24 years who have been staying in the Tema Metropolis within the last twelve (12) months prior to the study and indicated their willingness by providing consent or assent to participate in the study and received parental consent to participate. Heads of health facilities that render AYFHS (youth corners) in the metropolis, Service providers at Youth Corners and the focal person for Adolescent and Reproductive health at the Tema Metropolitan Health Directorate.

3.5.2 Exclusion criteria

All adolescents and youths who qualify for the study but were unable to communicate verbally were excluded due to inadequate resources to be able to harness other forms of communication apart from verbal communication.

3.6 Study variables

In order to evaluate the implementation of AHS policy and strategy, three (3) main objectives of the policy were evaluated for the purposes of the study. These objectives were measured as the dependent variables;

1. Access to information on health and health services relevant to Adolescents

This variable was explored with series of questions that focused on the source of information for adolescents, Social and Behaviour Change Communication (SBCC) strategies (including comprehensive school-based sexuality education and mass media messaging).

2. Capacity of health service providers and support staff in AYFHS

Questions were channelled towards processes of building capacity of service providers and support staff that are to enable them to obtain required knowledge, skills and a positive attitude

for the provision of adolescent and youth gender responsive services effectively at all health service delivery points.

3. Partnership and inter-sectoral collaboration among adolescent and youth groups, relevant institutions and communities.

This variable was explored to determine the depth of Involvement and collaboration of young people with their communities and other relevant stakeholders in the implementation of the AHS policy.

3.7 Definition of indicators and measurement

Table 1: Indicators and Sources of Measurement

OBJECTIVE	NAME OF INDICATORS	DEFINITION	MEASUREMENT
OBJECTIVE 1	Number of SBCC materials in the facility	Current revised SBCC materials available	Counts from the facility records
	Number of Social mobilization activities conducted in schools and communities	Behavioural change activities through Social mobilization activities conducted in schools and communities	Counts from Facility records Interview with AYFHS unit Manager
OBJECTIVE 2	Proportion of staff trained in AYFHS at the municipal level	Numerator: Number of Staff trained in AHS delivery (trained in using guidelines and protocols to provide information and counselling) Denominator: Total number of staffs in the Youth corner	Percentage calculated from facility records Cross sectional study at AYFHS unit Interview with AYFHS unit Manager
	Proportion of staff going through Induction program to orient new health personnel posted to the facility in AYFHS	Numerator: Number of new staffs oriented Denominator: Total number of new staffs for the year	Health Facility Manager Cross sectional study at AYFHS unit Interview with AYFHS unit Manager

OBJECTIVE	NAME OF INDICATORS	DEFINITION	MEASUREMENT
OBJECTIVE 3	Number of peer educators trained	Number of young people (10-24 years) trained in AYPHS to render education at the facility or community	Counts from records Interview with AYPHS unit Manager
	Number of regular educations at health facilities provided by peer educators	Number of educational talks given by young people (Peer educator) in the facility.	Counts from facility records/ Interview with Adolescent Client
	Number of young people fora formed	Adolescents and Young People's Forum for networking in place/organized/oriented at health facility and in community	Count from facility records Interview with AYPHS unit Manager
	Number of young people's meetings in community	Number of times Adolescents and Young People meet regularly at health facility or community.	Count from facility records Interview with Adolescent Client
	Number of Community actors' group formed	Community actors (Traditional leaders, religious groups, teachers Assemblymen/women Media, CBOs/NGOs, young people) group in place/organized/orientated in community	Facility Records Interview with AYPHS unit Manager
	Number of Community Actors' meetings	Actors' group meetings in the community to discuss and support service delivery for adolescents and young people	Facility records or records of meetings

Source: MOH/GHS standards and Tools for Monitoring AYPHS

3.8 Sample size determination

A total population sampling was employed due to the finite nature of the population of service providers in the Youth Corners and the heads of the facilities. This was done to reduce the occurrence of error and the introduction of bias when selecting a sample. Calculating a sample size from a small population will reduce the chance of detecting a meaningful significant outcome (Etikan, Musa, & Alkassim, 2016).

A purposive sampling method was also used to select adolescents attending the facility. A minimum of 8 and maximum of 12 homogeneous groups of adolescents were made to participate in the focus group discussions in the various facilities. A maximum of two focus group discussions were conducted as saturation was reached and response from participants were no more generating new themes.

3.9 Sampling method/Procedure

The main sampling technique employed in the study was purposive sampling. The purposive sampling technique was applied to select health facilities with youth corners. Hence, all the four health facilities with youth corners which are Tema General Hospital, Tema Polyclinic, Manhean Health Centre and Tema Metropolitan Assembly (T.M.A) Maternity and Child Clinic were selected. Homogenous sampling was employed to select an average of 8-12 adolescents from the various facilities after which they were required to assent or consent voluntarily to participate in a focus group discussion conducted in the Youth Corners. All adolescents between the ages of 10 and 17 years and not regarded as emancipated were informed about the study and asked of their interest and consent by signing an assent form after which a parental consent form was handed over to them to be signed by their respective parents and brought back on the set date for the discussion. Adolescents that returned with a signed parental consent form as a sign of parent's

approval were enrolled in the focus group discussion after confirmation of the signed parental consent with a phone call to the relative or parent's contact. Expert sampling technique was also employed to select heads of AYPHS units and the focal person for Adolescent and Reproductive health at the Tema Metropolitan Health Directorate. Total population sampling was used to recruit Service providers at the youth corners after they had consented.

3.10 Data collection techniques/methods and tool

The main data collection techniques employed in the study were: a facility based cross-sectional survey, activity records review, focus group discussions and key informant interview. A structured questionnaire (made up of closed and open-ended questions) was used for the cross-sectional survey among service providers in the various youth corners. An interview guide was used during the focus group discussion with adolescents visiting the Youth corners. Key informant interviews conducted for managers of the AYPHS units and the focal person for adolescent health services in the Tema metropolis was done using semi-structured questionnaires and guide. The questionnaires used in this study were adapted from the Standards and Tools for Monitoring Adolescent & Youth Friendly Health Services (AYFHS) in Ghana developed by the Ministry of Health and the Ghana Health Service to ensure standardization.

3.10.1 Data collection procedure

Quantitative approach

Structured questionnaires were administered to all service providers at the AYPHS units at the selected facilities during a face-to-face interview by the researcher and research assistants. This was done after the necessary consent was obtained. A maximum of 30 minutes was spent to complete a questionnaire per individual.

Indicator sheets were used during the recording of activity counts from the records review section at the various AYFHS units. This process was carried out in collaboration with the AYFHS units' managers to verify the units of measurements.

Qualitative approach

Focus group discussions were conducted during the qualitative approach to gather in-depth information on the implementation of the Adolescent Health Service Policy and Strategy. The first focus group discussion was organised at an agreed venue in one of the AFYHS units that comprised of 8 adolescents with an interviewer and a research assistant who was taking notes. Consent was initially obtained before the start of the focus group discussion in written forms where participants signed a consent form each with others thumb printing based on individual preference. Participants were again asked to re-affirm their consent verbally for the study and recording of the focus group discussion before the recording was started. Focus group guides made up of open-ended questions were used to obtain information from participants. The focus group discussion which was conducted in English and Twi lasted for fifty (50) minutes after which the participants were thanked and refreshment was announced and the recording stopped. A second focus group discussion for adolescents was organised in a different venue comprising of 9 different participants but conducted in similar way as the first focus group discussion.

Face-to-face in-depth interviews were conducted with the focal person for Adolescent and Reproductive Health Services at the Tema Metropolitan Health Directorate and the managers of the AYFHS units in the selected health facilities. Semi-structured questionnaires were administered amidst the face-to-face in-depth interviews. A tape recorder was used to record proceedings of the interview after taking consent. The recordings were used as references where

they were compared to notes that were taken during the interview to clarify issues that were ambiguous.

3.11 Data quality control/assurance

To ensure data quality, several interventions were put in place to ensure validity. Research Assistants were employed by the researcher in order to assist with data collection and entry.

3.11.1 Training of field staff

Adolescent sexual and reproductive health issues are sensitive. In respect to this, professionalism and skills were employed during data collection. A 3-day intensive training was organized for the three (3) research assistants and a supervisor. The training involved a comprehensive teaching on key concepts and methods regarding the study to adequately equip them for the data collection activity. Research Assistants were taken through the objectives of the study, rudiments of data collection, ethical interactions with study participants, importance of respect, voluntary participation, obtaining of assent and informed consents from study participants and parents/guardians, responding to participant questions, selection of study participants, administering of questionnaires and appropriate translations of questionnaires into the three most spoken Ghanaian languages (Twi, Ewe and Ga) in the metropolis for participants not fluent in the English language.

3.11.2 Pre-testing of data collection tools/questionnaires

Data collection tools used for the study were validated by pre-testing. Pre-testing was conducted in the same community as the actual study however such participants for the pre-testing were excluded from the main study. Research assistants were included in the pre-testing phase. This was to ensure that, research assistants familiarize themselves with data collection tools and

procedures. Pre-testing also ensured that ambiguous questions were modified to enhance clarity of questionnaires and interview guide.

3.11.3 Revision of data collection tools/questionnaires

Data collection tools were then modified to ensure clarity and reliability based on feedback from the pre-testing exercise. All data collection tools were revised to allow for modification of ambiguous questions.

3.11.4 Supervision of fieldwork

A supervisor was trained in addition to the research assistants to assist the principal investigator to supervise and monitor field work in order to ensure adherence to study protocols. All the answered questionnaires collected were checked manually on daily basis by the principal investigator for completeness and consistency.

3.11.5 Data coding and transcription

Data gathered from all the interviews were transcribed and typed out and stored in files created on a personal computer that was under password.

3.11.6 Data entry

Database for entry of questionnaires was created in Microsoft Excel (2016 version). Screen and forms for data entry were customized for easy entry of data and to validate and reduce errors.

3.12 Data processing and management

Data gathered from all the interviews, were stored in files created on a personal computer. A password which is changed frequently was placed on all data to prevent access by unauthorized persons. Printed versions of the transcripts and questionnaires that were used for the study were kept in a cabinet under lock and key. All data collected will be kept for a period of five (5) year

after the study after which they will be destroyed. Access to all data was available to only the researcher and supervisors for purposes of ensuring confidentiality.

3.13 Data analysis

3.13.1 Qualitative analysis

Qualitative data collected was analysed after explicitly transcribing interviews. Thematic data analysis which consist of reduction of data, display of the data and drawing conclusion or verifying data (Miles & Huberman, 1994) was employed during the analysis of the qualitative data. This was done as the recorded data and the notes taken were compared to enable expanding the data. The recorded note was then successfully transcribed by two researchers and then compared to reduce error and solve ambiguities by consulting a third researcher. The textual data was then read through again after which coding was done and then themes and patterns generated with the help of NVivo 11. Similar responses were then grouped under the same theme and assigned codes. The content and structure of the various themes were then interpreted. Names were not used in the analysis or report writing; however, verbatim reporting were done in instances where the actual words of the respondents were needed to make meaning or emphasize important issues for in-depth interviews. Also, simple descriptive statistics were conducted on the demographic characteristics of participants who participated in the interview.

3.13.2 Quantitative analysis

Quantitative data was analysed using STATA/IC 15. Prior to data analysis, data was cleaned and validated to ensure data quality and consistency. Simple descriptive statistics were conducted on demographic variables. The descriptive statistics were presented in frequency distribution tables inferences made with bar charts and pie charts.

3.14 Ethical considerations

The research proposal was subjected to ethical review of the Ghana Health Service Ethics and Review Committee. Permission was taken from the Greater Accra Regional Health Directorate after which the director forwarded a reply to the Tema Metropolitan Health Directorate where a letter of permission was sent to the management of the four (4) health facilities with adolescent youth corners (Manhean, Tema General, Tema Polyclinic, Tema Metropolitan Assembly Maternity and Child Clinic). Study was commenced after the approval of the letters from the facilities.

3.14.1 Study procedure

The objectives of the study were explained to all the study respondents. Those who signed the consent or assent forms and children whose parents/guardians gave consent were enrolled in the study. The questionnaires were given to the respondents and the technical terms explained to all respondents. Interviews followed allocated time and standard protocols.

3.14.2 Privacy and confidentiality

All respondents were assured of privacy and confidentiality in answering the questions. They were assured that information gathered from them will be accessed only by the student and supervisor.

3.14.3 Informed consent/assent

Consent forms were given to all respondents 18years and above including emancipated adolescents. Assent forms were signed by adolescent between 10-17years of age with their parents signing the parental consent forms.

3.14.4 Possible risks/discomfort

The study posed no risks to the respondents. The only discomfort caused by the researcher was the time respondents sacrificed to participate in the study.

3.14.5 Compensation

Study participants who consented to be part of this study were given refreshments after the discussions with no other monetary compensation.

3.14.6 Possible benefits

There were no personal gains in participating in this study. It is expected however, that the findings from this research will contribute to improving upon the implementation of the Adolescent Health Service Policy and Strategy.

3.14.7 Voluntary participation

Partaking in this study was completely voluntary. Participants who refused to answer any question or opted to end the interview at any point in time were permitted to without any repercussion. Participants were informed of their right to withdraw their participation should they decide to after consent has been given.

3.14.8 Conflict of interest

The researcher declares no conflict of interest of any form as far as this study is concerned.

CHAPTER FOUR RESULTS

4.1 Introduction

This chapter presents the findings of the study and how data collected for the study were analysed. The Statistical Package used to analyse the quantitative data was STATA version 15. Study results are presented in tables. NVivo was also used to analyse the Qualitative data according to themes that were generated.

4.2 Socio-demographic characteristics

A total of twenty-four (24) participants made up of seventeen (17) young people, six (6) service providers among which four (4) were managers in-charge of the AYPHS unit and one (1) Metropolitan Adolescent health service focal person participated in the key informant interview (KII) in the study. The young people participated in a focus group discussion. All respondents were females as no male young person was available at the time of data collection. More than half of the young people (10) 58.82% were between the ages of fifteen (15) to nineteen (19) years with very few (1) 5.88% between the ages ten (10) to fourteen (14) years and the remaining six (6) 35.29% between the ages of twenty (20) to twenty-four (24) years. The mean age of adolescent respondents was $18.24 \pm (2.19)$ as captured in table 2. The religious background of the young people revealed that, majority of 88. 24 % of them were Christians with the rest being Muslims. Thirteen (76.47%) of them were single and five (5) which represent 17.65% were married with the remaining co-habiting. Majority of the young people had some form of education with seven (7) that is 41.18% and six (6) representing 35.29 % of them having completed junior high schools or senior high schools respectively. The remaining young people have had only primary school education (11.76%) or no education at all (11.76%). (Table 2).

Table 2: Socio-Demographic Characteristics of Young People.

Characteristics	Frequency (n=17)	Percentage (100%)
<i>Gender:</i>		
Male	0	0
Female	17	100
<i>Age:</i>		
10-14	1	5.88
15-19	10	58.82
20-24	6	35.29
Mean Age: 18.24(±2.19)		
<i>Religion</i>		
Christian	15	88.24
Islam	2	11.76
African Traditional	0	0
Other	0	0
<i>Marital status:</i>		
Single	13	76.47
Married	3	17.65
Divorced	0	0
Co-habiting	1	5.88
<i>Level of Education:</i>		
None	2	11.76
Primary	2	11.76
JHS	7	41.18
SHS	6	35.29

Source: Field Data, 2019

A total of six (6) service providers participated in the facility cross-sectional survey at the AYPHS units. Three (3) out of six (6) service providers are between the ages of thirty-six (36) to forty-one (41) years. Half of the total number of service providers who participated in the study have the longest duration of service ranging from eleven (11) to fifteen (15) years working in the health service. (Table 3). Also, half of the total number of the service providers who responded have

worked for a minimum of one (1) and a maximum of five (5) years duration of service in the AYPHS unit. All service providers who responded to the questionnaires have received training in adolescent youth friendly health service provision. (Table 3).

Table 3: Socio-Demographic Characteristics of Service providers.

	Frequency (n=6)	Percentage (100%)
Age:		
24-29	1	16.67
30-35	2	33.33
36-41	3	50.00
Sex		
Female	6	88.24
Duration of Service (DOS) in Health Service		
1-5	2	33.33
6-10	1	16.67
11-15	3	50.00
DOS in AYPHS Unit		
<1	2	33.33
1-5	3	50.00
6-10	1	16.67
Trained in AYPHS		
Yes	6	100
No	0	0.00

Source: Field Data, 2019

4.3 Access to information on health and health Services relevant to adolescents.

Quantitative

The facility records review revealed that all four (4) facilities had SBCC materials available for young people to read in the facilities and also send home aside one (1) facility, TMA youth corner that does not have enough SBCC materials to be given to young people to be sent home. SBCC materials are being displayed at the various corners with posters around to furnish adolescents with all the information they needed when they come to the corners. The minimum number of 41 SBCC materials was recorded in the TPC with the maximum number of 155 SBCC materials in TGH. The SBCC materials identified at the facilities are in the forms of books, fliers, and pocket manuals. Despite the availability of the SBCC materials, most of them are old editions (more than 5 years) which may be outdated. Three (3) out of the four (4) AYFHS units conduct social mobilization activities both in schools and communities. A total of 16 social mobilization activities have been conducted by the youth corners in the communities and schools in the last quarter. Both TGH and MHC have conducted seven (7) activities signifying 43.75% each of the total conducted with the remaining (12.50%) conducted by TPC.

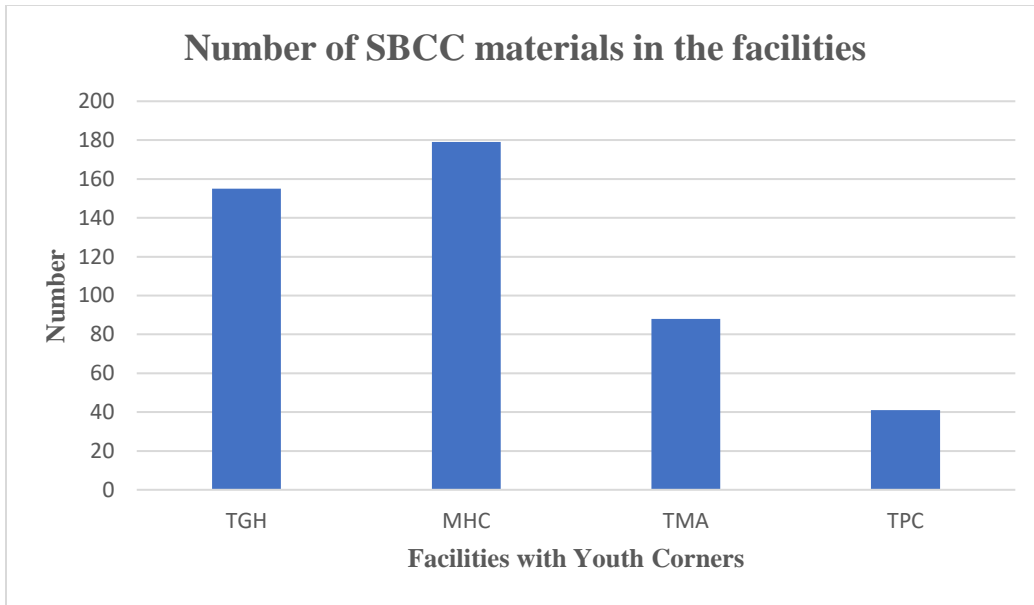


Figure 3: Number of SBCC Materials in the Facilities.

Source: field Data, 2019

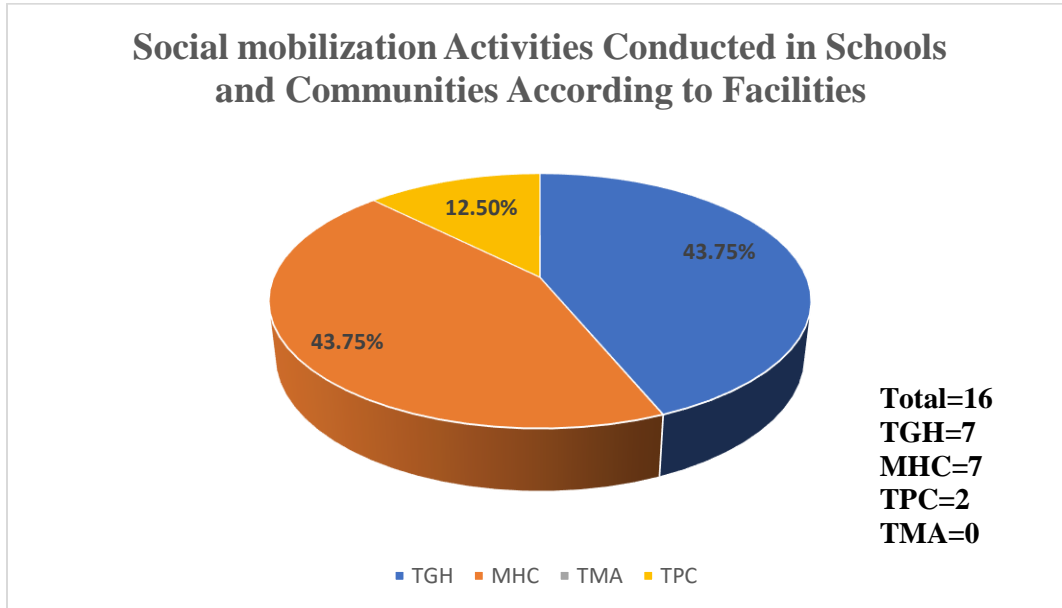


Figure 4: Social mobilization Activities Conducted in Schools and Communities According to Facilities.

Source: Field Data, 2019

Qualitative

Young people participating in the focus group conducted identified the radio, television, hospitals, schools, the internet and parents as the sources of information on Adolescent health services. Some adolescents further explained that they specifically get information on AYFHS at the various corners in the health facilities and also from youth clubs that have been formed in the schools. This was elucidated from the following few lines.

“...I get such information from the adolescent health corners in the hospital. They invite us to come and they talk to us about health issues that bother adolescents and everything about adolescents...”

_19-year-old female, FGD

“...I commonly get information about adolescent health from the school clubs in our schools. Sometimes the nurses come to the school to talk to us...”

_16-year-old female, FGD

SBCCs materials were sometimes given to the young people to read at the facility and in some circumstances given to them to be taken home. The particular problems experienced by young people determines the kind of booklets you are given and whether it could be taken home or not. Adolescents in general were satisfied with the contents of the various books and the amount of education they get from it. This was elucidated in the response that;

“...Anytime I come here, the books are displayed on the cabinets and shelves. I was given some copies to read at the facility and other ones to send home...”

_17-year-old female, FGD

“...For me, anytime I come here I am given some books to read. I like the things in the book. They teach us a lot of things that children who are growing need to know...”

_20-year-old female, FGD

Similar sentiment was shared by a participant but suggested the books could be produced in other local languages for those who could not read English.

“...I see the books when I come here and they tell me the things in them, but because I can't read, I don't take some away. It will be good if we had other languages...”

_18-year-old female, FGD

Participants reported the amount of information they receive from service providers as enough to meet their needs. Participants were satisfied with the quality of information and services rendered to them at the corners but indicated that most of the information they get were subject to asking more questions.

“...When I first came to this facility, I was pregnant and wanted to terminate it. I got here and was directed to the Adolescent corner. The nurses here advised me and even offered to go home with me to speak to my parents. They called me all the time to check on how I am doing and invite me over regularly...”

_19-year-old female, FGD

“...For me anytime I come, they have enough time to tell me all what I want to hear. Even me I ask a lot of questions before they go deep into it. But they answer all my questions very well...”

_21-year-old female, FGD

Key Informant interviews conducted with the adolescent focal person and managers who are in charge of the AYPHS units explained that they have SBCC materials as displayed however do not get regular supply as needed. The Tema metropolitan health directorate does not have requisition documents available indicating procurement of SBCC materials as they are not produced and supplied in any particularly defined intervals. This was ascertained from the following lines.

“...I get the SBCC materials sometimes when programs are organised at the national or regional level...”

_Metropolitan AYPHS focal person, KII

“...Sometimes I have to make a photocopy of some of the SBCC materials that are running out...”

_Manager In-charge of a youth corner, KII

4.4 Capacity of service providers in the health facilities

Quantitative

The number of service providers in all the facilities was a minimum of one (1) and a maximum of three (3). The TMA AYPHS unit had only one (1) staff trained and currently at post. Adolescent youth friendly units at both MHC and TMA have two (2) staffs each who have also been trained in provision of AYPHS. TGH have 3 staffs out of which two (2) have been trained in provision of Adolescent Youth Friendly health services.

Table 4: Indicators for Capacity Building of Service Providers.

		TGH	MHC	TMA	TPC
Proportion of staff trained in AYFHS	Numerator	2	2	1	2
	Denominator	3	2	1	2
Proportion of new staffs inducted on program to orient new health personnel posted to the facility in AYFHS	Numerator	-	-	-	-
	Denominator	-	-	-	-

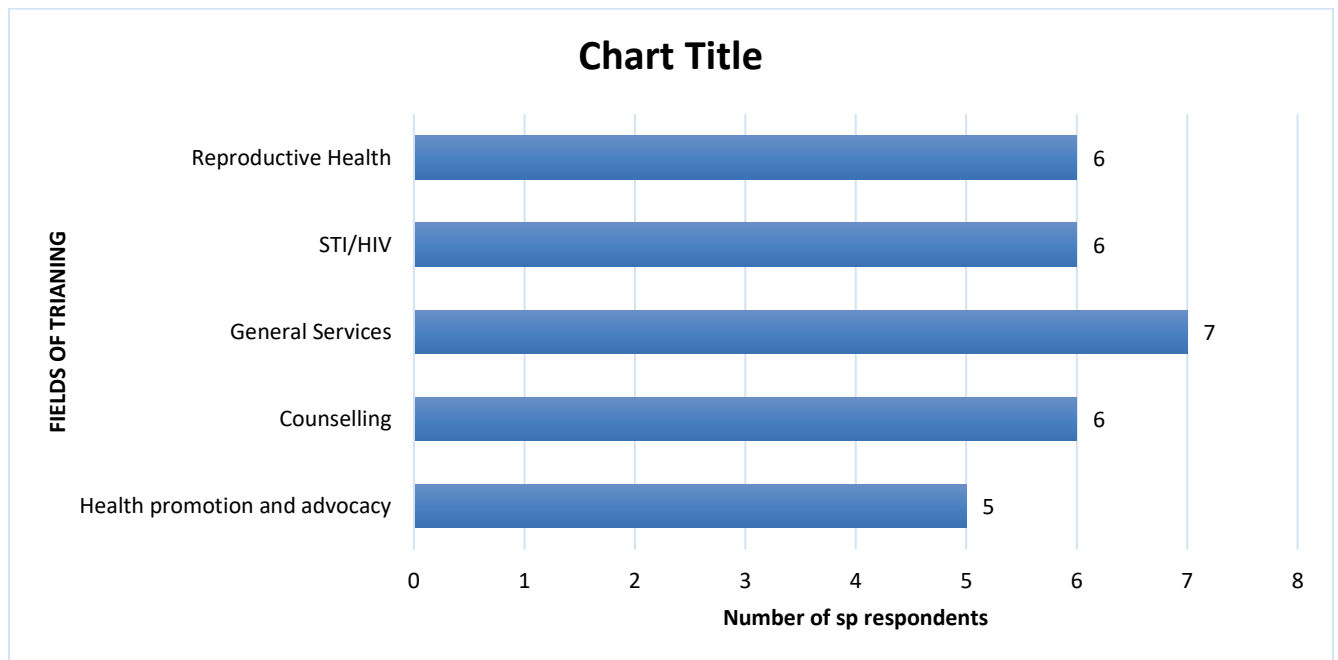


Figure 5: Fields of Training of Service Providers

The total of seven (7) service providers who responded to the questionnaires, received training in general services, six (6) out of the seven (7) received training in Reproductive health, STI/HIV, and counselling. Health promotion and advocacy had the least number of five (5) people trained in it. There have also been 16 training sessions organized for the sub-metropolis however no training has been organised for the sub-metropolitan TOTS in the use of protocols and guidelines. There have also been twelve (12) technical assistance visits to the youth corners in the last quarter.

There has also been only one (1) refresher training conducted in the last quarter. All AYPHS unit have some sort of induction program to orient new health personnel posted to the unit.

Qualitative

Young people who participated in the FGD were asked about the attitudes of service providers during service provision. In response to that, the health providers at the adolescent health corners were rated as very good, friendly and professional in providing services as compared to other departments. They were open to any kind of question that young people had and the issues bothering them.

“...They were very friendly, every time they are open to you and allow you to say anything on your mind. For the corner, they always smiling with us as compared to other parts of the facility...”

_19-year-old female, FGD

“I remember when I started visiting the corner but got pregnant, I posted something on my status that I feel like doing something crazy. Immediately I received a call from the corner that I should come. I didn't know why but when I got there, they were so professional in advising me about posting such things”

_17-year-old female, FGD

Similar sentiments were shared by other young people;

“...This people here, when you come, they laugh with you all the time. So, I don't feel shy to talk...”

_12-year-old female, FGD

“...they are very nice people, they even tell me that when I am not doing anything at home, I should come to them here...”

_15-year-old female, FGD

Despite the friendliness of the providers, it was reported that some providers create bad notions about young people who come to seek certain information on sexual and reproductive health. Others give out information about young people to friends who are familiar as understood from a statement that;

“...Some of the nurses, when you come to ask them for condoms, they will give you but when you live, you will sometimes hear about it from people who were not there. When it happens like that, I do not feel to come again...”

_21-year-old female, FGD

It was realized that, providers spent enough time with young people who patronized the corners. The time spent by each person was based on the issues the person had and the level of understanding whatever was being thought. In times of group sessions, each participant is given the opportunity to contribute to the discussion. The participants of the focus group discussions acknowledged that, service providers at the Adolescent corners have been performing their duties towards young people perfectly. Providers put in extra efforts to ensure that adolescent needs are met. Despite the efforts of the providers, unavailability of resources makes the providers not function very well sometimes.

“...The time they spend with us is okay because they give you the chance to say everything and ask questions. If you have more problems you keep long...”

_17-year-old female, FGD

“...On a scale of ten (10), I will give them nine and a half because they are doing very well for us...”

_19-year-old female, FGD

Interview with managers in-charge of the AYFHS units agreed that service providers in the units provide services to young people as per guidelines and protocols however they get overwhelmed as they have to share their staffs with other units of the facilities.

“... I am the only person at the AYFHS unit but as a midwife I also have to work at the maternity...”

_Service provider and Manager in-charge of AYFHS, KII

“...Sometimes because we are under-staffed in the facility, the staffs here have to leave the AYFHS unit and go and check vitals to help ease the pressure...”

_Manager of AYFHS, KII

4.5 Partnership and inter-sectoral collaboration among adolescent and youth groups, relevant institutions and communities

Quantitative

Records review at the AFYHS unit reveals that two (2) out of the four (4) AYFHS units do not have peer educators as a result have no educations provided by peer educators. The AYFHS even

though has four educators trained do not have them providing education to young people in the facility. Majority that is three (3) out of the four (4) facilities have formed fora for young people. The minimum number of fora formed is one (1) and a maximum of seven (7) for a fora per facility. Only one (1) of the AYFHS unit have a community actor’s group made up of teachers, NGOs, and young people. However, there has not been any meeting of community actors.

Table 5: Indicators for Partnership and Collaboration among Actors.

Name of Indicator	TGH	MHC	TMA	TPC
Number of peer educators trained	0	4	0	3
Number of regular educations at health facilities provided by peer educators (At least once a month)	0	0	0	4
Number of young people fora formed	0	4	1	7
Number of young people’s meetings in community (At least quarterly)	0	1	1	4
Number of Community actors’ group formed	0	0	0	1
Number of Community Actors’ meetings (At least twice a year)	0	0	0	0

Source: Field Data, 2019

Qualitative

In terms of partnerships and group opportunities to share information, young people reported during the focus group discussions that, there are limited to no opportunities for them to share information and ideas among each other. Aside the schools which had school clubs for partnerships, service providers do not frequently organize the young people’s meetings to facilitate exchange of ideas. It was further captured that, some of the school clubs are dysfunctional and with no frequent meetings.

“...The only place I know we share information and ideas are the schools. I mean the school clubs...”

_17-year-old female, FGD

“...Even in the schools, it is not that strong. I remember we had girls club in our school and I do not know where it ended. We went for the first and second time but it did not continue...”

_16-year-old female, FGD

“...Outside there in the community, I don't see anything like that, if you are not in school you don't have those groups to talk about things like that...”

_19-year-old female, FGD

Participants identified the use of social media as a good platform to share ideas and create partnerships but do not have phones to enable them do that. These were captured from the following quotes;

“...Social media and things like WhatsApp platforms are good places for us to share our ideas but most of us do not have phones that can do that...”

_15-year-old female, FGD

In relation to peer educators in the metropolis, most of the participants had little to no idea about peer educators and could not identify any peer educators they knew. Similarly, participants of the FGD did not know the roles of peer educators in the provision of adolescent and youth friendly health information and services but captured that, they would be happier and understand better if they were being educated by people of their own age group.

“...I don’t know much about peer educators, as you are asking right now, I can’t tell what they are supposed to do...”

_19-year-old female, FGD

“...I have heard that before but I don’t know any around here, even if they are there, I don’t here of them educating us...”

_20-year-old Female, FGD

4.6 Barriers and facilitators influencing implementation of Adolescent Health Service

Policy and Strategy

Participants of focus group discussions, key informant interviews mentioned some factors they perceive to be either barriers or facilitators influencing implementation of the adolescent health service policy and strategy.

4.6.1 Barriers to implementation.

The study found factors such as lack of awareness of the policy, limited dissemination of policy documents, Inadequate support from community actors, low involvement of adolescents, inadequate financial resource and other logistics, Inadequate Staff, Inadequate managerial support, Operating hours of AYFHS.

Lack of Awareness of the Policy and it Content

Key informants and FGD participants shared the opinion that lack of adequate awareness of the policy and it content is a hindrance to the implementation of the policy. While some service providers have limited knowledge about the content, strategic objectives of the policy, others who

are aware do not have copies of the policy at the facilities. Young people from focus group discussion also had very limited knowledge about the policy even though they knew about services being offered at the corners.

“...I do not know anything about the policy and I have not seen that book before. Maybe the nurses read it and just tell us the things we have to know in them...”

_17-year-old female, FGD

“...One thing hindering the implementation of the adolescent health service policy and strategy is inadequate awareness and knowledge of the policy on the part of service providers...”

_Adolescent health service focal person, KII

Limited Dissemination of Policy documents

The study found aside the unavailability of the policy in facilities, limited dissemination of other policy documents such as relevant and revised SBCC materials as a great challenge to the implementation of the policy.

“...Yes, lot of the SBCC documents are old and we don't get regular supply of them, in fact sometimes I pick some of them from stands of other institutions when programs are organised. Most a time SBCC materials from GHS are produced and distributed specifically for a program...”

_Adolescent health Service focal person, KII

Inadequate support from community actors

Managers of AYFHS also stated that inadequate support at the community level hinders implementation of the policy. Low community involvement is a barrier to the full achievement of the Adolescent health service policy and strategy.

“...low community involvement is a barrier to fostering partnership among young people and the communities...”

_Manager of AYFHS, KII

Inadequate financial resources and other logistics

According to managers of AYFHS units, inadequate financial resources is a barrier to the implementation of the policy. Service providers in some cases have to bear the cost of service provision to adolescent. Service providers fail to conduct social mobilizations in schools and communities due to financial difficulties. Capacity building activities such as in-service trainings are sometimes not regular due to lack of logistics such as projectors.

“...Sometimes I have to use my pocket money when going for school visits that is reaching out to adolescents in schools or community groups, so sometimes I don't go if I don't have enough money...”

_Service provider, KII

“...A barrier influencing capacity building of staff is the fact that we lack technological garget like projectors and laptops.

_Manager of AYFHS unit, KII

Inadequate staff

The KII participants generally share the opinion that inadequate staff at the AYFHS units is a contributing factor to the setback in the implementation of the adolescent health service policy and strategy.

“...We are understaffed in the youth corner that affect our community outreaches...”

_Service provider, KII

Inadequate managerial support

Inadequate managerial support is another barrier identified to be hindering implementation. Managers reported that due to the inadequate managerial support there is less prioritization of Adolescent health services and capacity building of staffs in that area.

Unfavourable opening hours of AYFHS.

Young people in the Tema Metropolis reported easy access to adolescent health information and services in the various health facilities due to the introduction of the Adolescent Health Corners. However, all AYFHS units in the health facilities open 5 days a week; from 8am- 2pm as a result Some young people were of the idea that, the time was not convenient for them since they may be in school during the opening hours of the corners.

“...We go to school and because we close late so we don't get time to go there. Even weekends they do not come...”

_16-year-old female, FGD

“...Sometimes the academic calendar interferes with our planned activities with the adolescents, this is a challenge because most of them don’t come unless on vacations...”

_Manager of AYFHS, KII

4.6.2 Facilitators of implementation

According to participants of key informant interviews advocacy on Adolescent Youth Friendly Health Services and creating awareness among stakeholders in the metropolis has been a great facilitator in the in the implementation of Adolescent Health Service Policy and Strategy. Varied degree of advocacy activities has led to creation of community adolescent corner and increase in social mobilization activities in schools.

“...Through advocacy the community adolescent corner was set up...”

_Manager of AYFHS unit

“...High level of awareness through continuous stakeholder engagement has contributed to social mobilization and increase utilization of AYFHS by adolescents in the metropolis...”

_Adolescent focal person, KII

CHAPTER FIVE DISCUSSION

The achievement of the objectives of this process evaluation, on the implementation of the Adolescent health service policy and strategy with focus on three (3) strategic objectives of the policy has been successful and enlightening.

5.1 Access to information on health and health services relevant to adolescents.

In assessing the access to information, the study revealed from the facility records that, facilities providing adolescent health services had SBCC materials available in different forms to provide information to young people visiting the facilities and a few other materials given to be taken home. This ensures that young people have all the information they needed by reading such materials thoroughly. This finding is in line with the implementation strategy of the policy to make widely available SBCC materials to provide all adolescent health related information to young people (GHS, 2016). A study by Limbu, Mehta, Connor, Dham, & Chakravarty (2015) also supports this finding in a report after a community intervention assessment that, the distribution and availability of SBCC materials was an effective way of communicating to adolescents of all backgrounds especially in the pictorial format.

Majority of the SBCC materials available and inspected at all the facilities were found to be old versions which could contain outdated information on adolescent health services that may not be relevant to the gender and age of the young people in recent times. Information gathered on the newer materials from the interviews indicated that, these materials are not being printed regularly and even the ones printed are not circulated adequately and on time. These findings do not correspond with the implementation strategy of the policy to make widely available new and most recent SBCC materials in the printed form to enhance access to adolescent friendly health services

and information. Similar to the implementation strategy in the Ghanaian Policy, the implementation guide on adolescent reproductive sexual health strategy in India prescribes the availability of IEC materials in various forms that adolescent could read in the corners and take home without requesting (MOH, 2006). The contents of the education materials tend to meet the information needs of young people but as reported by the findings of the study. Despite their satisfaction, other concerns identified that, the SBCC materials do not have other local language translations to meet the needs of illiterate young people. This is deficient in comparison to the strategy in the policy to provide educational materials to meet the needs of adolescents who have no education (GHS, 2016)

Social mobilization activities were being conducted by most of the facilities with one facility not being able to carry out such mobilization activities. These activities are essential to get the community members to support adolescents. In respect to this, a study highlighted that, community mobilization activities give opportunity to members of the community and young people to serve as agents of change (Greenberg, Davis, Tutt, & Katcher, 2017). These social mobilization activities are being conducted as prescribed by the Adolescent health service policy and strategy to get the support of the public for adolescents (GHS, 2016) but may need extra efforts to be able to meet policy targets. Observations made from the FGDs involving young people revealed that the commonest sources of Adolescent health information were the internet followed by hospitals (youth corners), television and radio stations and schools. This finding is similar to other studies on adolescents' sources of health information which reported the internet as the main source among other sources (Esmaeilzadeh, Ashrafi-rizi, Shahrzadi, & Mostafavi, 2018; Ettl, Nathanson, Ettl, Wilson, & Meola, 2012) especially due to the growing emergence of technology and the privacy in using one's own phone. However other studies have reported the health facilities,

schools and peers as the chief sources of information in Ghana, Burkina Faso, Malawi and Uganda (Biddlecom, Munthali, Singh, & Woog, 2007) and in Ethiopia (Tegegn & Birhanu, 2009).

5.2 Capacity of service providers in the health facilities

It is clear that service providers in the AYFHS unit have the needed training and experience to provide services in the AYFHS units. This capacity building has been demonstrated with the number of staffs that had training in the fields of Health promotion and advocacy, Counselling, General services, STI/HIV, and Reproductive health as well as frequent refresher trainings technical assistant visits, conducted in the youth friendly corners. Positive attitudes for the provision of adolescent and youth gender responsive services is also evident as service providers deliver services per the guidelines and protocols and are describe by young people as good and professional at the delivery of services in the AYFHS units. These findings are in line with evaluation of some other adolescent health service policies and projects (Geary, Webb, Clarke, & Norris, 2015; Thomée et al., 2016).

The staffing strength at AYFHS unit is evidently poor as service providers in the units continue to take other major roles in other parts of the health facilities in addition with their main responsibilities at the AYFHS units. This situation introduces service provider fatigue and has a negative effect on number of active social mobilization activities on Adolescent sexual and responsive health services organised in the facilities and communities. This finding does not seem to agree with the “new policy” that is keen on promoting equitable distribution of staffs at all levels of service delivery (GHS, 2016).

5.3 Partnership and inter-sectoral collaboration among young people, communities and relevant stakeholders

Level of partnership with adolescents in AYFHS varies across all facilities as some facilities train some number of peer educators of which some conduct regular educations at health facilities provided by peer educators at least once a month. Other facilities are unable to train peer educators while others who have trained peer educators fail to conduct regular educations at health facilities. As a result, most adolescents are not aware of the role and importance of peer educators in service delivery. This reduces the opportunity for young people to participate in the delivery of service an implementation of the policy. Young people fora have been formed at school and community levels with regular meetings to target engagement of both out of school and in school adolescents. These platforms provide them with the opportunity to share their views and experiences on AYFHS as captured in a study that explored how adolescents get information in group discussions (Gauducheau, 2016).

The study revealed that, only a single community actors' group made up of teachers, assemblymen/women, and the media that even fail to organize community actors' meetings. Inability to form community actor's groups made up of young people, assemblymen/women, the media, traditional and religious leaders, teachers, CBOs/NGOs weakens the level of involvement by community actors. Community actors' groups for AYFHS enable it members to have a sense of responsibility, commitments and acceptance towards service delivery. Community actors group meetings serve as platforms where suggestions are made on the best practices of service delivery that will be suitable for the culture differences in the society. Inadequate community actors' group and meetings extend greater challenges on service providers to render services, break through

social and cultural barriers with little or no support from the actors. The importance of community actors' groups has been captured in other similar studies (Fisher et al., 2011; Panahi, 2015).

Despite the non-existence of a well-established and recognised community actor's group individual social groups, CBOs/NGOs contribute their support and commitment to some social mobilization activities in AYFHS.

5.4 Barriers and facilitators influencing implementation of adolescent health service policy and strategy

To be able to obtain a better understanding of the policy implementation process, it is essential to identify the factors that serve as either facilitators or barriers that influence the implementation process. These factors when properly managed will enhance implementation in order to achieve policy objectives and enhance progress towards achieving set targets of the policy at the end of the policy time frame.

The new policy implementation is being hindered by lack of awareness of the policy, limited dissemination of policy documents, Inadequate support from community actors, low involvement of adolescents, inadequate financial resource and other logistics, inadequate Staff, inadequate managerial support, operating hours of AYFHS units and some of these findings are in agreement with findings from the implementation assessment of the Adolescent Reproductive Health and Development Policy in Kenya and Bangladesh (Ainul, Ehsan, Tanjeen, & Reichenbach, 2017; Population Reference Bureau, 2013).

The findings of the study indicate that, lack of awareness of the policy negatively affects the implementation process. Awareness of the contents and provisions of policies help to enhance successful implementation of such policies. The Limited knowledge of providers about the content

of the policy prevent them from carrying out needed activities to ensure that the policy meets its set targets. Adolescents who have no knowledge about the kind of services being planned for them have little or no expectations of their service providers. This is related to the findings of the assessment of the Kenya adolescent development policy (Population Reference Bureau, 2013) and the assessment in Bangladesh (Ainul et al., 2017) which reported that, the low level of knowledge adolescents had about policies and services influenced the way the policies were smoothly implemented. A corroborating study also reported lack of awareness of services and facilities developed through the adolescent health policy as a barrier to effective policy implementation to enhance services (Appiah, Badu, Dapaah, Takyi, & Abubakari, 2015). Other findings enhancing the limited knowledge about the policy was the unavailability of copies of the policy at the health directorate and other health facilities and the limited dissemination of the policy document.

One major barrier hindering the implementation of the policy was the less support service providers received from various community actors. Actors in the communities such as the chiefs, teachers, assembly members, parents, religious and traditional leaders and opinion leaders serve as an important point of contact to young people in communities. These group of people are needed to organize young people in communities for various activities conducted by health providers and other implementors. This is highlighted by the Population Reference Bureau, 2013 assessment report in Kenya also as a barrier of adolescent policy implementation.

The study further found inadequate financial resources and logistics as a strong barrier that halts various implementation activities. Funds are needed to cater for printing and dissemination of policy documents to ensuring that each strategy contained in the policy sees fruition. The inadequacy of these funds negatively affects the implementation process. The limited funds and logistics put pressure on service providers to sometimes provide adolescent services at their own

financial expense. Other studies have reported same findings (Abuosi & Anaba, 2019; Ainul et al., 2017; Calvès, 2002; Deogan, Ferguson, & Stenberg, 2012; Population Reference Bureau, 2013) and held that, adolescent policy implementation at various stages are hindered by the inadequacy and unavailability of financial and other resource to carry out designed projects.

The number of staffs trained and available to provide services to adolescents at the corners have not been encouraging from the earlier findings of the study. This in turn was reported as a barrier to the provision of planned services in the policy document to adolescents. Corners lack the adequate staff strength to manage the youth corners, perform school visits and organize social mobilization activities and durbars. The shared responsibilities where providers as the youth corners double as general hospital staff places extra burden such providers and most often get overwhelmed with excessive work load. Similar barriers were shared in the adolescent health policy evaluation of the Kenya (Population Reference Bureau, 2013) and Bangladesh (Ainul et al., 2017). Implementation of policy activities are delayed due to inadequate managerial support. Prioritization of AYFHS, budgeting and allocation of funds, capacity building of staffs at AYFHS units have less attention when management is unable to give equal attention to Adolescent health services just as other parts of the health service as captured by other studies in the United States (Hallum-montes, Middleton, Schlanger, & Romero, 2016).

Operation hours of AYFHS units in the health facilities are not favourable to allow young people to participate in adolescents' meetings at youth corners in the health facilities. Adolescents fora meetings provide the opportunity for young people to share their concerns and suggestions on AYFHS. It is a platform created for young people to contribute to adolescent health service delivery and enhance the implementation of the "new policy" that emphasizes on young people engagement in their own health status. Similar findings have been reported by the assessment of

other adolescent health policies (Abuosi & Anaba, 2019; Ainul et al., 2017; Population Reference Bureau, 2013).

The major facilitator in the implementation of the “new policy” is continuous advocacy among all stakeholders in the communities. Advocacy activities such as community durbars draws the attention of community leaders, parents and teachers, religious leaders, CSOs/NGOs on the important of Adolescent friendly health services and the need for collaborative action to achieve policy set objectives. These attentions have led to the creation of new youth corners in the communities.

5.5 Study limitations

The study was limited to adolescents attending youth corners in the health facilities excluding other communities and school clubs that could have other perspectives. The study was female biased due to unavailability of males.

The challenges encountered in the study were that, some service providers were unavailable to participate in the study. Some records could not be traced for verification.

CHAPTER SIX CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The study revealed that, radio, television, hospitals, schools, the internet and parents as the sources of information on Adolescent health services. Adolescent clubs set up in schools and other social mobilization activities conducted in AYFHS units and community were also identified as sources of relevant information. SBCC materials offers adequate information to adolescents relevant to their needs.

Majority of service providers have been trained in adolescent health service provision and have been describe by adolescents as good, opened and professional as compared to other service providers in other units of the health facilities aside the AYFHS unit. Generally, AYFHS units are understaffed and or staffs are over-burdened as majority run shifts at AYFHS units and other units concurrently.

Although some institutions like NGOs, schools, have been identified to support AYFHS, there are very few community actors' groups, young people peer educators hence a weak partnership and collaboration among young people, and their communities in the delivery and utilization of adolescent health services.

Participants from the study perceived that lack of awareness of the policy, limited dissemination of policy documents, Inadequate support from community actors, low involvement of adolescents, inadequate financial resources and other logistics, inadequate Staff, inadequate managerial support, operating hours of AYFHS as barriers of implementation of the policy.

Policy implementors in the metropolis believed continuous advocacy and stakeholder engagements is a facilitating factor in the implementation of the Adolescent health service policy and strategy.

6.2 Recommendations

Policy Makers

1. Increase dissemination of policy documents, plan of action for implementation, training guidelines and other relevant documents to the lowest level of service delivery.
2. Regular printing of new and relevant SBCC materials into local languages.

Metropolitan Health Directorate

3. Prioritizing capacity building and recruitment of staffs specifically for AYFHS units.
4. Increase recruiting of adolescents to engage in planning, implementation and provision of AYFHS.
5. Adequate allocation of funds to support AYFHS units especially in social mobilization activities in schools and communities.
6. Provision of logistics and equipment to facilitate implementation of the policy.
7. Operating hours should be extended by introducing weekend shifts to make it convenient for young people.
8. Increase awareness on the policy and its content among service providers and other relevant stakeholders.
9. Increase formation of community actors' groups to promote partnership and inter-sectoral collaboration.

Research

10. Further researches should be conducted in other parts of the country and should consider using quantitative methods in studying adolescents.
11. Future research should be conducted to evaluate other objectives of the policy and consider interviewing policy makers.

REFERENCES

- Abuosi, A. A., & Anaba, E. A. (2019). *Barriers on access to and use of adolescent health services in Ghana*. 33(3), 197–207. <https://doi.org/10.1108/JHR-10-2018-0119>
- Ainul, S., Ehsan, I., Tanjeen, T., & Reichenbach, L. (2017). *Adolescent Friendly Health Corners (AFHCs) in Selected Government Health Facilities in Bangladesh : An Early Qualitative Assessment*. Retrieved from <http://evidenceproject.popcouncil.org/resource/adolescent-friendly-health-corners-afhcs-in-selected-government-health-facilities-in-bangladesh-an-early-qualitative-assessment/>
- Anaba, E. A., & Abuosi, A. A. (2018). Assessing health care quality in adolescent clinics, implications for quality improvement. *International Journal of Health Governance*, 23(4), 269–280. <https://doi.org/10.1108/IJHG-03-2018-0012>
- Aninanya, G. A., Debpuur, C. Y., Awine, T., Williams, J. E., Hodgson, A., & Howard, N. (2015). Effects of an adolescent sexual and reproductive health intervention on health service usage by young people in northern Ghana: A community-randomised trial. *PLoS ONE*, 10(4), 1–16. <https://doi.org/10.1371/journal.pone.0125267>
- Appiah, S. C. yaw, Badu, E., Dapaah, J. M., Takyi, H., & Abubakari, M. (2015). *Youth friendliness of sexual and reproductive health service delivery and service utilization in the Kwadaso Sub-Metro of the Ashanti Region , Ghana*. 10(2), 716–725.
- Awusabo-Asare, K., Abane, A., & Kumi-Kyereme, A. (2004). “*Adolescent Sexual and Reproductive Health in Ghana: A Synthesis of Research Evidence*.” New York. www.guttmacher.org.
- Biddlecom, A. E., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents’ views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health*, 11(3), 99–110. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/18458737>
- Calvès, A.-E. (2002). *ASSESSING ADOLESCENT REPRODUCTIVE HEALTH POLICIES AND PROGRAMS Case Studies from Burkina Faso, Cameroon, and Togo*.
- Curtis, A. C. (2015). Defining Adolescence. *Journal of Adolescent and Family Health*, 7(2), 1–39. <https://doi.org/http://scholar.utc.edu/jafh/vol7/iss2/2/>
- Deogan, C., Ferguson, J., & Stenberg, K. (2012). *Resource Needs for Adolescent Friendly Health Services : Estimates for 74 Low- and Middle-Income Countries*. 7(12). <https://doi.org/10.1371/journal.pone.0051420>
- Eliason, S. R., Mortimer, J. T., & Vuolo, M. (2015). The Transition to Adulthood: Life Course Structures and Subjective Perceptions. *Social Psychology Quarterly*, 78(3), 205–227. <https://doi.org/10.1177/0190272515582002>
- Esmaeilzadeh, S., Ashrafi-rizi, H., Shahrzadi, L., & Mostafavi, F. (2018). *A survey on adolescent health information seeking behavior related to high-risk behaviors in a selected educational district in Isfahan*. 1–14.
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). *Comparison of Convenience Sampling and*

- Purposive Sampling*. 5(1), 1–4. <https://doi.org/10.11648/j.ajtas.20160501.11>
- Ettel, G., Nathanson, I., Ettel, D., Wilson, C., & Meola, P. (2012). *How Do Adolescents Access Health Information ? And Do They Ask Their Physicians ?* 16(1), 35–38.
- Fine, A., & Large, R. (2005). *A Conceptual Framework for Adolescent Health*. Retrieved from <http://www.amchp.org/programsandtopics/AdolescentHealth/Documents/conc-framework.pdf>
- Fisher, C., Reece, M., Wright, E., Dodge, B., Sherwood-Laughlin, C., & Baldwin, K. (2011). The Role of Community-Based Organizations in Adolescent Sexual Health Promotion. *Health Promotion Practice*, 13, 544–552. <https://doi.org/10.1177/1524839910390359>
- Gauducheau, N. (2016). An exploratory study of the information-seeking activities of adolescents in a discussion forum. *Journal of the Association for Information Science and Technology*, 67(1), 43–55. <https://doi.org/10.1002/asi.23359>
- Geary, R. S., Webb, E. L., Clarke, L., & Norris, S. A. (2015). *Evaluating youth-friendly health services: young people’s perspectives from a simulated client study in urban South Africa*. 1, 1–9.
- Ghana AIDS Commission. (2017). *Ghana AIDS Commission National and Sub-National HIV and AIDS Estimates and Projections Report*. 10–11.
- Ghana Health Service. (2013). *2013 ANNUAL REPRODUCTIVE AND CHILD HEALTH REPORT*. Accra.
- Ghana Health Service. (2015). *Family Health Division Report 2015*. Ghana Health Service (GHS). Retrieved from http://www.ghanahealthservice.org/downloads/2015_FAMILY_HEALTH_DIVISION_ANNUAL_REPORT.pdf
- Ghana Health Service. (2016). *Family Health Division Annual Report 2016*. Retrieved from https://www.ghanahealthservice.org/downloads/FHD_2016_ANNUAL_REPORT_Final_June 19.2017 nat final.pdf
- Ghana News Agency. (2012). GHS develops strategic plan to address adolescent health problems in Ghana. Retrieved January 15, 2019, from <http://www.ghananewsagency.org/health/ghs-develops-strategic-plan-to-address-adolescent-health-health-problems-in-ghana--46879>
- Ghana Statistical Service. (2014). *2010 Population & Housing Census: District Analytical Report: Tema Metropolitan*. Accra, Ghana. Retrieved from www.statsghana.gov.gh.
- GHS. *Adolescent Health Service Policy and Strategy 2016-2020*. , (2016).
- Glover, E. K., Bannerman, A., Pence, B. W., Jones, H., Miller, R., Weiss, E., & Nerquaye-Tetteh, J. (2003). Sexual Health Experiences of Adolescents in Three Ghanaian Towns. *International Family Planning Perspectives*, 29(1), 32–40. Retrieved from <https://www.guttmacher.org/about/journals/ipsrh/2003/03/sexual-health-experiences-adolescents-three-ghanaian-towns>
- Greenberg, S. E., Davis, L., Tutt, C., & Katcher, T. (2017). Community Mobilization : A

- Community-Wide Approach to Promoting Adolescent Sexual Health. *Journal of Applied Research on Children*, 8(1).
- GSS. (2015). Ghana demographic health survey. *Demographic and Health Survey 2014*, 530. <https://doi.org/10.15171/ijhpm.2016.42>
- GSS. (2018). *Ghana Maternal Health Survey 2017: Key Indicators Report*. Accra, Ghana.
- Hallum-montes, R., Middleton, D., Schlanger, K., & Romero, L. (2016). Barriers and Facilitators to Health Center Implementation of Evidence-Based Clinical Practices in Adolescent Reproductive Health Services. *Journal of Adolescent Health*, 58(3), 276–283. <https://doi.org/10.1016/j.jadohealth.2015.11.002>
- Hesse, A., & Samba, A. (2006). *Comprehensive Reproductive Health in Ghana*. Retrieved from <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjO3vCmy9LjAhUOUhoKHwoNDCoQFjAAegQIARAC&url=https%3A%2F%2Fdawnnet.org%2Ffeminist-resources%2Fsites%2Fdefault%2Ffiles%2Farticles%2Fghana.pdf&usg=AOvVaw09-CHaBj1E8Lt6mpNu30Bg>
- Jaworska, N., & MacQueen, G. (2015). Adolescence as a unique developmental period. *Journal of Psychiatry and Neuroscience*, 40(5), 291–293. <https://doi.org/10.1503/jpn.150268>
- Kleinert, S., & Horton, R. (2016). Adolescent health and wellbeing: a key to a sustainable future. *The Lancet*, 387(10036), 2355–2356. [https://doi.org/10.1016/S0140-6736\(16\)30297-5](https://doi.org/10.1016/S0140-6736(16)30297-5)
- Kleintjes, S., Lund, C., & Flisher, A. J. (2010). *A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia*. *African journal of psychiatry* (Vol. 13). <https://doi.org/10.4314/ajpsy.v13i2.54360>
- Kumi-kyereme, A., & Awusabo-asare, K. (2007). Adolescents' Sexual and Reproductive Health : Qualitative Evidence from Ghana Ann Biddlecom. *Health Care*, (30).
- Limbu, P., Mehta, M., Connor, H. J., Dham, S., & Chakravarty, S. (2015). *Empowering Adolescents To Take Charge Of Their Reproductive And Sexual Health Through A Multisectoral , Multipronged Awareness Campaign In Jharkhand , INDIA*. (November), 2015.
- Mazur, A., Brindis, C. D., & Decker, M. J. (2018). Assessing youth-friendly sexual and reproductive health services: A systematic review. *BMC Health Services Research*, 18(1), 1–12. <https://doi.org/10.1186/s12913-018-2982-4>
- Mcintyre, P., & Williams, A. (2003). *Adolescent Friendly Health Services An Agenda for Change Adolescent Friendly Health Services — An Agenda for Change written for the WHO by*. <https://doi.org/10.4274/tpa.46.20>
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks, CA: Sage Publications.
- Odendaal, W., Atkins, S., & Lewin, S. (2016). Multiple and mixed methods in formative

- evaluation: Is more better? Reflections from a South African study. *BMC Medical Research Methodology*, 16(1), 173. <https://doi.org/10.1186/s12874-016-0273-5>
- Odoi, A. N. K. (2017). *Utilisation Of Youth-Friendly Health Services Among Adolescents In The Tema Metropolis*. University of Ghana. <https://doi.org/10.1038/253004b0>
- Panahi, S. (2015). Role of parents, Teachers, and Community in Adolescents` issues. . . *Unique Journal of Pharmaceutical and Biological Sciences*.
- Patton, G. C., & Sawyer, S. M. (2014). Adolescent Health Globally: Issues and Challenges. In *Nestlé Nutrition Institute Workshop Series* (Vol. 80, pp. 1–14). <https://doi.org/10.1159/000360147>
- Patton, G., Coffey, C., Sawyer, S. M., Viner, R. M., Haller, D. M., Bose, K., ... Mathers, C. D. (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *The Lancet*, 374(9693), 881–892. [https://doi.org/https://doi.org/10.1016/S0140-6736\(09\)60741-8](https://doi.org/https://doi.org/10.1016/S0140-6736(09)60741-8)
- Population Reference Bureau. (2013). *Kenya Adolescent Reproductive Health and Development Policy (Implementation Assesemnt Report)*. Retrieved from <https://www.prb.org/kenya-policy-assessment-report/>
- Quarshie, E. N. B., Osafo, J., Akotia, C. S., & Peprah, J. (2015). Adolescent suicide in Ghana: A content analysis of media reports. *International Journal of Qualitative Studies on Health and Well-Being*, 10, 1–13. <https://doi.org/10.3402/qhw.v10.27682>
- Sawyer, S. M., Azzopardi, P., Wickremarathne, D., & Patton, G. (2018). The Age of Adolescence. *The Lancet Child and Adolescent Health*, 2(3).
- Settersten, R. A., Ottusch, T. M., & Schneider, B. (2015). Becoming Adult : Meanings of Markers to Adulthood. *Emerging Trends in the Social and Behavioral Sciences: An Interdisciplinary, Searchable, and Linkable Resource.*, 1–16.
- Shikha, K. (2015). Adolescence: The stage of transition. *Horizons of Holistic Education*, 2(September), 233–250. Retrieved from https://www.researchgate.net/publication/285299181_ADOLESCENCE_THE_STAGE_OF_TRANSITION
- Steinberg, L. (2014). *Age of opportunity: Lessons from the new science of adolescence*. Retrieved from https://books.google.com.gh/books/about/Age_of_Opportunity.html?id=sppdBAAQBAJ&printsec=frontcover&source=kp_read_button&redir_esc=y#v=onepage&q&f=false
- Tegegn, A., & Birhanu, Y. (2009). Adolescent Reproductive Health Services in Jimma city, Accessibility and Utilization. *Ethiop Journal of Health Science*, 19, 91–102. <https://doi.org/10.4314/ejhs.v19i2.69414>
- Thomé, S., Malm, D., Christianson, M., Hurtig, A., Wiklund, M., Waenerlund, A., & Goicolea, I. (2016). Challenges and strategies for sustaining youth-friendly health services — a qualitative study from the perspective of professionals at youth clinics in northern Sweden. *Reproductive Health*, 1–13. <https://doi.org/10.1186/s12978-016-0261-6>

- UNFPA. (2018). *The state of the World's Population*. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwiqt5KkwdLjAhWnxoUKHbxPCAUQFjAAegQIAhAC&url=https%3A%2F%2Fwww.unfpa.org%2Fsites%2Fdefault%2Ffiles%2Fpub-pdf%2FUNFPA_PUB_2018_EN_SWP.pdf&usg=AOvVaw32eAm0ft_FBEmuUfjIggdF
- UNICEF. (2011). Adolescence: An Age of Opportunity. <https://doi.org/423>
- UNICEF. (2016a). Adolescent Demographics. Retrieved from Monitoring the situation of children and women website: <https://data.unicef.org/topic/adolescents/demographics/>
- UNICEF. (2016b). *The State of the World's Children 2016: A fair chance for every child*. Retrieved from https://www.unicef.org/publications/index_91711.html
- WHO. (2017). *Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation*. Geneva.
- WHO. (2018). Adolescent pregnancy. Retrieved February 19, 2019, from Fact Sheet website: <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>
- Wisdom, J., & Creswell, J. W. (2013). Mixed Methods: Integrating Quantitative and Qualitative Data Collection and Analysis While Studying Patient-Centered Medical Home Models. In *PCMH Research Methods Series* (No. 13-0028-EF). Retrieved from <https://pcmh.ahrq.gov/page/mixed-methods-integrating-quantitative-and-qualitative-data-collection-and-analysis-while>
- World Health Organization. (2009). Quality Assessment Guidebook-A guide to assessing health services for adolescent clinics. *World Health Organization*. <https://doi.org/10.1108/eb043585>
- World Health Organization. (2015). *GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS Volume 2: Implementation guide. 2*.

APPENDICES

APPENDIX A: PARTICIPANT INFORMATION SHEETS, CONSENT AND ASSESNT FORMS

UNIVERSITY OF GHANA



PARTICIPANT INFORMATION SHEET FOR ADOLESCENTS, SERVICE PROVIDERS, MANAGERS OF YOUTH FRIENDLY CORNERS AND ADOLESCENT HEALTH SERVICES FOCAL PERSON

TITLE OF STUDY: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

INTRODUCTION: My name is Ivy Akushika Agbenu. A student of MSc. Public Health Monitoring and Evaluation at the University of Ghana, School of Public Health. I am the Principal Investigator (PI) for the above-mentioned study. My contact number is 0540529151 and my email is aivyakushika@gmail.com. This study is being conducted in partial fulfillment for the award of MSc. Public Health Monitoring and Evaluation degree.

BACKGROUND AND PURPOSE OF RESEARCH: Due to the importance of adolescents in the future of a nation, it has become necessary to consider the well-being of adolescents in order to drive national development. Adolescent friendly health services under the Adolescent Policy and strategy are currently available in several parts of the country to provide adolescent friendly services such as counselling, family planning services, Sexually Transmitted Infections (STIs) testing and safe motherhood to provide solutions to the many adolescent health issues confronted by the country. Since the inception of the Adolescent Health Service Policy and strategy 2016-2020, there is no available literature about a process evaluation of the policy and how effectively the strategies are being implemented. It is against this background that this study aims to evaluate the Adolescent Health Service Policy and Strategy 2016-2020 midway into its implementation.

NATURE OF RESEARCH: The study is a one-time study that will involve young people (10-24years) attending youth corners in health facilities in the Tema Metropolis, Service providers in the corners, managers of the youth friendly corners and the director and focal persons of Adolescent Health Service at the Tema Metropolitan Health Directorate. The study seeks to find the views of participants on the level and processes of implementation of the policy and also factors influencing implementation.

PARTICIPANTS INVOLVEMENT:

- **DURATION/ WHAT IS INVOLVED:** The study will take 30 to 45min to complete a questionnaire of sixteen (16) questions for young people (10-24years) and thirteen (13) questions for service providers. Another group of young people (10-24 years) who consent will take part in a focus group discussion that will take a maximum of 50min and also recorded for reference. Interviews which may be recorded for reference will be conducted for managers of the youth friendly corners and the director and focal persons of Adolescent Health Service at the Tema Metropolitan Health Directorate. Youth corners Activity Records books will also be reviewed.
- **POTENTIAL RISK:** The study does not pose any risk however 30 to 50 minutes of your time will be spent in participating in this study
- **BENEFIT:** This study will not provide you any direct benefit, however findings from this study will contribute to general health knowledge. The information obtained from this study will help to improve on the efficient implementation of the policy hence the improvement on adolescent health status at a long run.
- **COST:** There will not be any form of cost incurred by you.
- **COMPENSATION:** You will not receive any form of gift or compensation however your time taken for participation will be appreciated.
- **CONFIDENTIALITY:** Data collected is for only research purposes and will be held in confidence. Information and voice recordings will be stored on computers with passwords and filled questionnaires safely locked in a drawer. Access will be limited to only the researcher and research supervisor. Your name and other details of your identity are not needed for the study. However, the information you would provide is going to be identified by a special code and would be treated strictly as confidential. We assure you that your name shall not appear or be mentioned in any report that might come out from this study.
- **VOLUNTARY PARTICIPATION/WITHDRAWAL:** Participating in this study is completely voluntary. You have the right to refuse answering any question we ask you and you may stop or end the interview at any point in time. You may also withdraw your participation at any time of the study without losing anything or getting any form of penalty.
- **OUTCOME AND FEEDBACK:** The outcome of the study will be disseminated to the Tema metropolitan health directorate to be communicated to the staffs of youth corners in the metropolis. Findings will be published to increase health knowledge.
- **FUNDING INFORMATION:** The study is solely sponsored by the PI.
- **SHARING OF PARTICIPANTS INFORMATION/ DATA:** The data will be owned by the principal investigation and the Tema metropolitan health directorate. Only group information and not individual information will be shared.

- **PROVISION OF INFORMATION AND CONSENT FOR PARTICIPANTS:** You will be given a copy of the information sheet and the consent form after you have agreed and signed to take part in this research.

- **WHO TO CONTACT FOR FURTHER CLARIFICATION/QUESTIONS:**

1. If you have questions about the research please contact the principal investigator and supervisor on this address:

Ivy Akushika Agbenu (Principal Investigator)
University of Ghana, SPH
P. O. Box LG 25
Legon, Accra
(0540529151/ aivyakushika@gmail.com)

Dr. Genevieve Cecilia Aryeetey (Supervisor)
0244865387

2. For further clarification on ethical issues and your right as participants please contact the Ghana Health Service Ethics Review Committee Administrator:

Madam Hannah Frimpong
P. O. BOX MB 190, Accra
0507041223

UNIVERSITY OF GHANA



**PARTICIPANT INFORMATION SHEET FOR PARENTS/ GAURDIANS OF
ADOLESCENTS (10-14 YEARS)**

TITLE OF STUDY: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

INTRODUCTION: My name is Ivy Akushika Agbenu. A student of MSc. Public Health Monitoring and Evaluation at the University of Ghana, School of Public Health. I am the Principal Investigator (PI) for the above-mentioned study. My contact number is 0540529151 and my email is aivyakushika@gmail.com. This study is being conducted in partial fulfillment for the award of MSc. Public Health Monitoring and Evaluation degree.

BACKGROUND AND PURPOSE OF RESEARCH: Due to the importance of adolescents in the future of a nation, it has become necessary to consider the well-being of adolescents in order to drive national development. Adolescent friendly health services under the Adolescent Policy and strategy are currently available in several parts of the country to provide adolescent friendly services such as counselling, family planning services, Sexually Transmitted Infections (STIs) testing and safe motherhood to provide solutions to the many adolescent health issues confronted by the country. Since the inception of the Adolescent Health Service Policy and strategy 2016-2020, there is no available literature about a process evaluation of the policy and how effectively the strategies are being implemented. It is against this background that this study aims to evaluate the Adolescent Health Service Policy and Strategy 2016-2020 midway into its implementation.

NATURE OF RESEARCH: The study is a one-time study that will involve young people (10-24years) attending youth corners in health facilities in the Tema Metropolis, Service providers in the corners, managers of the youth friendly corners and the director and focal persons of Adolescent Health Service at the Tema Metropolitan Health Directorate. The study seeks to find the views of participants on the level and processes of implementation of the policy and also factors influencing implementation.

PARTICIPANTS INVOLVEMENT:

- **DURATION/ WHAT IS INVOLVED:** The study will take 30 to 45min to complete a questionnaire of sixteen (16) questions for young people (10-24years) and thirteen (13) questions for service providers. Another group of young people (10-24 years) who consent will take part in a focus group discussion that will take a maximum of 50min and also recorded for reference. Interviews which may be recorded for reference will be conducted for managers of the youth friendly corners and the director and focal persons of Adolescent

Health Service at the Tema Metropolitan Health Directorate. Youth corners Activity Records books will also be reviewed.

- **POTENTIAL RISK:** The study does not pose any risk however 30 to 50 minutes of your child's time will be spent in participating in this study
- **BENEFIT:** This study will not provide your child any direct benefit, however findings from this study will contribute to general health knowledge. The information obtained from this study will help to improve on the efficient implementation of the policy hence the improvement on adolescent health status at a long run.
- **COST:** There will not be any form of cost incurred by you or your child.
- **COMPENSATION:** Your child will not receive any form of gift or compensation however your child's time taken for participation will be appreciated.
- **CONFIDENTIALITY:** Data collected is for only research purposes and will be held in confidence. Information and voice recordings will be stored on computers with passwords and filled questionnaires safely locked in a drawer. Access will be limited to only the researcher and research supervisor. Your child's name and other details of his/her identity are not needed for the study. However, the information he/she would provide is going to be identified by a special code and would be treated strictly as confidential. We assure you that his/her name shall not appear or be mentioned in any report that might come out from this study.
- **VOLUNTARY PARTICIPATION/WITHDRAWAL:** Participating in this study is completely voluntary. Your child has the right to refuse answering any question we ask and may stop or end the interview at any point in time. He/she may also withdraw his/her participation at any time of the study without losing anything or getting any form of penalty.
- **OUTCOME AND FEEDBACK:** The outcome of the study will be disseminated to the Tema metropolitan health directorate to be communicated to the staffs of youth corners in the metropolis. Findings will be published to increase general health knowledge.
- **FUNDING INFORMATION:** The study is solely sponsored by the PI.
- **SHARING OF PARTICIPANTS INFORMATION/ DATA:** The data will be owned by the principal investigation and the Tema metropolitan health directorate. Only group information and not individual information will be shared.
- **PROVISION OF INFORMATION AND CONSENT FOR PARTICIPANTS:** You and your child will be given a copy of the information sheet and the consent form after you have agreed and signed for him/her to take part in this research.

• **WHO TO CONTACT FOR FURTHER CLARIFICATION/QUESTIONS:**

1. If you have questions about the research please contact the principal investigator and supervisor on this address:

Ivy Akushika Agbenu (Principal Investigator)
University of Ghana, SPH
P. O. Box LG 25
Legon, Accra
(0540529151/aivyakushika@gmail.com)

Dr. Genevieve Cecilia Aryeetey (Supervisor)
0244865387

2. For further clarification on ethical issues and your right as participants please contact the Ghana Health Service Ethics Review Committee Administrator:

Madam Hannah Frimpong
P. O. BOX MB 190
Accra
0507041223

ASSENT FORM FOR ADOLESCENTS 10-17 YEARS OLD

STUDY TITLE: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

PARTICIPANT'S STATEMENT

I acknowledged that I have read or have the purpose and content of the participant's information sheet read and explained to me. I have been given the opportunity to ask questions about the research and all questions have been answered to my satisfaction in English [], Twi [], Ga [], Ewe []. I fully understand the content and any potential implications as well as my right to change my mind (withdraw from the research) even after I have signed this form. I voluntarily agree to participate in this study.

I agree for my voice to be recorded Yes [] No []

.....
Name/Initials of Adolescent ID Code

.....
Participants Signature/ Thumbprint Date

INTERPRETER'S STATEMENT

I interpreted the purpose and content of the participant's information to the aforementioned participant to the best of my ability in the (Twi [] Ga [], Ewe []) language to the participant understanding. All questions and clarifications sought by the participants were duly interpreted.

.....
Name of Interpreter Signature of interpreter Date

STATEMENT OF WITNESS

I was present when the purpose and content of the participant's information sheet was read and explained satisfactorily to the participant in the (Twi [] Ga [], Ewe []) language. I confirm that he/she was given the opportunity to seek clarification and ask questions that were duly answered to his/her satisfaction before voluntarily agreeing to be part of the study.

.....
Name of witness Signature/ thumbprint of witness Date

INVESTIGATOR'S STATEMENT

I certify that the participant has been given ample time to read and learn about the above study. All questions and clarification raised by the participant have been addressed.

.....
Researcher's name Signature of researcher Date

PARENTAL CONSENT FORM FOR ADOLESCENTS 10-17 YEARS OLD

STUDY TITLE: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

PARTICIPANT'S STATEMENT

I acknowledged that I have read or have the purpose and content of the participant's information sheet read and explained to me. I have been given the opportunity to ask questions about the research and all questions have been answered to my satisfaction in English [], Twi [], Ga [], Ewe []. I fully understand the content and any potential implications as well as my child's right to change his/her mind (withdraw from the research) even after I have signed this form. I voluntarily agree that my child should participate in this study.

I agree for her voice to be recorded Yes [] No []

.....
Name/Initials of Parent/Guardian of Adolescent Name/Initial of Adolescent / ID Code

.....
Parents Signature/ Thumbprint Date

INTERPRETER'S STATEMENT

I interpreted the purpose and content of the participant's information to the aforementioned parent to the best of my ability in the (Twi [], Ga [], Ewe []) language to the participant understanding. All questions and clarifications sought by the child's parent were duly interpreted.

.....
Name of Interpreter Signature of interpreter Date

STATEMENT OF WITNESS

I was present when the purpose and content of the participant's information sheet was read and explained satisfactorily to the participant's parents in the (Twi [] Ga [], Ewe []) language. I confirm that he/she was given the opportunity to seek clarification and ask questions that were duly answered to his/her satisfaction before voluntarily agreeing for the child to be part of the study.

.....
Name of witness Signature/ thumbprint of witness Date

INVESTIGATOR'S STATEMENT

I certify that the child's parent has been given ample time to read and learn about the above study. All questions and clarification raised by the child's parent have been addressed.

.....
Researcher's name Signature of researcher Date

CONSENT FORM FOR ADOLESCENTS 18-24 YEARS OLD

STUDY TITLE: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

PARTICIPANT'S STATEMENT

I acknowledged that I have read or have the purpose and content of the participant's information sheet read and explained to me. I have been given the opportunity to ask questions about the research and all questions have been answered to my satisfaction in English [], Twi [], Ga [], Ewe []. I fully understand the content and any potential implications as well as my right to change my mind (withdraw from the research) even after I have signed this form. I voluntarily agree to participate in this study.

I agree for my voice to be recorded Yes [] No []

.....
Name/Initials of Adolescent ID Code

.....
Participants Signature/ Thumbprint Date

INTERPRETER'S STATEMENT

I interpreted the purpose and content of the participant's information to the aforementioned participant to the best of my ability in the (Twi [] Ga [], Ewe []) language to the participant understanding. All questions and clarifications sought by the participants were duly interpreted.

.....
Name of Interpreter Signature of interpreter Date

STATEMENT OF WITNESS

I was present when the purpose and content of the participant's information sheet was read and explained satisfactorily to the participant in the (Twi [] Ga [], Ewe []) language. I confirm that he/she was given the opportunity to seek clarification and ask questions that were duly answered to his/her satisfaction before voluntarily agreeing to be part of the study.

.....
Name of witness Signature/ thumbprint of witness Date

INVESTIGATOR'S STATEMENT

I certify that the participant has been given ample time to read and learn about the above study. All questions and clarification raised by the participant have been addressed.

.....
Researcher's name Signature of researcher Date

CONSENT FORM FOR EMANCIPATED ADOLESCENTS 10-17 YEARS OLD

STUDY TITLE: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

PARTICIPANT'S STATEMENT

I acknowledged that I have read or have the purpose and content of the participant's information sheet read and explained to me. I have been given the opportunity to ask questions about the research and all questions have been answered to my satisfaction in English [], Twi [], Ga [] Ewe []. I fully understand the content and any potential implications as well as my right to change my mind (withdraw from the research) even after I have signed this form.

I voluntarily agree to participate in this study.

I agree for my voice to be recorded Yes [] No []

.....
Name/Initials of Adolescent ID Code

.....
Participants Signature/ Thumbprint Date

INTERPRETER'S STATEMENT

I interpreted the purpose and content of the participant's information to the aforementioned participant to the best of my ability in the (Twi [] Ga [] Ewe []) language to the participant understanding. All questions and clarifications sought by the participants were duly interpreted.

.....
Name of Interpreter Signature of interpreter Date

STATEMENT OF WITNESS

I was present when the purpose and content of the participant's information sheet was read and explained satisfactorily to the participant in the (Twi [] Ga [] Ewe []) language. I confirm that he/she was given the opportunity to seek clarification and ask questions that were duly answered to his/her satisfaction before voluntarily agreeing to be part of the study.

.....
Name of witness Signature/ thumbprint of witness Date

INVESTIGATOR'S STATEMENT

I certify that the participant has been given ample time to read and learn about the above study. All questions and clarification raised by the participant have been addressed.

.....
Researcher's name Signature of researcher Date

CONSENT FORM FOR MANAGERS IN-CHARGE OF YOUTH FRIENDLY CORNERS

STUDY TITLE: Evaluation of the Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis.

PARTICIPANT’S STATEMENT

I acknowledged that I have read the purpose and content of the participant’s information sheet. I have been given the opportunity to ask questions about the research and all questions have been answered to my satisfaction in English. I fully understand the content and any potential implications as well as my right to change my mind (withdraw from the research) even after I have signed this form.

I voluntarily agree to participate in this study.

I agree for my voice to be recorded Yes [] No []

.....
Name/Initials of Managers In-charge of Youth friendly corners ID Code

.....
Participants Signature/ Thumbprint Date

INVESTIGATOR’S STATEMENT

I certify that the participant has been given ample time to read and learn about the above study. All questions and clarification raised by the participant have been addressed.

.....
Researcher’s name Signature of researcher Date

**APPENDIX B: QUESTIONNAIRES AND GUIDES
FOCUS GROUP DISCUSSION GUIDE FOR YOUNG PEOPLE**



**University of Ghana
School of Public Health**

Questionnaire Code: Date: Facility: H/C

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age _____		2. Sex [0] Male <input type="checkbox"/> [[1] Female <input type="checkbox"/>	
3. What is your Highest educational level?			
[0] None <input type="checkbox"/>	[1] Primary <input type="checkbox"/>	[2] Junior High <input type="checkbox"/>	[3] Senior High <input type="checkbox"/> [4] Tertiary <input type="checkbox"/> [5] Other.....
4. What is your marital status?			
[1] Married <input type="checkbox"/>	[2] Single <input type="checkbox"/>	[3] Divorced <input type="checkbox"/>	[4] Widowed <input type="checkbox"/> [5] Co-habiting <input type="checkbox"/> [6] Other
5. What is your Religion?			
[1] Christianity <input type="checkbox"/>	[2] Islam <input type="checkbox"/>	[3] Traditional <input type="checkbox"/>	[4] Other.....

(II) ACCESS TO ADOLESCENT YOUTH FRIENDLY HEALTH INFORMATION

1. How do you obtain educational information on Adolescent Health and Services?
 - a. Could you list the sources?
2. How will you describe the amount of information provided for you at the Youth Friendly Corners by the provider?
3. How will you describe the IEC/BCC materials in terms of the content?
4. What about the availability of the IEC / BCC in case you want to read or send it home?

(III) III. CAPACITY OF SERVICE PROVIDERS IN THE HEALTH FACILITY

1. Can you describe the way and manner the health care provider treated you?
2. How will you describe the time the provider spent with you?
3. What is your opinion about the performance of the service provider with respect to the service delivery?

(IV) IV. PARTNERSHIP AMONG ADOLESCENTS AND YOUNG PEOPLE, HEALTH INSTITUTIONS AND COMMUNITIES IN THE PROVISION AND UTILIZATION OF AYFHS

1. What are the opportunities (aside interacting with service providers when seeking care) you get to share ideas with one another and the service providers?
 - a. How often do you get the opportunity?
2. What are the means you use to share ideas with one another and the service providers?
3. Describe who is a peer educator and give example of one you know.
4. Discuss the role of peer educators?

QUESTIONNAIRE FOR HEALTH SERVICE PROVIDER



**University of Ghana
School of Public Health**

Questionnaire Code: Date: Facility:

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age _____	2. Sex [0] Male <input type="checkbox"/> [1] Female <input type="checkbox"/>
3. What is your Highest educational level? [0] None <input type="checkbox"/> [1] Primary <input type="checkbox"/> [2] Junior High <input type="checkbox"/> [3] Senior High <input type="checkbox"/> [4] Tertiary <input type="checkbox"/> [5] Other.....	
4. What is your marital status? [1] Married <input type="checkbox"/> [2] Single <input type="checkbox"/> [3] Divorced <input type="checkbox"/> [4] Widowed <input type="checkbox"/> [5] Co-habiting <input type="checkbox"/> [6] Other	
5. What is your Religion? [1] Christianity <input type="checkbox"/> [2] Islam <input type="checkbox"/> [3] Traditional <input type="checkbox"/> [4] Other.....	

II. ACCESS TO ADOLESCENT YOUTH FRIENDLY HEALTH INFORMATION

6. Are behaviour change communication/information, education and communication (bcc/iec) materials on ADHD/AYFHS available in the health facility? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
7. Do you give out IEC materials on ADHD/AYFHS to adolescents? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>

III. CAPACITY OF SERVICE PROVIDERS IN THE HEALTH FACILITY

8. Have you been trained in AYFHS provision? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
9. Which fields did you receive training in? (<i>tick as many as apply</i>) [1] Health promotion and advocacy <input type="checkbox"/> [2] Counselling <input type="checkbox"/> [3] General services <input type="checkbox"/> [4] STI/HIV <input type="checkbox"/> [5] Reproductive health <input type="checkbox"/> [6] Other.....
10. Is there any orientation program for new health personnel in AYFHS? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>

IV. PARTNERSHIP AMONG ADOLESCENTS AND YOUNG PEOPLE, HEALTH INSTITUTIONS AND COMMUNITIES IN THE PROVISION AND UTILIZATION OF AYFHS

11. Is there any adolescents and young people's forum for networking organized at health facility and in community?

[0] No [1] Yes

12. If yes how many times do you meet in a year

[1] Once [2] Twice [3] Thrice [4] More than 3

13. Are you aware of peer educators or young people contributing to decisions about how health services should be delivered to adolescent clients?

[0] No [1] Yes

V. WHAT ARE SOME OF YOUR CHALLENGES YOU ENCOUNTER IN IMPLEMENTING AHS POLICY AND STRATEGY?

Comments:

QUESTIONNAIRE FOR METROPOLITAN HEALTH DIRECTORATE



**University of Ghana
School of Public Health**

Questionnaire Code: **Date:**

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS	
1. Age _____	2. Sex [0] Male <input type="checkbox"/> [1] Female <input type="checkbox"/>
3	Professional background:
4	Duration of Service in this facility:
5	Number of years in service (in the health sector):

II. ACCESS TO ADOLESCENT YOUTH FRIENDLY HEALTH INFORMATION	
6. Do you know about the Adolescent Health Service Policy and Strategy 2016-2020? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
7. Does the metropolis have requisition document available indicating procurement of IEC materials? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
8. Does the metropolis have a supply list of IEC materials to the sub-districts [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
9. How many training sessions and participants have you organized for the sub-districts? Number of sessions Number of Participants	
10. How many training sessions have you organized for the sub-district TOTS in the use of protocols and guidelines? Number.....	
III. CAPACITY BUILDING OF STAFF IN THE HEALTH FACILITY	
11. How many technical assistance visits have you conducted in the last quarter? Number	
12. What plans have you put in place to conduct refresher training? Number	

<p>IV. PARTNERSHIP AMONG ADOLESCENTS AND YOUNG PEOPLE, HEALTH INSTITUTIONS AND COMMUNITIES IN THE PROVISION AND UTILIZATION OF AYFHS</p>
<p>13. How many SHMTS have been oriented on the guidelines for community participation? Number</p>
<p>14. Have you held any stakeholders meeting at the municipal level within the last quarter? (Review Minutes of meetings) [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>15. Have you held review meetings on the organization and conduct of social groups meetings? (Review Minutes of meetings) [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>16. Do you involve adolescents in the preparation and implementation of AYFHS component of the local development plan at the district level? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>17. WHAT ARE THE FACTORS AFFECTING IMPLEMENTATION OF AHS POLICY?</p>
<p>V. WHAT ARE SOME RECOMMENDATIONS TO ENHANCE IMPLEMENTATION?</p>

Factors influencing the implementation of the AHS policy and strategy? (IN TERMS OF OBJECTIVE 1, 2 AND 3) EXAMPLES

1. What are some of the facilitators or barriers that influence access to adolescent youth friendly health service information and how to control and improve them?

.....

.....

.....
2. What are some of the facilitators or barriers that influence capacity building of staff in AYFHS and how you have planned to improved or control them?

.....

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3. What are some of the barriers or facilitators of fostering partnership among adolescents and young people, health institutions and communities in the provision and utilization of AYFHS and how you have controlled them or planning to?

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QUESTIONNAIRE FOR HEALTH FACILITY MANAGERS



**University of Ghana
School of Public Health**

Questionnaire Code: Date: Facility: Manhean

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age _____		2. Sex [0] Male <input type="checkbox"/> [1] Female <input type="checkbox"/>	
3	Professional background:		
4	Duration of Service in this facility:		
5	Number of years in service (in the health sector):		

II. ACCESS TO ADOLESCENT YOUTH FRIENDLY HEALTH INFORMATION

6. Are Adolescents and Youth Friendly Health Services (AYFHS) provided in this facility? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
7. Are Behaviour Change communication/Information, Education and communication (BCC/IEC) materials on adolescent health and development (ADHD)/AYFHS available in the health facility? (Standard 1) [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
8. Are the BCC/IEC materials displayed to adolescents? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
9. Are the BCC/IEC materials provided to adolescents	
a. To read at facility only	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
b. To take home	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
10. How many peer educators have been trained in ADHD within the last 12 months? Number	
11. Are peer educators providing education on ADHD at the health facility at least once in a month? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	

12. Are service providers providing AYFHS to adolescents & young people as per guidelines and protocols? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
13. Is there a plan on adolescent related social mobilisation? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
14. Are activities of adolescent related social mobilization being implemented as per the plan? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
III. CAPACITY BUILDING OF STAFF IN THE FACILITY	
15. How many health service providers provide AYFHS in this health facility (Standard 2)? Number	
16. Is there a system (induction program) to orient new health personnel posted to the facility in AYFHS? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
IV. PARTNERSHIP AMONG ADOLESCENTS AND YOUNG PEOPLE, HEALTH INSTITUTIONS AND COMMUNITIES IN THE PROVISION AND UTILIZATION OF AYFHS	
14. Is a forum for Adolescents and Young People in place a) in this health facility?	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
b) in the community?	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
15. Are young people meeting a) in this facility at least once in a month?	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
b) in the community at least quarterly?	[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>
16. Are adolescents & young people involved in planning of services? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
17. Is there a forum of community actors on ADHD (Traditional leaders, religious groups, teachers, Assemblymen/women, Media, CBOs/NGOs, young people) in place? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	
18. Are community members meeting regularly on ADHD (at least twice a year) as set out in the plan of the forum? [0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/>	

<p>19. What are the categories of these community members?</p> <p>[1] Traditional Leaders <input type="checkbox"/> [2] Religious Leaders <input type="checkbox"/> [3] Teachers <input type="checkbox"/> [4] CBOS/NGOS <input type="checkbox"/></p> <p>[5] Young People <input type="checkbox"/> [6] Media <input type="checkbox"/></p>
<p>20. Has the facility identified social groups to work with on issues related to Adolescent Health and Development?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>21. Is there a plan in place to meet with social groups in the community on issues related to adolescent health and development?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>22. Are plans to meet with social groups in the community being implemented?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>23. Do you provide information on health services on adolescent and young people to the community?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>24. Is the community involved in the planning of ADHD programmes?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>25. Are the planned ADHD programmes for the community implemented?</p> <p>[0] No <input type="checkbox"/> [1] Yes <input type="checkbox"/></p>
<p>26. What advocacy relating to adolescent health and development has been carried out in the community?</p> <p>.....</p> <p>.....</p>

What are the factors you think are influencing the implementation of the AHS policy and strategy? (IN TERMS OF OBJECTIVE 1, 2 AND 3) EXAMPLES

1. What are some of the facilitators or barriers that influence access to adolescent youth friendly health service information and how to control and improve them?

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.....
2. What are some of the facilitators or barriers that influence capacity building of staff in AYFHS and how you have planned to improved or control them?

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.....

3. What are some of the barriers or facilitators of fostering partnership among adolescents and young people, health institutions and communities in the provision and utilization of AYFHS and how you have controlled them or planning to?

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4. **What recommendations do you have to enhance implementation?**

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.....

APPENDIX C: CLEARANCE AND SUPPORTING LETTERS

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
9th August, 2019

MyRef. GHS/RDD/ERC/Admin/App
Your Ref. No. 19/344

Ivy Akushika Agbenu
The Community Hospital
P.O. Box LG 1041
Legon - Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-FRC Number	GHS-ERC 076/04/19
Project Title	Evaluation of Implementation of Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis
Approval Date	9 th August, 2019
Expiry Date	8 th August, 2020
GHS-ERC Decision	Approved

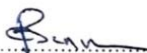
This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....


Dr. Cynthia Bannerman
(GHS-ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

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

My Ref. No. **GHS/GARHD/007/19**

Your Ref. No.



GHANA HEALTH SERVICES
REGIONAL HEALTH DIRECTORATE
GREATER ACCRA
P. O. BOX 184
ACCRA

Tel : 233-0302-234325-226703

E-mail: hsako@yahoo.com

12th June 2019

THE METRO DIRECTOR OF HEALTH SERVICES
TEMA METRO HEALTH DIRECTORATE
TEMA

RE: LETTER OF INTRODUCTION
IVY AKUSHIKA AGBENU

This is to introduce to you Ivy Akushika Agbenu MSc. Monitoring and Evaluation student of the Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon who has approval from the Regional Health Directorate to conduct a research on the topic: ***"Evaluation of the Implementation of the Adolescent Health Service Policy and Strategy (2016 – 2020) in the Tema Metropolis"*** in your District/Facility as per attached.

You are kindly entreated to provide the needed assistance.

Thank you.



DR. (MRS.) CHARITY SARPONG
REGIONAL DIRECTOR OF HEALTH SERVICES
GREATER ACCRA

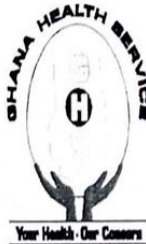
In case of reply the number and date of this letter should be quoted.

My Ref. No. GHS/MHD/

Your Ref. No.

GHS Core Values

- PEOPLE-CENTERED
- PROFESSIONALISM
- TEAMWORK
- INNOVATION/EXCELLENCE
- DISCIPLINE
- INTEGRITY



Tema Metro Health Directorate
GHANA HEALTH SERVICE
PRIVATE MAIL BAG
TEMA
Tel: 0302 975 715

26TH JUNE, 2019

**THE PUBLIC HEALTH SPECIALIST
MANHEAN HEALTH CENTRE
TEMA**


MANHEAN HEALTH CENTRE
RECEIVED
DATE 26/6/2019

LETTER OF INTRODUCTION
IVY AKUSHIKA AGBENU

This is to introduce to you **Ivy Akushika Agbenu** MSc. Monitoring and Evaluation student of the Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon who has approval from the Regional Health Directorate to conduct a research on the topic: **“Evaluation of the Implementation of the Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis”** in your Facility as per attached.

You are kindly entreated to provide the needed assistance.

Thank you.


MRS. JUDITH AMO-MENSAH
DEPUTY DIRECTOR OF NURSING SERVICES
For: METRO DIRECTOR OF HEALTH SERVICES
TEMA

Sen
Atty. J. DONS PAUL
Adolescent Health Unit
D. Dons
01-07-19

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

My Ref. No. GHS/MHD/

Your Ref. No.

GHS Core Values

- PEOPLE-CENTERED
- PROFESSIONALISM
- TEAM WORK
- INNOVATION/EXCELLENCE
- DISCIPLINE
- INTEGRITY



Tema Metro Health Directorate
GHANA HEALTH SERVICE
PRIVATE MAIL BAG
TEMA
Tel: 0302 975 715

26TH JUNE, 2019

**THE MEDICAL DIRECTOR
TEMA GENERAL HOSPITAL
TEMA**



LETTER OF INTRODUCTION
IVY AKUSHIKA AGBENU

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You are kindly entreated to provide the needed assistance.

Thank you.

**MRS. JUDITH AMO-MENSAH
DEPUTY DIRECTOR OF NURSING SERVICES
For: METRO DIRECTOR OF HEALTH SERVICES
TEMA**

*Hem/Hoa
Approved*

pls let her see me

*Jm
26/6/19*

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

My Ref. No. GHS/MHD/

Your Ref. No.

GHS Core Values

- PEOPLE-CENTERED
- PROFESSIONALISM
- TEAM WORK
- INNOVATION/EXCELLENCE
- DISCIPLINE
- INTEGRITY



Tema Metro Health Directorate
GHANA HEALTH SERVICE
PRIVATE MAIL BAG
TEMA
Tel: 0302 975 715

26TH JUNE, 2019

**THE SENIOR MEDICAL ASSISTANT
TMA MATERNITY AND CHILDREN'S CLINIC
TEMA**

LETTER OF INTRODUCTION
IVY AKUSHIKA AGBENU

This is to introduce to you **Ivy Akushika Agbenu** MSc. Monitoring and Evaluation student of the Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon who has approval from the Regional Health Directorate to conduct a research on the topic: **"Evaluation of the Implementation of the Adolescent Health Service Policy and Strategy (2016-2020) in the Tema Metropolis"** in your Facility as per attached.

You are kindly entreated to provide the needed assistance.

Thank you.

**MRS. JUDITH AMO-MENSAH
DEPUTY DIRECTOR OF NURSING SERVICES
For: METRO DIRECTOR OF HEALTH SERVICES
TEMA**