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**AN ASSESSMENT OF ADOLESCENT/YOUTH FRIENDLY
SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN THE
VOLTA REGION OF GHANA**

BY

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AWARD OF A MASTER OF PUBLIC HEALTH DEGREE.**

JULY, 2015

DECLARATION

I hereby declare that apart from specific references which have duly been acknowledged, this dissertation is my own work put together. I further declare that this dissertation has not been submitted for the award of any degree in this institution or other universities elsewhere.

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..



DEDICATION

I dedicate this research work to the Atiku family who, as in their usual role, have been my support and backbone through this programme. It is also to the memory of my late father, Mr. Felix Bill Komla Atiku. You were both the pathfinder and trail blazer. Remembering you makes me understand the reason why I must be like the hardy plant that strikes its root deep into the most unfavourable soil. This is my source of inspiration. It spurs me on to greater heights.



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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ADC H	Adolescent Client in Ho
ADC HHZ	Adolescent Client in Hohoe
ADC KHC	Adolescent client in Kpando
AFSRH	Adolescent Friendly Sexual and Reproductive Health Services
FGD ADC	Focus Group Discussion, Adolescent in the Community
FGD PIC	Focus Group Discussion, Parent in the Community
FP	Family Planning
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
HSP H	Health Service Provider in Ho
HSP HH	Health Service Provider in Hohoe
HSP KHC	Health Service Provider in Kpando
KI	Key Informant
MOH	Ministry of Health
PEP	Post Exposure Prophylaxis
PPAG	Planned Parenthood Association of Ghana
PP	Prevention Practitioner
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFSRHS	Youth-friendly Sexual and Reproductive Health Services

DEFINITION OF TERMS

Adolescent: The World Health Organization (WHO) defines adolescents as persons between 10 and 19 years of age (WHO 1998).

Adolescence: Adolescence is a period in human growth and development that occurs during the transition from childhood to adulthood, from ages 10 to 19 years. It begins with the onset of (normal) puberty, and ends with adult identity and behaviour.

Health: A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1948).

Youth: People whose ages fall within the range of 15 and 24 years (WHO 1998).

Sexual and Reproductive Health: having pleasurable sexual experiences without coercion and deciding to have children freely and responsibly, making use of information and guidance to attain good health.

Service: skills acquired through special training by registered professionals.

Service provider: a registered nurse, midwife, community health nurse and clinical health assistant working in the reproductive health unit and facility managers.

Utilization: accessing health services in the form of receiving information, care or treatment for the betterment on one's sexual and reproductive life.

ABSTRACT

Background

Over the past decade, the framework of adolescent-friendly health care has been used to better orient health services to the needs of young people. In fulfilling this worthy aim, the state of this adolescent-focused care and the performance based on client perceptions have to be regularly evaluated.

Objective

This study seeks to assess the satisfaction with the youth friendly sexual and reproductive health services rendered to young people in the Ho, Hohoe and Kpando Municipalities.

Methodology

This is a descriptive exploratory study analysing qualitative data collected from 21 female adolescents aged 15-24 years, 9 service providers and 12 parents from Kpando, Ho and Hohoe communities. Using both English and Ewe languages, 24 in-depth interviews with the aid of a guide was done among adolescents, and providers, while three focus group discussions among adolescent and parents were conducted. These were recorded on audio tapes and transcribed. Specific indicators of youth-friendliness were developed in a checklist that measured health provider factors/perceptions, client factors/perceptions and program characteristics at each study site. Similarly, indicators of community acceptance were developed that measured whether parents supported the provision of reproductive health services to youth. Thematic content analysis to develop themes was done on all interview and focus group discussion transcripts using Nvivo version 7.

Findings and conclusion

Although there appeared to be general satisfaction expressed by adolescent clients about the services they received, there were challenges of funding, infrastructure, poor youth involvement, breached privacy and confidentiality, poor staff training and parental antagonism to some of the services. The findings suggest that improvements in health services for the youth may have a larger impact on the health-seeking behaviours of adolescents.

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, sexual and reproductive health services for the youth have gained the interest of researchers and health policy makers (WHO, 2003; Sawyer, Proimos, & Towns, 2010; Tylee, Haller, Graham, Churchill, & Sanci, 2007). The past decade has witnessed the use of the framework of adolescent-friendly health care to tailor health services to the needs of young people (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). The provision of patient-centered health care has also become an emergent feature of health care policy (Patient care outcomes research institute, 2012).

An amazing half of the world's population is below 25 years, translating that about three billion children and young people are either in the reproductive age or will soon be. Young people, principally those in the developing world, suffer unreasonably from poor sexual and reproductive health outcomes, such as early and unintended pregnancies, criminal abortion, and sexually transmitted infections, including HIV/AIDS (Petroni, 2011). These outcomes are often associated with elevated emotional, social and economic expenditures that have an effect on individual, community and national progress.

Youth-friendly sexual and reproductive health services are planned to make the use of existing services more acceptable and less traumatizing to young people. Based on years of data inquiry and consultations with specialists, WHO discovered that interventions can scale up young people's use of services contingent on the fact that service providers are well trained to ensure

the health facilities are adolescent or youth-friendly, and create demand and community backing through projects in the community, a decision based on findings of data analysis overtime and expert advice (World Health Organization, 2013).

There is a widespread deficiency in knowledge on sexual and reproductive issues in developing countries. Young people, predominantly young women, were said to be among the most susceptible to HIV infection (USAID Ghana, 2010) with statistics indicating that one and a half percent of young women aged 15-24 were living with HIV in 2007, as compared to a half of a percentage of young men the same age (UNICEF, 2009). Only 20% of young women and 33% of young men aged 15-24 had full knowledge of HIV and its mode of transmission.

1.2 Problem Statement

Seventy-eight percent of the 1.5 billion young people in the world are said to live in the developing world. In Ghana, young people aged 10 to 24 years, make up the largest population in the country. Professional organizations from across the globe including the United States of America, United Kingdom, and Australia are more and more relating the principles of adolescent-friendly practice within position papers and service guidance about delivery of quality health care to young people (American Academy of Pediatrics, 2008; Department of Health, 2012) yet, in acknowledgment of the significance of young people's involvement in health service development, monitoring, and evaluation, there have also been calls for improved pointers of quality health care to be outlined (Royal College of Paediatrics and Child Health, 2012; Tylee, Haller & Graham, 2007). Young people in the developing world are confronted with suffering stemming from preventable problems of early pregnancy, sexual

violence, unsafe abortion, and sexually-transmitted infections (STIs), such as HIV/AIDS (WHO, 2013).

More devastating are the facts obtained from sexually active Ghanaian adolescents, who, from the time when the revision of the National Population Policy was done in 1994 (Programme of Action, 1994), became the object of many of such programs like the popular campaign which was about promoting abstinence, encouraging people to be faithful and resounding the message for the use of condoms (Awusabo-Asare, Abane, & Kumi-Kyereme, 2004). Regardless of those efforts, it is projected that 80% of females and 63% of males in the 15-19 year old group presently do not use any contemporary method of contraception (Awusabo-Asare et al., 2004) and analysis of associations between knowledge, behavior and HIV status have shown little change of health knowledge into protective behavior (Akwara, Fosu, Govindasamy, Alay³n, & Hyslop, 2005).

The Planned Parenthood Association of Ghana (PPAG) pioneered a program “Innovate” to tune the minds of young people more to their sexual health, grant them access to the services they provide and crave their indulgence. Subsequent to this initiative, the PPAG went ahead and opened a youth clinic, “Young and Wise Centre” in Accra. The facility had state of the art features including a counseling unit, a spacious reception, a library and computer Centre. The services rendered covered education, arts and entertainment activities. This smart combination of the non-sexual health component services and the sexual health services resulted in an effective delivery of the reproductive health services (Advocates for youth).

The Ghana Health Service (GHS) came out with the youth friendly services and has a list of two hundred and eighty clinics in its facilities in eight out of the ten regions of Ghana in an effort to address the unfortunate developments in the kind of data that was pouring in from its facilities. In 2009 for instance, the Ministry of Health (MOH) reported in its adolescent health and development report that 8,717 unsafe abortions were attempted by adolescents. The number shot up to 10,785 in 2010. In 2011, the figure doubled to 16,182 with respect to 2009 records. Out of this, adolescents aged 10-14 recorded 216, 15-19 years recorded 7,800 cases and another 7,800 for the age range of 20-24 years. With the increasing incidence of teenage pregnancy and its attendant problems, there is the need to assess the services being provided by the facilities to tease out the hindrances to achieving its goals.

1.3 Justification

Most studies conducted on youth sexual and reproductive health service were predominantly quantitative (Akinyi, 2009; Munthali, 2011; Omobuwa, Asekun-Olarinmoye, & Olajide, 2012). This study employed qualitative methodology to assess the sexual and reproductive health services being provided to the youth in Ho, Hohoe and Kpando in the Volta region of Ghana. The subject of youth sexual and reproductive health service has actually not been well explored in Ghana. This study is necessitated to assess the factors that influence the access and provision of youth sexual and reproductive health services in the three municipalities.

1.4. General Objective

The aim/objective of this study is to assess the satisfaction with the youth friendliness of sexual and reproductive health services rendered to young people in the Ho, Hohoe and Kpando Municipalities.

1.4.1. Specific Objectives

The following specific objectives help to address the general objective of the study:

1. To describe the delivery of adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities, in terms of the range of adolescent sexual and reproductive health services provided, working hours and waiting time.
2. To explore service-provider factors/perceptions of the adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities.
3. To explore client factors/perceptions of the adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities.

1.4.2. Research Questions

The following questions help to find answers to address the specific objectives of the study:

1. What range of adolescent sexual and reproductive health services are provided in the focal health facilities in Ho, Hohoe and Kpando Municipalities?

1. What are service-provider factors/perceptions of the adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities?

2. What are client factors/perceptions of the adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities?

1.5. Conceptual Framework

The conceptual framework depicted in figure 1.1 of the study is modified based on the Donabedian (2002) model of measuring quality of care. Donabedian explains that to measure quality of care, we need to examine the structure, the process and the outcome.

In this study, this was modified to reflect the provider’s perspective and the client’s perspective of the friendliness or satisfaction with AFSRH services in the selected facilities in the Volta region as shown in figure 1.1 below.

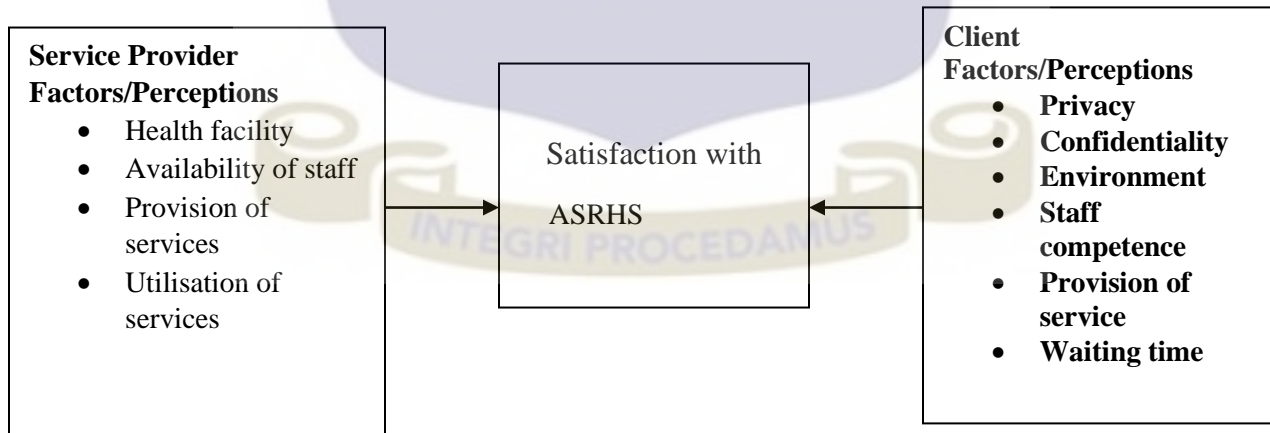


Figure 1. 1: Conceptual Framework for the assessment of adolescent/youth friendly sexual and reproductive health services

CHAPTER TWO

LITERATURE REVIEW

2.0. Introduction

This chapter presents review of available literature on the youth friendly sexual and reproductive health services. There are five sections. Section one presents review on the provision of Adolescent Sexual and Reproductive Health Services (ASRHS). Section two presents literature on the utilization of adolescent / youth friendly reproductive services. Section three presents literature on the perceptions of service-providers and clients of the Adolescent Sexual and Reproductive Health Services. Section four presents literature on the evaluation of Adolescent/Youth-Friendly Sexual and Reproductive Health Services. Section five presents the chapter summary where the main ideas in the chapter are summed up.

2.1. Provision of ASRHS

This section provides review of literature on the provision of ASRHS. Policies inform how services will be delivered to clients. Based on this assertion, Obare and Birungi (2013) explored the sexual and reproductive health (SRH) policy context and the realities facing in-school young people in Kenya. Findings demonstrated that although the policies accentuate the right to access to accurate SRH information, there were limits on the content of information that could be made available to in-school young people. Their findings suggest that as policy-makers, parents, teachers, civil and faith-based organizations debate the value and content of sexuality education in schools, it was important to consider the views and experiences of students who are the intended recipients of such education.

Mparana (2009) assessed the effectiveness of ASRH services in Bushenyi District of Kyabugimbi sub-county in Uganda. The researcher reported that the ASRH services in Kyabugimbi Sub County were fairly available, especially through most of the programmes and activities such as adolescent clubs, guidance and counseling services, condom distributions, prevention and management of STI/STDs by government health facilities in collaboration with other agencies. The researcher noted however, that as regards the delivery room, the health service providers pointed out that the non-existence of an equipped theatre made it tough for them to attend to expecting mothers, especially in case of an emergency as they had to travel over a long distance before reaching them.

The researcher suggested ways to improve on the service provision. For instance, the researcher suggested that young people had pressing needs that included access to information, counseling and guidance services, family planning services, STI/STD treatment and prevention, accessibility to the health centre, in case of emergencies, availability of youth friendly services and friendly service providers, availability of medicines amongst others (Mparana, 2009).

Mparana (2009) suggested that health service providers needed to be trained more in adolescent youth friendly service provision, especially in aspects of privacy and confidentiality and gentleness while handling adolescents because of their very sensitive nature. Furthermore, the researcher recommended that the government should put more funding into the health sector programmes so that government facilities such as ambulances would be well equipped to handle any in-flowing emergencies that might arise.

The researcher suggested that while there was the need to place emphasis on the adolescent youth friendly service provision to make it prominent, parents also needed to be involved in planning for the reproductive health programmes in the community, as this would help expose them to the urgency of such services and possibly drive them to own the programmes, participate and approve of their presence in the community (Mapana, 2009).

2.2. Utilization of Youth-Friendly Sexual and Reproductive Health Services

The assessment of the friendliness and satisfaction with the adolescent youth-friendly sexual and reproductive health services could be based on the extent to which intended users access the services. This section examines few studies that have evaluated the extent of utilisation of the ASRHS.

In a study in Kenya, Akinyi (2009) found that lengthy queues, unfavorable working hours put out-of-school youth and those in school at a disadvantage. The researcher observed that financial constraints unhelpfully affected utilization of the youth friendly reproductive health services. Since the involvement of parents and teachers in passing reproductive health information was found to be low, majority of the youth reported that they got information of these services from friends. The study concluded that the utilization of reproductive health services among the school and college youth was low, largely due to unfriendliness of the reproductive health facilities and a lack of awareness of the availability of reproductive health services.

Mapfunia (2013) noticed that the youth friendly corners were developed in Zimbabwe as a strategy to address Adolescent Sexual and Reproductive Health issues. Utilization of services at the youth friendly corner started showing a drastic decline. The researcher reported that the rate of utilization of services dropped far below the target of 30% when the facility was first set up. The study concluded that youth who were employed, lived alone and were aware of the presence of a youth friendly corner in Harare and other places offering similar services were more likely to utilize services offered at Harare youth friendly corner as compared to others who were not.

Motuma (2012) examined youth-friendly health services utilization and factors in Harare, Zimbabwe. The researcher explored the experiences and expectations of male and female students at Makerere University's main campus and the campus of the University's Business School towards youth-friendly sexual and reproductive health services; and the attitudes and perceptions of health workers and parents towards young peoples' sexuality. It was revealed that female university students in this study feared pregnancy more than STIs/HIV in fear of social stigma and early child-care responsibilities. The researcher concluded that the failure to recognize young people as clients for sexual and reproductive health services had created a yawning gap between young peoples' needs and service utilization, and therefore, recommended that their voices needed to be fully represented.

According to Biddlecom, Munthali, Singh and Woog (2007) a substantial proportion of sexually-active adolescents do not know of any avenues to get contraception or treatment for STIs and psychosocial reasons and financial constraints remain common hitches to getting services. These researchers observed that though some differences exist with regard to gender and locality, yet

on the whole, views from females and males were the same. The researchers recommended that there was the need to inform the youth about facilities, increase availability and improve the youth's access to services, particularly by reducing social barriers. The researchers argued that the feedback from the adolescents was an indication of the inappropriateness of service delivery system pertaining to adolescent sexual and reproductive health in Mochudi.

Regmi, Simkhada and Teijlingen (2008) summarized the state of sexual and reproductive health of young people in Nepal. The findings revealed that delayed onset of sexual activity and responsible sexual behaviours were necessary to avoid the dual risk of unwanted pregnancies and STIs/HIV among young people. The researchers reported that although adolescents and young people made up a significant proportion of the total population in Nepal, their sexuality, typically developing intimacy with the opposite sex and their ability to bargain sex and make wise decisions in relation to the risk of becoming pregnancy and contracting STIs/HIV, and the role they must play within that partnership were poorly understood. The researchers concluded that there was the need to understand and adopt safe and responsible sexual and reproductive behaviour for young people in Nepal.

Indeed the subject on adolescent sexual and reproductive health continues to gain worldwide interest. Tesso, Fantahun and Enquesselassie (2012) conducted a cross-sectional study among young people in Nekemte town and semi urban areas in western Ethiopia. These researchers concluded that parent-communication about sexual and reproductive issues took place not only rarely, but with strong warning, and sometimes in a threatening manner. These researchers recommended that programmes and policies related to young people's reproductive health

should address not only individual or behavioral factors, but also cultural and social factors that negatively influenced parent-communication.

Anusornteerakul, Khamanarong, Khamanarong, and Thinkhamrop (2011) found that although the running of reproductive health service for the youth had gained a lot of attention in contemporary times, management had no clear indication of the influential factors of concern. The researchers identified six factors and grouped them into three main categories as ‘three systems’ to explain the important factors that might be of concern to management of reproductive health services. These were also related to the personnel, service, and family support systems which had to be addressed in order to remove the limitations.

Delany-Moretlwe *et al.* (2015) reviewed the needs, barriers and gaps for other non-HIV health specific age-related data on sexual and reproductive health, mental health, violence, and substance abuse problems for adolescent, youth or young commercial sex workers, homosexuals and people who inject drugs. The results showed that young key populations are exposed more to unprotected sex, sexually transmitted infections including HIV, unintended pregnancy, violence, psychological disorders and substance abuse relative to older members of key populations and youth among the general populace. Young key populations, the researchers noted, are confronted with a number of significant obstacles to accessing care. The researchers noted that coverage of services was low principally because of stigmatization and discrimination at health system and policy levels. Whilst adolescent sexuality was highly charged moral issue in Kenya and Zambia, public health facilities are poorly utilized by adolescents (Delany-Moretlwe *et al.*, 2015).

Warenius *et al.* (2006) probed the attitudes of nurse-midwives toward adolescent sexual and reproductive health problems in two countries, in order to improve services for adolescents. Findings revealed that whereas the nurse-midwives frowned on adolescent sexual activity, including self-stimulation, contraceptive use and abortion, they were down-to-earth in handling them. The researchers argued that those with in-depth education as well as those who had received continuing education on adolescent sexuality and reproduction were more inclined towards more youth-friendliness. The researchers recommended that a critical thinking around the cultural and moral scope of adolescent sexuality should be hammered in schools in order to help nurse-midwives deal more kindly with the truth about adolescent sexuality. In addition, they recommended that those in nursing and other leadership positions should encourage wider social discussion of the subject to create an environment that would be more tolerant to issues bothering on adolescent sexuality. This is bound to showcase the public health benefit for adolescents' greater access to youth-friendly sexual and reproductive health services (Warenius *et al.*, 2006).

Sovd, Mmari, Lipovsek and Manaseki-Holland (2006) investigated features of health service quality that were most likely to decide client satisfaction with health services among adolescents in Mongolia. They discovered that the strongest determinants to client satisfaction as acceptability in terms of adequate facility, physical environment, and receiving the right and adequate information about the facility. In addition, clients who reported they received a form of disruption, either from other health workers or other clients while they were being attended to were to a large extent less likely to be pleased with the services. These researchers noted that although both accessibility and acceptability of services had been shown to be relevant in other

works, characteristics relating to acceptability emerged as crucial in determining client satisfaction among adolescents in Mongolia (Sovd *et al.*, 2006).

These researchers recommended that efforts directed at improving the delivery of health service to adolescents needed to attend to the friendly characteristics that were most important. They suggested that governments should not only promote and fund research on the health and development of young people, but rather actively make use of evidence generated to guide policies and programs targeted at the youth. They also suggested that researchers needed to develop ground-breaking channels to connect to national authorities, policy makers and key stakeholders who would use their evidence as cues to help take calculated decisions. The researchers recommended that funding agencies and governments should support research on typically under-researched areas of young people's health in Sub-Saharan Africa, including mental health, injuries, and non-communicable diseases (Sovd *et al.*, 2006; Kabiru, Izugbara, & Beguy, 2013).

2.3. Perceptions of ASRHS

The perceptions of satisfaction with the ASRHS could be examined from both the service-provider and client perspectives as presented in this section.

Researchers Lesedi, Hoque and Ntuli-Ngcobo (2011) studied the youth's view towards sexual and reproductive health services in Botswana. The researchers discovered that while one-third of participants were of the opinion that the referral system was not youth-friendly and/or not adequate, judgmental attitude and friendliness of the health providers were rated the lowest, and

the referral system factor was perceived as a barrier. Nevertheless, the youth perceived sexual and reproductive health services positively and had positive expectations of health providers (Lesedi *et al.*, 2011).

Lindberg, Lewis-Spruill and Crownover (2006) explored attitudes and perceptions of urban black male adolescents regarding the availability of and access to reproductive healthcare in the United States of America. The results showed that adolescents felt obtaining sexual health services was a hectic experience saturated with bottlenecks from within and without. Barriers from within the individual included fear of stigma and loss of social status, shame, and humiliation. External barriers included ill-mannered providers, a lack of privacy and confidentiality, and challenges associated with accessing and negotiating the healthcare system. The researchers observed that participants described a fanciful clinic environment as one which is informal, welcoming, and respectful.

On the part of providers, these reserachers recommended that there was the need to focus on improving the quality of care in existing clinics, particularly in the areas of access, privacy, and confidentiality, and on developing adolescent-friendly clinics with a focus, for once on male services as well as providers trained to be comfortable with and able to communicate effectively with male adolescents. With respect to the adolescents, these reserachers recommended that there was the need to encourage them to visit clinics for information on their sexual and reproductive health prior to a critical need for services (Lindberg *et al.*, 2006).

Berne *et al.* (2000) examined the important messages parents gave at home regarding sexual behaviour and sexual responsibility in Australia. Findings suggested that parents (mothers and fathers) clearly appreciated sex within relationships over casual sex, and encouraged their children to protect themselves and others when engaging in sexual behaviour. They were rather appreciative of school sexuality education programs and thought they made it easier to discuss sex at home. However, most parents opposed messages on abstinence-until-marriage, explaining not only why they would not be effective but what rippling effect could be expected (Berne *et al.*, 2000).

Godia (2012) explored the health service providers' experiences of the sexual reproductive health service provision to young people in Kenya, and found that while the majority of health service providers were aware of the youth friendly service concept, they were not aware of the supporting national policies and guidelines. Health service providers felt they lacked competency in providing sexual and reproductive health services to young people, especially regarding counseling and interpersonal communication on contraception. The researcher noted that health service providers reported being puzzled about personal feelings, cultural and religious values and beliefs and their wish to respect young people's rights to accessing and obtaining sexual and reproductive health services.

Omobuwa *et al.* (2012) explored the knowledge and perception of reproductive health services among in-school adolescents in Ile-Ife, Osun State in Nigeria. The study showed that the most commonly perceived adolescent health problems included menstrual related difficulties, unwanted pregnancy, HIV/AIDs and lack of sexuality education. Most schools attended by

respondents had no health facility and the few with clinics had inadequate/unfriendly staff and inadequate drugs. These researchers reported that respondents' most preferred places of seeking healthcare were government hospitals and private hospitals. However, the study showed that the adolescents had little or no access to youth-friendly services even with their preference for government hospitals as their place of choice for seeking healthcare (Omobuwa *et al.*, 2012).

2.4. Evaluation of Youth-Friendly Sexual and Reproductive Services

Munthali (2011) evaluated youth friendly reproductive health services for adolescents aged in Lunzu Ta-Kpeni, Malawi. The study indicated that 38% had ever accessed youth friendly reproductive health service; and there was a connection between education and access to youth friendly reproductive health services. Moreover, 30% of males and 38% of females had at least, used a modern contraceptive method. This researcher indicated that societal customs, judgmental attitude and lack of dialogue between adolescents and parents on sexuality issues were some of the major factors that were attributed to low access to youth friendly reproductive health services by adolescents.

Matatu, Njau and Yumkella (2001) evaluated a program providing adolescent friendly services in Uganda, and found favourable changes in sexual behavior among youth, including reported delays of first sexual encounter, reduced number of partners, and higher use of family planning methods. Whereas greater knowledge of STIs, including HIV/AIDS, was found not only among young people in the intervention sites, similar idea was also reported among service providers.

Kesterton and Cabral de Mello (2010) investigated the effectiveness of interventions directed at creating a demand for and use of sexual and reproductive health (SRH) services by young people gaining community support for their use. The researchers suggested that the participation of key community members such as parents and religious leaders was vital to winning a wider community support. Regmi (2008) assessed the knowledge, attitudes, and understanding of sex, sexual health, and related sexual risk behaviours, among young people in accordance with current sociocultural and health service practices in Nepal. The study concluded that social, economic, demographic, and cultural factors were identified as factors encouraging risk-taking behaviours among young people.

Researchers Renju *et al.* (2010) examined parental control and monitoring and their effects on young people's decision making on sexual matters in a rural setting in North-Western Tanzania. The study concluded that girls, typically those in school were supervised more compared to boys and young women who had already had unplanned pregnancy. Speizer, Magnani and Colvin (2003) assessed the effectiveness of peer education in enhancing knowledge, attitude, and preventive practices on HIV among in-school adolescents in Osun State, Nigeria. The researchers recommended that education about HIV/AIDS should be planned to target this age group with ample consideration to their exceptional characteristics.

The WHO (2003) reports that youth in many developing countries are at heightened risk of sexually transmitted infections (STI) and human immunodeficiency virus (HIV) infection and unintended pregnancies. Whereas about one-half of people presently infected with HIV are females in developing countries aged less than 25 years, over 13 million adolescent girls have

unintended births annually. Erulkar, Onoka and Phiri (2005) used large scale population-based surveys to explore characteristics of adolescent sexual and reproductive issues among the youth in Kenya and Zimbabwe. Since the adolescents scored confidentiality on information given, short waiting time, token charges for services and friendly staff as the most essential characteristics, the findings implied that most existing clinical services, even in the most resource-poor settings, were in a position to improve their level of youth friendliness (Erulkar *et al.*, 2005).

One more motion for placing a priority importance on the reproductive health of this group of people was the frightening increase of sexually transmitted infections (STIs), including HIV since young people particularly, young women embody the fastest-growing cases of new HIV infection (Senderowitz, 1999). Deogan, Ferguson and Stenberg (2012) estimated the extra resources required to scale up adolescent friendly health service interventions in order to reduce mortality and morbidity among individuals in low-and middle-income countries. The results showed that there was a substantial investment gap that was suggestive of the additional monetary commitments necessary to scale up health service delivery to adolescents towards universal coverage by 2015.

Doyle, Mavedzenge, Plummer and Ross (2012) explained the sexual and reproductive behaviour of adolescents in sub-Saharan Africa, using data from DHS and AIS (2000-2010). They reported that exactly 25% of adolescents aged 15 to 19 years reported sex before age 15, but this proportion reduced over time in many countries. The researchers recommended routine data collection of sexual and reproductive behaviour for adolescents aged below 15 years, and the

inclusion of comprehensive information on sexual behaviour within relationships, and grouping data according to socio-demographic variables.

Afenyadu and Goparaju (2003) examined adolescent sexual and reproductive health behavior in Dodowa, Ghana. The findings showed that adolescent pre-marital sexual activity was quite common: an estimated 54% of the never-married male students and 32% of the never-married female students reported to have had a sexual experience. The findings also indicated that even though three in five adolescents used condoms, the use was selective and not consistent. Pearson (2003) in a study in England. This researcher concluded that effective promotion campaigns centred on the input of indigenous young men, with appropriate and accessible services, could help to increase service use among young men.

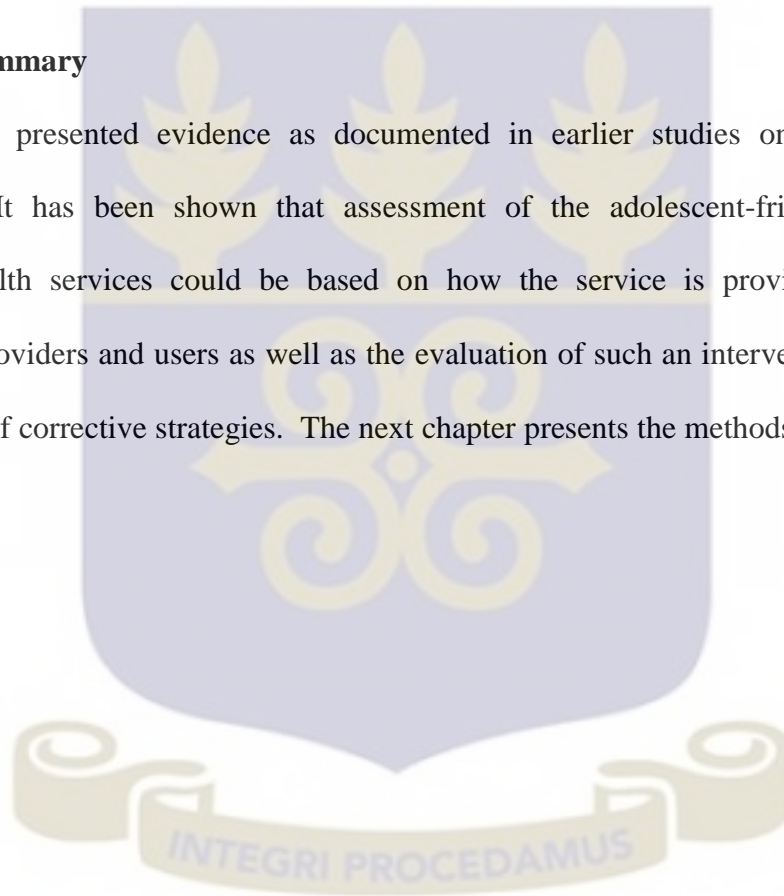
The unique nature of the health needs, behaviours and expectations of adolescents makes regular health care services inappropriate to provide these services. Agampodi, Agampodi, and Piyaseeli, (2008) explored the seeming reproductive health problems, health seeking behaviors, knowledge of adolescents in Sri Lanka. The researchers concluded that adolescent health services were inadequate and the ones available were not being delivered in a satisfactory manner. They recommended proper training of health care providers on youth friendly service provision with a call for a National level integrated health care program for the adolescents.

Gavin *et al* (2010) identified the positive youth development programs that improved adolescent sexual and reproductive health. These reserachers suggested that tested, effective positive youth development programs should be made part of a wide-ranging approach to championing

adolescent health. Tylee *et al.* (2007) explained that since social determinants of health are the circumstances in which people are born, grow, live, work, and age, the families (or institutions) in which young people are raised, the communities in which they live, and the opportunities for schooling, work, and entertainment which are available; against the backdrop of the national stage shaped by the decisions governments make grossly affect adolescents (Tylee *et al.*, 2007).

2.5. Chapter Summary

The chapter has presented evidence as documented in earlier studies on the topic under consideration. It has been shown that assessment of the adolescent-friendly sexual and reproductive health services could be based on how the service is provided, utilized, the perceptions of providers and users as well as the evaluation of such an intervention to aid in the implementation of corrective strategies. The next chapter presents the methods applied to collect data for analysis.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter gives a vivid description of the research method and design used in this study, the setting and context under which the study is presented, the target population for the study, the sampling techniques and procedures for data collection, data processing and data analysis. It also captures the pre-testing of the interview guide and audio recording instrument used and finally, the rigor associated with the qualitative study and the ethical considerations that were observed for the study.

3.2 Study Design

This study utilized qualitative research methods, with a descriptive exploratory design considering the fact that there was the need for an enquiry into understanding a human or social phenomenon. The concept of qualitative research is based on building a complex, holistic picture of the situation under study, formed with words, reporting the views of informants in details, and conducted in a natural setting (Creswell, 2009). This then translates that qualitative research is a method of inquiry in which phenomena are explored in their natural environment (Mayan, 2001).

3.3 Research Setting

This study was conducted at the reproductive and child health units of Ho, Hohoe and Kpando Municipal Health Directorates in the Volta region of Ghana. Ho municipal area lies between latitudes $6^{\circ} 20' 7''$ and $6^{\circ} 55'$ and longitude $0^{\circ} 12' 7''$ and $53^{\circ} E$. it covers an area of 2,660 square kilometres. It shares boundaries with Adaklu Anyigbe district to the south, Hohoe to the north,

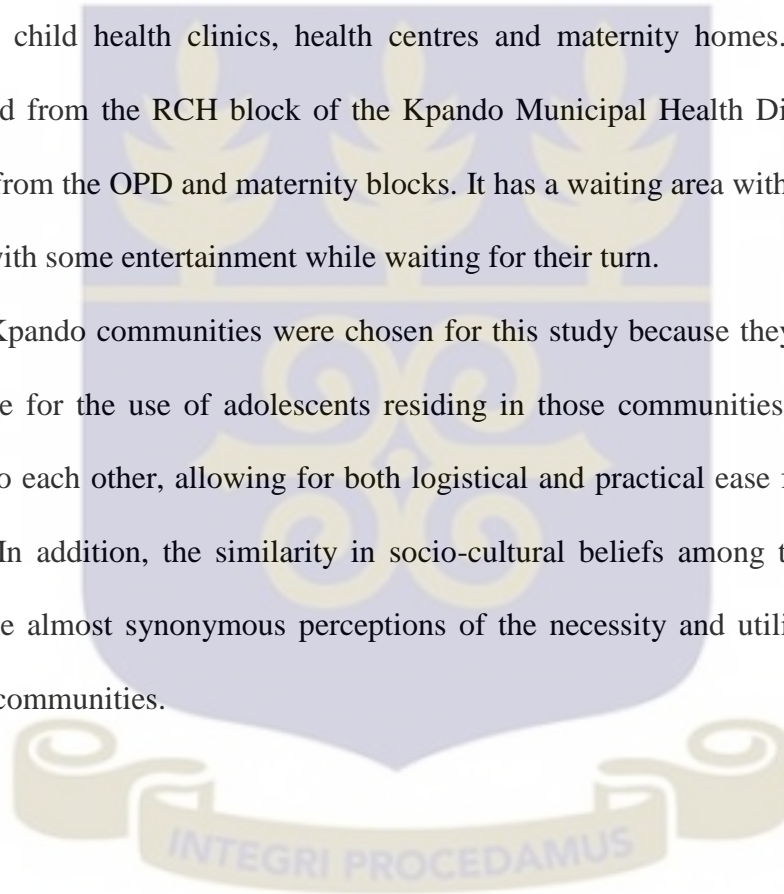
South Dayi to the west and the Republic of Togo to the East. Ho is the administrative capital of the Volta region. It has 772 communities with a total population of 271,881 according to the 2010 population and housing census. The economically active workforce is engaged in agriculture and animal husbandry. Tourism in the district is boosted by the presence of ancestral caves, animal sanctuaries and waterfalls. There is a total of 29 health facilities. The University of Health and allied sciences is located in Ho. The youth friendly centre is located at the Council Hall within the Ho Municipal Assembly. It shares the same block with the Ho Magistrate Court. The facility has limited space for operation though the service providers have made efforts to reserve a room for the adolescent corner. There is an exit point at the back of the building across the adolescent corner which favours the privacy much desired by the adolescents. Plywood has been used to create partitions to separate the area for child welfare clinics and the corridor where family planning services are rendered to both adolescents and adults.

Hohoe Municipal Assembly is one of 18 and one of 170 administrative districts of the Volta region and Ghana respectively. It has a total land surface area of 703.20 kilometre square. It shares borders with the Republic of Togo on the east, south east and south with Afajato district assembly, north with Jasikan district, North West with Kpando and Biakoye districts. The estimated population according to the 2010 population and housing census is 172,950 with 83,317 males and 89,633 being females. Economic activity is mainly agriculture engaging about 70% of active labour. It has two colleges of education and a total of 21 health facilities with one municipal referral hospital. The adolescent corner is housed within the RCH facility of the Municipal Health Directorate which is located on a plot next to the Magistrate Court. A chamber has been provided for the adolescent corner on the extreme end of the building cutting it off from

the busy point of service. The RCH also has a shed outside for holding child welfare clinics for both adolescents and adults.

Kpando, the third study area shares boundaries with Biakoye district in the north, Hohoe district in the east and south Dayi in the south. According to the 2010 population and housing census, it has a population of 93,649. There are public and private schools. There are two hospitals, four reproductive and child health clinics, health centres and maternity homes. Their adolescent corner is detached from the RCH block of the Kpando Municipal Health Directorate which is further detached from the OPD and maternity blocks. It has a waiting area with television to keep clients engaged with some entertainment while waiting for their turn.

Ho, Hohoe and Kpando communities were chosen for this study because they all have AFSRH facilities available for the use of adolescents residing in those communities; also, these areas were proximate to each other, allowing for both logistical and practical ease for the study to be well conducted. In addition, the similarity in socio-cultural beliefs among these communities gives depth to the almost synonymous perceptions of the necessity and utilization of AFSRH services in these communities.



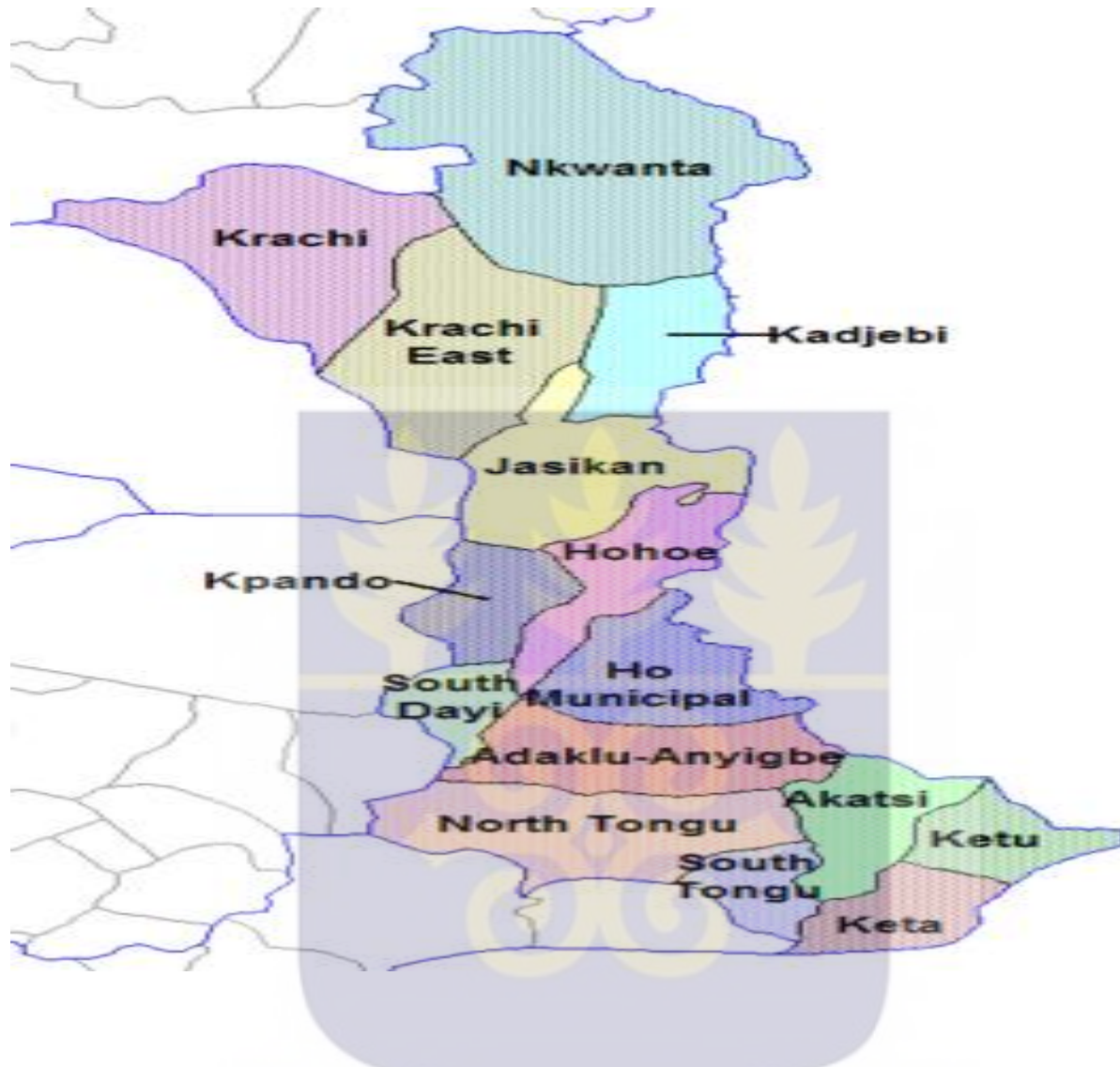


Figure 3. 1 Area map showing Ho, Hohoe and Kpando municipalities.

3.4 Study Population and Sample

The target population for this study will consist of:

1. Service Providers
2. Users of the youth friendly sexual and reproductive health services
3. Young people and parents in the community

3.4.1 Inclusion Criteria

This comprised youth aged 15-24 in the community, those accessing services at the time of the study and parents in the community.

3.4.2 Exclusion Criteria

Those parents and youth in the community, service providers and those accessing services who declined to grant informed consent and those aged below 15 years and above 24 years.

3.4.3 Selection Criteria

Purposive sampling technique was used to select respondents from the facilities and snowball technique was used to select respondents in the communities for this study. A total of 42 respondents were selected for an in-depth interviews and focus group discussions for the study with the aid of a an interview guide to explore factors influencing utilization and perceptions of young people about packaging youth sexual and reproductive health services that are attractive and appealing in terms of the types of services young people would like to use and the factors that encourage young people to seek services. Each study area had three service providers and five clients interviewed with six members from each community engaged in the focus group discussions. The choice for the sample size was based on the work of Baker and Edwards (2012) who argued that to be able to thoroughly explore a phenomenon qualitatively; a sample size of between 12 and 60 is adequate, with 30 being the average.

According to Creswell, (2009), the primary intent of a descriptive qualitative research is to thoroughly explore and understand a phenomenon of interest. In that regard, assessing the sexual and reproductive health services provided at the adolescent/youth friendly centres is a

phenomenon that needs to be explored using a qualitative method. Therefore, the fulfillment of the purpose that necessitated the establishment of the adolescent/youth friendly sexual and reproductive health service centres with an objective to curb the incidence of sexually transmitted infections, including HIV, and teenage pregnancy among young people through health education on the physical, cognitive and the emotional changes that occur during the period of transition from childhood to adulthood needs to be assessed. The situation was described from the perspective of the experiences of the people involved ((Ryan, Pascoe, & Morse, 1999). The researcher described the situation from the framework of policies and guidelines approved for the implementation of the programme.

The methodology afforded the researcher the chance to painstakingly explore and elicit from participants what realities there are about adolescent/youth friendly sexual and reproductive health services that have contributed to the spate of rising teenage pregnancy, STIs and HIV among the young people.

3.5 Study area and study population

The study population in this study comprised 21 female adolescents aged 15-24 years from Kpando, Ho and Hohoe communities (5 adolescents from each facility for in-depth interviews, and 6 adolescents recruited into the focus group discussions at Ho), 9 service providers (2 males and 7 females) from same communities and 12 parents (4 males, 8 females) from Hohoe municipality, all in the Volta region of Ghana. The decision to interview these sub-groups was based on the premise that adolescents in the study would provide client information needed to assess the strengths, failures and impediment to utilization of the adolescent-friendly sexual and reproductive health (AFSRH) services. Parents were included as they not only have an oversized

influence on the sexual beliefs and perceptions of their children but also because they are the ones who always tend to initiate the discussion concerning sexuality and reproductive health issues to their adolescents. Furthermore, the providers were made part of the study due to the operational perspective of the facility that they provide.

3.6 Data Collection techniques and tools

A descriptive qualitative method was chosen over a quantitative method because an observation checklist and in-depth interviews of 3 purposively chosen service providers from each centres and 5 purposively chosen adolescent facility users from each facility was done to collect data in order to describe and interpret a phenomenon based on the viewpoints of the people who have experienced it (Thorne, Kirkham, & MacDonald-Emes, 1997). A qualitative approach was adopted because it best explores behaviours, feelings, thoughts, actions and experiences (Mayan 2001, Burns & Groove, 1993). Also, three focus group discussions were conducted among two different groups (parents and adolescents, each comprising 6 participants), to collect primary data because it allows participants to express their ideas about the topic being investigated. With these methods, participants also feel that they can give more deep and detailed information. Data was collected by the researcher (with the help of a research assistant for focus group discussions) and the exercise lasted for three weeks in June, 2015.

Data were collected within three weeks through in-depth interviews and focus group discussions by the researcher with the help of a research assistant who had the desirable qualification. In addition, the research assistant was trained by the researcher for one day to help in the task; the training focused on focus group methodology, taking field notes, assuring participant confidentiality, privacy and anonymity. Ewe language was used in collecting information from

some participants. Before data collection, the interview guide (Appendix F) and facility observation checklist (Appendix G) were pre-tested with three service providers from the 37 Military hospital. This allowed for clearing all ambiguities about the questions making them easy to understand. Pre-testing the interview guide also ensured credibility and dependability of the guide since modifications were made to portions of the guide to enable the questions to produce data that would meet the desired expectations of the study. The exercise also equipped the researcher with the skills to handle the voice recorder in the major interviews.

3.6.1 Sampling techniques

Qualitative studies aim to illuminate and provide understanding to the nuances of complex psychosocial subjects; they are useful for answering socially-situated questions of 'why?' and 'how?' As such, in qualitative studies, an appropriate sample is not governed by probabilistic aims, but a good sample is one that properly answers the research question considering that qualitative research methods are about studying real people in natural settings rather than in artificial isolation.

Sampling therefore has to take account not only of the individual's characteristics such as being an adolescent who is probably still in school, but also the context of the study. Hence, the subjects for this study included parents, service-providers and adolescents.

3.6.2 Data Management

Data gathered from all the interviews and focus group discussions were transcribed and typed out and stored in files created on a personal computer. A password was placed on the transcribed data to prevent access to unauthorized persons. Printed versions of the transcripts and the voice

recorder used for the study were kept in a cabinet under lock. Transcripts of the data collected will be kept for a period two months after which they will be destroyed. Access to the transcribed data was available to only the researcher and supervisors for purposes of ensuring confidentiality.

3.6.3 Data Analysis

Thematic content analysis was used to report the views of participants word for word. The analysis and data collection were done simultaneously, providing the researcher the opportunity to probe further into the subject being investigated. The validation of information helped the researcher in recognizing the point at which no new information emerged from the interview leading to saturation of the data. Following this was the development of themes that emerged. This was achieved by reading the transcripts over and over to ensure that they were representative of the exact expression by the participants regarding the phenomenon under investigation. Data from the field notes were also analyzed to boost the understanding for the various categories and themes that emerged. Verification of the themes was done by getting back to some of the participants who had agreed to do so. The qualitative method demands that data analysis begins immediately with the preceding interview. Data collected generated interesting and quite intricate results. Interviews conducted in the Ewe language were translated into the English language after which the data was then transcribed verbatim. This transcription was first written out, typed and printed out. The transcribed data were first read thoroughly for meaning and understanding. Data was imported into the Nvivo 7 software. Coding of the data was done by identifying similar words, phrases, sentences, ideas and concepts. A five column table was

created in word with headings for themes, categories, coding, excerpts and identity to quotes cited.

3.7 Ethical consideration

The following procedures were observed during the study:

Before the commencement of this study, ethical approval was sought from the Ghana Health Service Ethical Review Committee of the Research and Development Division of the Ghana Health Services (Appendix A).

Permission to conduct this research in the selected study area was obtained from the Regional Health Directorate, Volta region. An introductory letter was sent to the three facilities sited for this study (Ho, Hohoe, and Kpando) to request for necessary assistance and assure of the benefit of the study to their facilities (Appendix B).

The study population was made up of adolescents aged 15-24 who were users of AFSRH services, health service providers at the AFSRH centres, and parents of adolescents using those centres.

This research work stands to benefit society and adolescents specifically by highlighting how to strengthen the provision of AFSRH services and educate them on sexual health issues and their rights in service demanded from the AFSRH facilities. Apart from the time spent in answering the questions posed to participants, this study posed minimal risk to both the participants and the community at large.

This research work ensured that the confidentiality and anonymity of participants was observed during data collection, and that all data analyzed was stripped of participants' personal details.

The study findings were also reported in a way that reduced the possibility of tracing information gathered back to respondents; this was done to ensure confidentiality and anonymity.

The researcher declares that no compensation was given to participants whose data is used in the work.

Data gathered from all the interviews and focus group discussions were transcribed and typed out and stored in files created on a personal computer. A password was placed on the transcribed data to prevent access to unauthorized persons. Printed versions of the transcripts and the voice recorder used for the study were kept in a cabinet under lock. Transcripts of the data collected will be kept for a period two months after which they will be destroyed. Access to the transcribed data will be available to only the researcher and supervisors for purposes of ensuring confidentiality.

Informed consent was sought and obtained from all study participants after reading and explaining the contents to them. They were fully informed of their rights not to partake in the study, as well as to withdraw at any time in the course of the study without any consequence or loss of benefit. Those who accepted to be part of the study filled the details of the form and signed accordingly (Appendix C). Provision was also made for parental consent from parents of adolescents who fell below age 18 years (Appendix D).

Apart from the academic and public health importance of the study, the researcher hereby declares that there is no other personal interest in the study.

3.8 Rigour of the Study

The quality of qualitative research, it is debated "*cannot be determined by following prescribed formulas. Rather its quality lies in the power of its language to display a picture of the world in*

which we discover something about ourselves and our common language.”(Carlson & Johansson, 2006)

The clear task in qualitative research is to ascertain what questions are most essential for creating research rigor (also referred to as trustworthiness) and to show how such questions could be answered (Holloway & Wheeler, 2013). Undoubtedly, rigorous research is expected to be both transparent and open, that is, being able to describe to others what was done (or what the researcher plans to do) in clear, simple language.

In addressing the rigour of the study, the researcher placed premium on trustworthiness which calls for member checks, thick descriptions, audit trail and dependability. A member check was done by following up on interviews with some of the participants requesting that they validate the accuracy of the transcribed interview and the emerging themes. The thick description as explained by Hungler and Polit, (1999) include the thorough descriptions of the research setting, the context where interviews were conducted and the processes throughout the investigation period. This was achieved through the vivid descriptions of the research setting and the recording of things that happened during the interview processes in the field notes. All transcribed interviews together with the field notes and themes that emerged were available to fulfill the objectives of this study.

In this study, before commencing data collection, the proposal was examined and accepted by the supervisors and the Ghana Health Service Ethical Review Committee. The consent of participants was sought before conducting the interview at a serene setting to ensure client’s comfort, privacy and confidentiality. Prior to the interviews, the researcher used the facility observation checklist to find out what items on the list are in place in each facility (Appendix G). All important verbal and non-verbal cues were documented in the field notes so that the

researcher's decisions, choices and insights could be scrutinized and appreciated by the supervisors.

Dependability refers to the findings of the study yielding similar results with other groups in a similar context (Hungler& Polit, 1999). The participants expressed varied views because of their personal experiences at the adolescent/youth friendly sexual and reproductive health services centre and in the community.



CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 Introduction

This chapter presents the findings from the qualitative assessment of adolescent/youth friendly sexual and reproductive health services in selected health facilities located in the Volta region of Ghana. Qualitative study is said to be a bottom-up or otherwise inductive process. The works of Morse and Richards, (2002) clearly illustrate the cognitive process of inductive reasoning as a gradual shift from understanding through synthesizing, theorizing and to re-contextualizing. The first step in comprehending began when the researcher considered the research topic and setting and searched available literature to educate herself more on the subject. This continued through to data collection and the early stages of data analysis where saturation occurred (on the 21st respondent) allowing the researcher to have a detailed description of the phenomenon under study.

The stage of synthesis saw the researcher blending the stories and accounts rendered by the respondents from their experiences at youth friendly service provision points. The narratives were ‘attached’ to the respondents by the use of pseudonyms based on the facility and the order of entry into the study rather than their names and other means of identity to ensure confidentiality and anonymity. For instance, the first adolescent respondent at Kpando Health Centre was coded ADC KHC 1, in that order.

The interest of this study is stated in its objectives which are to describe the delivery of adolescent sexual and reproductive health services in Ho, Hohoe and Kpando Municipalities, in terms of the range of adolescent sexual and reproductive health services provided, working hours and waiting time; to explore service-related factors that may affect the utilization of these

services in terms of service provider attributes and youth-friendly characteristics of the adolescent and reproductive health facilities. The final specific aim of this work is to explore the perceptions of adolescents/youth about how they would want the adolescent sexual and reproductive health services to be packaged to make it attractive and appealing in terms of the types of services young people would like to use, and the factors that encourage young people to seek services.

The researcher, in analyzing, first read thoroughly through the transcripts of the interviews and focus group discussions, and then identified important words and essential narratives through coding, which were merged into meta-narratives that formed the categories. These categories presented the specifics of respondents' perceptions of various issues relating to the services provided by the adolescent/youth friendly sexual and reproductive health centres, and related categories were synthesized into sub-themes and further into themes. This synthesis enabled the researcher to describe the phenomenon of interest by providing excerpts as examples of the generalizations that were made. The excerpts used were linked to respondents using pseudonyms according to the participants' sequence of entry into the study as well as by location and status as either a parent, service provider or adolescent in order to ensure confidentiality and anonymity. For instance, HSP-KHC 1 represents a health service provider at Kpando Health Centre who was interviewed first.

4.2 Demographic characteristics of participants

A total of twenty one (21) adolescents participated in the study with all of them being females as no males were available at the time of collecting data. The ages of the participants ranged from 18 to 23 years. Eleven adolescent participants from the three study sites fell within the age group

of 18 and 19 years whilst the other ten were between ages 20 and 23 years respectively. All the adolescent participants had had basic education which presupposes some ability (regardless of skill) to communicate in basic English language, but they all had a much better grasp of the indigenous Ewe language.

Two of the study areas, Hohoe and Kpando have predominantly the Gbi ethnic groups. Ho, on the other hand had a different ethnic group. Six participants spoke English during the interview and the other fifteen opted to speak Ewe, with those interviews being translated into English before transcription. Six of the participants for the focus group discussion were in apprenticeship at a sewing centre whereas the other fifteen had dropped out of Junior High school for many reasons including pregnancy.

Six parents of adolescents (with a composition of two fathers and four mothers for each study site) participated in focus group discussions at Hohoe and Kpando. Participants were within the age range of 33 to 42 years. Each group from a study site had six members who are into a mix of economic ventures including farming, trading and teaching. All members preferred to speak Ewe for the discussion of the subject.



4.3 Themes and categories

The findings of this study were aggregated into categories, which were then further merged into themes. Ten themes were identified, and they are discussed below. The table in Appendix H shows the identified categories and themes.

4.3.1 Privacy and confidentiality in service delivery

Most providers and adolescent clients expressed general satisfaction at the state of privacy and confidentiality accorded them, although some adolescent clients felt that the facility failed to ensure enough privacy. Most adolescents had their sessions held privately and were attended to in a one to one interaction. One of the adolescents, during a focus group discussion had this to say:

*“It [the session with the provider] was a one-on-one interaction in the consulting room. She [the service provider] told me that whatever I said to her will be held in confidence.”*FGD ADC H R6

The providers also attested to the informational privacy they provided by explaining their obligation to keep whatever they told them in confidence:

“We normally tell them that they should feel free and talk because whatever they tell us, we are not going to tell anybody outside so it will be within us here, like you the service provider and the client, it will be between the two of you...we tell them and we practice it.” HSP KHC 3

The providers also revealed there were policies that encourage the practice of privacy and confidentiality including structural considerations in enforcing the privacy of their clients:

“Yes, there is [privacy and confidentiality policy], because even when you are carrying out or you are constructing the center, you need to look at that- privacy, confidentiality, very difficult because if you don’t do that you can’t get them. They will not come. Yeah, so we take into consideration that.” HSP HH 1

However, there were exceptions, as expressed by one of the adolescents who felt the providers were not professional and her confidentiality was violated:

“Yes, in a way [they ensure privacy and confidentiality]. This place is open so everyone will see you though you try to speak undertone.” ADC HHZ 3

From the above, it is clear that adolescents expect their concerns and complaints to be kept confidential, and while many had their expectations satisfied, there still remained gaps to fill.

4.3.2 Staff knowledge, training and competence

Staff competence is gauged by knowledge and training in adolescent sexual and reproductive health issues. However, it goes beyond that to include exhibiting the learned skillset and being able to apply it to the adolescent client’s satisfaction. Adolescent respondents had lots of praise for the competence demonstrated in carrying out their duties. A provider throws more light on the knowledge and training given to staff at the centre:

“I think we have eh... individuals here...eh...that have been given in-service training by our stakeholders and they are dedicated, attached to this facility to render these services so not that they, only [have] the general knowledge but they have been specifically trained to render the service.”HSP KHC 1

Adolescents also stated their opinions on the competence of staff, including their general approaching, teaching skills and the way they ensured there was constant feedback while impacting knowledge:

“Please, the way they [service provider] went about the teaching and the way they conduct themselves, makes me conclude they are competent... Please, they gave an interpretation of the video after we had finished watching. They asked us questions about what we viewed...Yes, those that we could not answer, they explained further.

ADC KHC 1

Another adolescent was very satisfied not only with the provider’s attitude and competence:

“She [service provider] did well, she did everything well and she even direct me to go somewhere else and come back.” ADC KHC 10

However, adolescents expressed ignorance about the standards they were supposed to demand from the service providers, even though they were content with the service they were receiving

*“The way they handle the work is okay for me but as to whether they have specific tasks that their bosses have asked them to do, I do not know about unless maybe they are made available for us to read.”*FGD ADC H R6

4.3.3 Range of services provided at the facilities

The range of services refers to the kind of services that are available in the facility for clients to access. It encompasses all services rendered by the health service providers within the facility and outside the facility as outreach programmes and the scope that they are able to cover within the capacity that the facility can operate with regard to resources. With reference to the checklist, all three facilities provide a wide range of services including family planning, STI treatment and

prevention, HIV counselling and testing, and post natal care. Antenatal and delivery care is however not available in the adolescent corner but then pregnant adolescent girls who visit the facility are counseled and directed to the antenatal clinics in the hospital for the appropriate care.

This is further highlighted in the comment of a service provider as follows:

“...And also, we have the family planning devices here. We give, we have, eh...HIV counseling and testing unit too. So those are the facilities that we give them [adolescent clients].” HSP HCH 1

To buttress the point raised about the range of services provided by the facility, an adolescent had this much to say in the dialogue below:

“What range of services do they provide apart from the one that you have come for?”

Many, some is counseling and family planning.” ADC HHZ 2

One other adolescent client in the focus group discussion was precise on the range of services available in the facility:

“Counseling and guidance services on any health related issues, management of STIs and testing of HIV status, teenage pregnancy” FGD ADC HR6

Hence, it can be deduced from the excerpts that there is a wide range of services provided by the facility for young people who need it.

4.3.4 Youth Involvement in designing, assessment and provision of services

The youth are the main stakeholders as far as the adolescent/youth friendly sexual and reproductive health services are concerned, and are therefore expected to have a say in what kind of services that should be provided for them. Youth involvement revolves around a myriad of actions that should culminate in the realization of the goals set for the establishment of the

adolescent/ youth friendly sexual and reproductive health service facility. These include but aren't limited to consulting youth on facilities, consulting youth on services and planning, involving youth in assessment and provision of services. This is what a service provider had to say when asked if they involve adolescents in the planning, assessment and provision of services:

“Eh...yes, it's, it's quite good that we [the service providers] consult them [adolescent client] in deciding on the facilities we provide them.” HSP KHC 1

Adolescents expressed their sentiments in different ways when asked if service providers do consult them for their opinions to craft the services to meet their peculiar needs. A participant in her response said:

“I've not yet seen that. It has not happened yet No, No. they [the service providers] don't ask us what we want. It would have been very good.” ADC HHZ 5

In a separate development, another adolescent participant re-echoed what the previously quoted adolescent said and further elaborated:

“No, we are not involved in the decision making process as to how to plan a service or any other. The service providers are totally in charge of them. They only bring to us what they have.” FGD ADC H R1

There is evidence adolescents would have wished to be called to the table of decision-making as clearly stated below:

“It would have been nice to get us involved in the planning so that we will also have the opportunity to make inputs.” FGD ADC H R2

The health service provider's perspective on the matter indicates there are hitches to implementing this idea though it obviously appears to be the best.

*“I think it will be, it will be due to funding because eh... eh... eh... our infrastructural development, we only depend on the government or donors to provide those things for us so if we should go ahead to involve these adolescents in, ...in contributing to the services that we provide, in case they come out with something that we will not be able to provide, then we will be found wanting.”*HSP KHC 1

Essentially, involving the adolescents in the planning of the services will not only improve outcomes, but also ensure increased utilization.

4.3.5 Equipment and Infrastructure for service delivery

The service provided can only be said to be available when the equipment and infrastructure are in place to ensure smooth delivery of the skillsets. There are concerns for the provision, adequacy, and use of the equipment. Responding to a question on the availability and adequacy of these items, including supplies, a health service provider said:

“Okay. For now we have adequate [equipment] but sometimes as the months go by, we have shortages but sometimes when we send or we write requisitions, they bring them to us but we have not like encountered any shortage as at now.” HSP HCH 3

A reinforcement to the above quote from another service provider is that, there the centres have available a range of family planning methods for clients to choose from.

“The family planning methods, we have the injectable, the implants, IUD, we show all to them and the condoms.” HSP HH 3

The comment however from an adolescent client’s gives an impression that opposes what the service providers said though she admits it does not happen always.

“As for the items... its adequacy is not good enough because we are many. Sometimes so if it will be okay they should have them in excess so that the nurses can have inner satisfaction and work.” ADC HCH 5

The use of teaching aids is very critical in the dissemination of sexual and reproductive health education due to the practicality of the subject under discussion. It allows for first hand transfer of knowledge from the health service provider to the adolescent client and a subsequent return demonstration where appropriate. Therefore, in a facility where this is lacking, the health information transfer may only be partially achieved. The dialogue below confirms this even though it may be justified by some other explanations from the health service provider.

“Do they teach you using posters, models etc. to illustrate what they are teaching or they give the talks without using evidence -based protocols?”

Yes, they use it but not always” ADC HHZ 5

The view of another adolescent corroborates the importance of the teaching aids to make the teaching/learning process easier and effective. This client said:

“They use flyers, posters and models to explain what they teach. It gives a better understanding.” FGD ADC H R5

4.3.6 Staff Friendliness towards adolescents

Friendliness of the facility in general is said to be embodied in the safety, effectiveness and affordability of the services. Staff friendliness is the foundation on which all other services can be built. A non-judgmental attitude to the presence of the adolescent seeking help in the facility is crucial to cementing a good rapport between the adolescent and the service provider. A question to an adolescent client on how she was treated by the provider went like this:

“With respect” FGD ADC H R5

The answer lends credence to the fact that people in general like to be appreciated no matter what the subjective impression one holds about them and adolescents are no exception.

4.3.7 Sexual Health Education for adolescents

Sexual health education plays a critical role in the attempt to reduce the incidence of sexually transmitted infections including HIV infection. Consistent condom use is the only method of contraception that guards against STIs and pregnancy hence the need for a stepwise demonstration of how to use the condom. This requires the use of the penis model (for the male condom and dummy) to demonstrate its use. A service provider tells about the efforts made to ensure that the education is given the right way in the interaction below:

“So if you are teaching them how to use the male condom, you don’t have the penis model to demonstrate that?”

“...I collect it from my people there.... The other office and use (alright) penis model and male condom, even the injectable, Jadelle...those things.” HSP HH 2

Health education is extended beyond the borders of the adolescent health facility into the surrounding communities by the service providers. This activity is reinforced on radio programmes as explained by a service provider below:

“Yes, em,.. I think for the facility here, em... apart from the eh... general outreach clinic that our staff render and then from eh...community service that they organize, ...there are radio stations where health education is given concerning all these and em...these radio stations are accessible from our municipality so in

effect, our populace eh... our population listens to this health education..." HSP

KHC 1

Parents however, do not seem to connect sexual health education to adolescents because they believe that the consequences that may follow may be grave and so must be handled with the necessary attention it deserves. The perspective of a parent reads this way:

"In my view, sexual and reproductive health matters are very delicate issues that should be dealt with tactfully when passing the information on to our children. These days I understand a lot of teenage girls are abusing emergency contraceptive pills in particular and the other forms...This is certainly not our culture and our Sunday school teachings do not accept it." FGD PIC K R5

Obviously, there are opposing views to educating adolescents on sexual health matters. As to whether all the parties involved would come to a compromise for an agreement to be reached on what kind of services should be rendered to young people, the future holds the answer.

4.3.8 Future Plans and Desires for improving services

Working in a dynamic environment requires that facility managers, especially, adopt a proactive rather than a reactive posture if they want to be on top of issues in their business circles. Health service providers look forward to improving coverage, competency areas amongst other things in the nearest future as far as adolescent sexual and reproductive services are concerned. The quote below expresses one of those desires by a service provider:

"Okay from my eeh, what...it's a team work so I'll not say I so what we intend doing is that we want to create more service-friendly clubs and then we want to

collaborate with other NGOs who are into eh...adolescent health in the municipality so that we can also boost eh or raise the eh... challenge aspect and also,... we'll try and also educate and counsel them adequately. Yeah, those are some of the plans we have for next year.” HSP HCH 3

Another service provider who was asked if they could collaborate with private sponsoring agencies to better the lot of adolescents said:

“Yes, I think so. I think we should, we should be looking at that. Looking at support from other eh... areas... NGOs, other areas. We have some NGOs that have been supporting us in adolescent... area of adolescent service. I think we should get more support specifically in the area of adolescent health.” HSP HH 1

The readiness to look for support from NGOs to advance the services provided to adolescents by the facility is a commendable one. The service provider here has in this statement demonstrated the zeal to work with such agencies in support of adolescent health.

The same question about future plans and desires to another service provider yielded this response:

“Ooh, for the improvements, I may say maybe it is the home visiting (laughs). Sometimes, we do go, but the T and T (Travelling and Transport) to go with is from our own pockets so for that one I may say it's a challenge for us. If something could be done about it.” HSP HCH 2

The above sentiments place emphasis on funding as a more pressing need for a frog-leap onto the next pedestal in order to make headway to achieving success with good speed and accuracy.

The same issue of funding is touted here by adolescents who also believe that securing the necessary funding will be the breaking point for improvement over the current performance. This is how they put it:

“Improving work, first it is money that does it and the supplies and equipment so they [service providers] can expand it beyond what it is now.” ADC HCH 5

More interesting is the desire of an adolescent client who sees improvement of services from a different bearing:

“The youth should be brought together in their numbers so that they will educate us more.” ADC KHC 1

To sum it up, funding, space and increased coverage of services are the priority areas to improving adolescent sexual and reproductive health services for both service providers and adolescent clients.

4.3.9 Perception of what ASRHS is to respondents

Adolescent sexual and reproductive health is an area of healthcare that in spite of the numerous benefits it rolls out to protect adolescents, it has also raised a lot of controversies surrounding the cultural and religious beliefs of the community. Meanwhile, the scope of the services that can be accessed from the facility include giving educational talk, giving care to adolescents, family planning and STIs prevention, addressing reproductive health problems, menstrual hygiene, perception of adolescence, perception of adolescent sexuality, responsibility for actions, secondary sexual characteristics development, physical and sexual maturation, increased questioning, adolescent perspective, psychological development

“Yeah.....You know adolescents need (clears throat) health care. During that time, there are a lot of changes that take place in the development of the people... during the ages of 10 to 19 and some of them too, let’s say majority of them cannot take the right decision for themselves so they many need to be given that care so that they will be able to take care of themselves.” HSP HH 1

“The adolescent health services is the programme which is aimed at assisting the adolescents who are in one, any reproductive, problem. They come here for counseling, they come here for family planning and we go into the schools, apprentices then we talk to them about sexual health. That’s what we basically do.” HSP HCH 1

Nonetheless, parents have issues with why adolescents should be conscientized on sexual health issues including contraceptive use. This parent shares her opinion like this:

“Culturally, it is expected that adults and married people be the only ones who should talk about sex. We should not disregard our values. If we look at religion too, the bible speaks against sexual immorality. Allowing our children to access services such as family planning/contraception as they call it means we are encouraging promiscuity. If this aspect will be removed from it, then it will be better for us all.” FGD PIC H R5

There is an undeniable fact that parents of adolescents will continue to have difficulties to consenting to some of the services provided by the facility. One of the parents out rightly expressed opposition to the service:

“I, as a parent would not want to because I do not want my children to start learning about these things this early. I believe that the teachers in school already do mention some of that in class so it is okay.” FGD PIC K R1

A possible reason for this deep skepticism about the adolescent-friendly service is that they believe there are dire consequences to introducing their wards to sexual education, as two parents voiced below:

“You know it that once they [adolescent] start [getting sexual education] they may become pregnant and drop out of school and no parent wants that!” FGD PIC HH R3

“If you are there and they bring a girl to your house that your son has impregnated her, then now you have double responsibility to care for your son and the pregnant girl. Where is the money to do so?” FGD PIC HH R2

Another parent went on to state her disbelief in the effectiveness of the service:

“I think that whether we educate them or not, they still have access to all that information from their peers and other platforms like the internet. Today, they call something “whatsapp” through which people communicate a lot. So whether we teach them or not, some will still engaged in sexual intercourse. And so, it does not make any change.” FGD PIC K R4

Importantly, some parents do not share such pessimistic views as they believe that satisfying the sexual health needs of adolescents is an essential service:

“What we need to do is to meet as stakeholders with teachers’ health service providers and policy makers to discuss how these services need to be delivered. What the context of the information should be, who should provide the service, how it should be presented, where and when. This is because parents are

interested in knowing what messages their wards will receive from this outlet and would want to contribute to it...” FGD PIC R4



4.3.9.1 Facility Operation (Working hours& waiting time)

Essential to the success of a health-service organization is its mode of operation. This comprises the working hours, waiting time and some other organizational culture that is characteristic of the service providers. The importance of how a facility is operated cannot be overemphasized due to the critical role it plays in communicating to the public what services they offer and the hour range within which these services can be accessed from the facility. Based on this information, people who have any interest in visiting the facility are expected to decide when they could do so at their convenience within the time-frame allotted. This vital communication is often displayed on notice boards and sign boards that are strategically positioned and well highlighted, sometimes in reflective colours to capture the attention of passersby. It is in the same vein that the adolescent sexual and reproductive health services should be tailored to suit all adolescents, students and non- students alike. An adolescent client's remarks about it:

“The timing is convenient for us to access the services they provide.” FGD
ADC H R6

This is what another adolescent said regarding the working hours at the facility level

“Yes, they work into the evenings and on weekends so that you can visit them after close of school or work.” FGD ADC R3

Aside the working hours, waiting time is one other factor that clients are apprehensive about. They always would require from others, how quickly they would be attended to should they visit the facility. It is even more of a problem to the adolescent who is shy and naïve, in want of attention but would not want to be seen in the clinic by too many people accessing services from a facility she believes adults and therefore society frowns on. An adolescent's remark about waiting time is as follows:

“Waiting time was short. Within the next 10-15 minutes I was taken care of.”

FGD ADC H R2

There were however special circumstances that allowed for extended waiting times, as this adolescent explains:

“When there are a lot of people, it could take an hour but when people are few, before it is 30 minutes I would have left” ADC KHC 9

In summary, there is a consensus that waiting times are short and that issues are quickly attended to.



CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

The previous chapter analysed the qualitative responses of participants in assessing the delivery of adolescent sexual and reproductive health services in Ho, Hohoe and Kpando municipalities. This chapter discusses the findings of this study. This study used a phenomenological analytical framework in achieving its stated objectives, begun with the use of a facility observation and assessment checklist to find out what requirements for service provision are in place. In-depth interviews were conducted for fifteen adolescents within the age range of 15 to 24 years, nine service providers at post and three focus group discussions for parents and clients in the community for the three study sites, Ho, Hohoe and Kpando.

The youth friendly service delivery is about providing services based on a broad understanding of the needs of young people in a particular society or community, rather than being based only on what providers consider they need (Tylee et al (2007). It is also grounded in the thoughtfulness of, and respect for, the realities of young people's varied sexual and reproductive lives (Doyle et al, 2012). The focus is on creating a service which young people trust and feel is there for them and their needs.

It is also important to realize that a young person's use of a service depends not only on his or her ability to access the services, but on their perceived need and knowledge of available services (Mmari & Magnani, 2003). Crucial to the youth friendly service provision, therefore, is the need for service providers to be mindful of the special difficulties that young people face in accessing sexual and reproductive health services. For instance, convenient working hours, legal and policy

challenges, apprehensions about confidentiality, fear of discrimination (especially among sexually active girls), being treated with disrespect and high costs are some of the factors that can inhibit young people's ability to access services (Erulkar et al, 2005).

There is the need to pay attention to the health needs of adolescents to: reduce death and disease, now and during their future lives. It is incumbent on society to deliver on the rights of adolescents to health care, especially reproductive health care; ensure that this generation of adolescents will, in turn, safeguard the health of their own children (WHO, 2002).

It is important to note that adolescents are not a homogeneous group. Their needs vary with their sex, stage of development, life circumstances and the socio-economic conditions of their environment (Kabiru et al 2013). The results from this study indicate that a lot more efforts will have to be directed at restructuring the adolescent sexual and reproductive health services in order to realize the expected outcomes.

Results from the study show that there is still a gap to be filled regarding the perception participants hold about what adolescent friendly sexual and reproductive health is. Some items on the observation checklist were either not available or available in limited proportions. For instance, a facility was being manned by a nurse-midwife who has not received any special training on adolescent care. She admitted she provides the service based on personal experience. Another instance bothered on whether the services are offered free of charge, the service providers said it was so except for family planning for which they charge a token. Most of the clients met at the centres were pregnant or newly-delivered adolescent mothers. They were able to describe the service as being a platform for giving educational talk, giving care to adolescents, a family planning centre and treatment of STIs amongst others. Though they were able to

identify one or two services that are available to adolescents in the facilities, they could not tell the rationale behind this kind of service (Bearinger, Sieving, Ferguson, & Sharma, 2007).

Waiting time was mostly brief, and the facilities operated at hours convenient for clients to utilize the services. The providers volunteered that there was increased attendance during off-school/vacation periods, as more adolescents are able to have the time to attend (Erulkar et al, 2005).

Another key theme that emerged was about sexual health education. Participants were able to mention a number of activities they perceive as sexual health education. They saw it as an avenue to learn about practicing safe sex to prevent contracting any diseases or infections. Health service providers commendably extended the services through community outreach programmes, the use of visual aids such as video and other forms of printed material.

However this study provides an overview of adolescents' health seeking behaviours, knowledge about available services and barriers to reach services. Even though evidence is abundant through years of research on this subject, specific problems needed to be investigated to provide services in a more acceptable manner (WHO, 2013)

Most of the current study findings are not too different from what has been found in other studies conducted in different parts of the world (Tylee et al, 2007; Sovd et al, 2006). However, some of the outcomes are quite exclusive to this study. Health service providers are working assiduously with the limited resources they have to reach as many young people that they can especially adolescents in the community who for innumerable reasons cannot make it to the facility to get information on sexual and reproductive health services. Out-of-school adolescents have also benefited from these efforts including health talks and post-natal care. Others have had the message at community durbars where service providers were invited to give health talks on

adolescent health. Health service providers in these three study sites are confronted with issues about funding. The number one barrier to effectiveness of the ASRHS is funding (Deogan et al, 2012). Sometimes service providers have to fund the outreach programmes from their own pockets and even help those adolescents who are impoverished and are in need of some basic essentials for day-to-day survival.

Funding has also been mentioned as a reason for not involving the youth in the planning, assessment and provision of health services (Deoganet 2012; Kesterton et al, 2010). This is contradictory to the plans of youth involvement spelt out in the policy document of the Ghana Health Service. Donor support is not adequate. Marie Stopes International is the only private organization that is helping two out of the three facilities where this study was conducted. Their support is in the form of providing the logistics to work with such as information leaflets and training service providers in special areas of handling adolescents. Donor support is very limited as most of these agencies have specific projects that they fund and so cannot be pushed to switch attention to adolescent health (Senderowitz, 1999).

Another barrier to effective service provision is infrastructure. Space within which these services have to be rendered is very narrow. From direct observation, the shelter under which services are provided is not roomy enough. Though service providers have been able to create an adolescent corner, there is the need to expand the facility or even get a complete structure for that purpose. The use of existing public health care infrastructure for adolescent health care services is a good strategy in the interim. A recent review done by WHO has shown that this strategy has been more successful than other strategies for reproductive health service provision (WHO, 2003).

Dissemination of information on sexual and reproductive health can be said to be intensive with the formation of school clubs and radio programmes in some of the municipalities but behaviour change is slow. Empirical evidence suggests that infusing sexual education into the curriculum will help prevent adverse outcomes of adolescent reproductive health problems (Biddlecom et al, 2007; Speizer et al 2003). So, as advised by a parent, curriculum based programmes are needed, but it is also important to train teachers to tackle these sensitive issues in order to gain adolescents' confidence. From a rights-based approach, it is unethical to give education on sexuality and sexual and reproductive health to young people without providing them with appropriate services, including contraceptives and counselling.

Myths and misconceptions about family planning continue to hinder some adolescents who are sexually active from accessing any of the methods available as many convinced it has adverse effects on health in later life (Hillard, 2013; Yee & Simon, 2010). This perhaps may be a reflection of poor guidance and counselling skills, health education on the part of service providers.

Notwithstanding the venue for service provision, whether in a clinical setting, a youth oriented site, in schools or in the community, certain youth friendly characteristics are essential for effective services (Agampodi et al, 2008). Providers of service should be trained to work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs without being judgmental (Warenius et al, 2006; Senderowitz, 1999). Some service providers have received special training to deliver services at the adolescent friendly centre. The numbers, however, are not encouraging considering the population of adolescents within the municipalities used for this study.

There are also issues about quality assurance. Quality embraces respecting confidentiality, giving varieties for people to choose from and raising awareness on rights (Gavin et al, 2010). Quality transcends the service delivery point to include community acceptance of adolescent sexual and reproductive health services (Kesterton et al, 2010). Furthermore, the quest for services contribute to quality by responding to the realities of young people's lives. Strict measures do not seem to be in place to address matters pertaining to quality. The quality of a service refers to its availability, affordability and acceptability. A service provider said the bureaucracy involved in getting slides they have prepared for presentation to the public moderated and approved by the public health nurse was time-wasting so they sometimes sneak out to give information that has not been scrutinized for the appropriateness of its content. This could translate into misinformation and distortions of established facts.

There are also strong concerns for violating cultural and religious values (Aarø et al., 2006). For instance, service providers in Kpando cannot have access to students of Bishop Herman College because it is a Catholic school and the Catholic Church does not encourage artificial contraception. Cultural connotations against educating adolescents on contraception and family planning were also raised (Awusabo-Asare et al, 2004). It is said to have helped adolescents to remain virgins until they were handed over to their husbands in marriage. Hence, it is rather a disservice to society to give adolescents information on sexual health when in fact, they should be focusing on academic pursuits.

The negative attitude of side-lining parents and teachers in the planning and implementation of the adolescent sexual and reproductive health services has dire consequences as the service providers in Ho have challenges meeting students because of issues relating to their curriculum (Kesterton et al, 2010; Wamoyi et al, 2011). For instance at the time of collecting data for this

study, the researcher could not meet the students who were members to the school club for any interaction due to the preparation they were having towards the Basic Education Certificate Examination. There is the need for reproductive health education to be given greater attention as a key step to removing these barriers.

Privacy and confidentiality is one important feature of health service provision that is very likely to win the trust of adolescents who visit the facility (Renju et al, 2010). All three facilities have their adolescent corners sited away from where the mainstream clients' access services to ensure some privacy. Apart from that, there is a consulting room that accepts one client at a time for a one-on-one interaction with the service provider. The staff in charge of providing these services have cabinets with locks to keep clients' folders and records. Access to these folders is allowed for only staff members who are directly involved in giving care just in a bid to observe confidentiality of client's information. Although most adolescents said privacy and confidentiality was assured them during service delivery, one person felt this characteristic was violated because other clients who sat close to the consulting room must have overheard the conversation between her and the service provider who spoke loudly (Agampodi et al, 2008).

The range of services provided by the facilities include guidance and counselling, family planning, diagnosis and treatment of sexually transmitted infections amongst others.

The recreational setting for all three facilities cannot be said to be the best. From the standpoint of the health service providers in Ho and Kpando have enjoyed from Marie Stopes, and the singular initiative of service providers in Hohoe (provision of recreational items like oware, ludo, etc.) it must be appreciated that service providers have been versatile in their performance to remain resourceful even with limited provision. This activity has made it more appealing to

adolescents to attend the centres. Overall, it can be said that the acceptance and use of these facilities by adolescent girls is an encouraging sign. Improvement of confidential care and training in youth friendly service provision should, however, be encouraged. It can also be widened by integrating RH concepts as well as cognitive development principles into the program (Renju et al, 2010). Finally, a major challenge for the effective implementation of programs would be adjusting the service provision to meet the needs of adolescent boys (Pearson, 2003).

The present study opens a huge area for further qualitative research in order to gain more understanding of these problems. Parent-child perceptions and its impact on adolescent reproductive health is a priority area for future studies (Berne et al, 2000; Wamoyi, Fenwick, Urassa, Zaba, & Stones, 2011). In this study, although most parents were concerned about the consequences of adolescent sexuality, they were mainly antagonistic to the provision of AFSRH services, with one parent going further to state that:

*“There is a subject at the basic level called religious and moral education. Sometime ago it was taken out of the curriculum and you saw how people reacted seriously to have it back. We should use this subject as a medium to educate our young people to restrain themselves from sexual and reproductive health issues until they marry.”*FGD PIC KR6

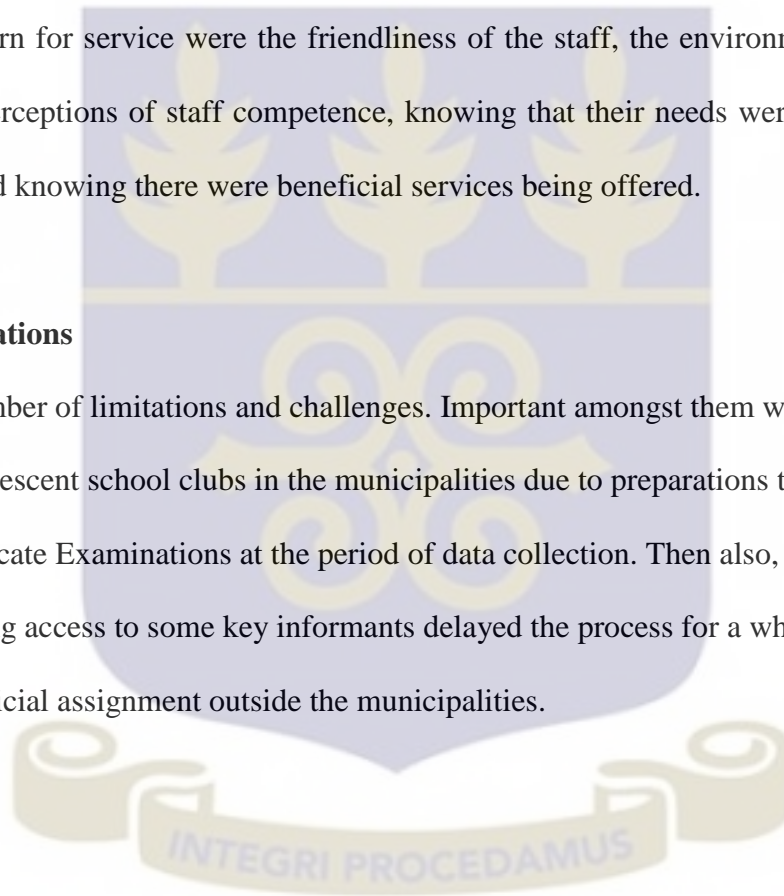
However, a moderating voice such as one provided by a parent inspires hope that by channelling proper awareness, parents can be brought around:

“It is about time parents broke the silence on sex education. They need to sit their adolescents down and teach them about the implications of early sexual activities so that they will adopt the right attitudes and behaviours. They should also make sure that they provide their children’s needs so that men will not abuse them by using those things as baits” FGD PIC HH R4

In conclusion, according to adolescents' perception on availability, accessibility and acceptability of health services, the present system has been able to mostly provide appropriate services to them but improvements can still be made. Confidentiality and the youth involvement is a major concern among adolescents. Planning of adolescents health care services should be initiated with participation of adolescents, so that the services will be more user friendly. Program planning should be based on qualitative studies in order to get a deeper understanding. Major factors that made clients return for service were the friendliness of the staff, the environment/infrastructure of the facility, perceptions of staff competence, knowing that their needs were private and kept confidentially and knowing there were beneficial services being offered.

5.2 . Study limitations

There were a number of limitations and challenges. Important amongst them were the lack of access to the adolescent school clubs in the municipalities due to preparations towards the Basic Education Certificate Examinations at the period of data collection. Then also, the bureaucracy involved in getting access to some key informants delayed the process for a while as some of them were on official assignment outside the municipalities.



CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This study has endeavoured to assess the delivery of adolescent-friendly SRH services. In this chapter, a summary and conclusion of the study was described outlining study's findings and themes including their implications to public health practice and recommendations for future research.

6.2 Conclusion

In line with the purpose of the study, qualitative data on the state of the youth friendly sexual and reproductive health services rendered to young people in the Ho, Hohoe and Kpando Municipalities. Content analysis of the data generated the following themes: privacy and confidentiality, staff knowledge, training and competence, range of services provided, youth involvement in services development, equipment and infrastructure, sexual health education, future plans and desires, perception of what AFSRH is and facility operation (waiting times and operating hours).

Service delivery was generally favourable, as many adolescent clients expressed satisfaction with the quality of delivery, including staff attitude and competence, environmental conduciveness and the range of services provided to them. Waiting hour and operation times were convenient for the clients, and the providers expressed willingness to maintain and improve on this. In terms of the service-related and youth friendliness factors that may affect the utilization of the services, the checklist showed that on most issues such as affordability of service, privacy and confidentiality, variety of service, provision of recreational facilities and existence of referral

systems, all the facilities did commendably. Improvements were seen to be needed in terms of youth involvement, facility location, client complaint and quality monitoring, as well as weekend openings.

In exploring the perceptions of adolescents/youth about how they would want the adolescent sexual and reproductive health services to be packaged, this study found that most of the services young people needed were provided, but their preferences were not taken into consideration. However, the factors that encourage young people to seek services were mostly present for females but were largely absent for males. Such factors included the availability of recreational facilities, distance from where young people live, study, or work, increased visibility and awareness, presence of male service providers and assurance of confidentiality and privacy.

6.3 Recommendation for policymakers

Policy makers should formulate policies that will favour the facilities so that service providers can improve service delivery by improving locational access and improving infrastructure at those present facilities to fulfil the comfort and privacy needs of adolescent clients. Also staff training, creating simpler administrative systems and increased program funding should be assured. Active involvement of donors and ensuring they are more attentive to peculiar facility needs are also pertinent to strengthen the AFSRH services provided.

6.4 Recommendation for service providers

Service providers need to sit and juggle ideas as to how they can partner with non-governmental organizations. Meanwhile, they should continue to show commitment by making personal sacrifices since that may become a baseline to win the support of individual philanthropists or

groups. Frequent and strategic contact with community members may be one of the avenues to identify such opportunities.

The Ghana Health Service, which is the main service provider can lobby the extension of

6.5 Recommendation for public health practice

A finding of this study was the antagonistic perspective of most parents to the provision of AFSRH services, which implies that practitioners of public health must build messages that will allay their fears, educate them properly on adolescent sexuality, and channel them through the right avenues to impact on them. This means effective collaboration with social and religious institutions, cultural festival grounds, sports centres, educational institutions and night markets as well as using the power of the media to increase knowledge on the necessity of this service.

6.6 Implication for future research

There is the need for further research on assessing the state of AFSRH services employing mixed method and longitudinal design; this would aid in a quantitative exploration of the effectiveness and performance of the facilities, while also investigating specifically the barriers to utilization of the available services.

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APPENDICES

Appendix A: Supporting Letter from the Volta Regional Health Directorate.



APPENDIX 1: Supporting Letter from the Volta Regional Health Directorate

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

My Ref. No. VRHD/ORD/31

Your Ref. No.....

Our GHS Core Values
PEOPLE-CENTRED SERVICES
PROFESSIONALISM
TEAM WORK
INNOVATION/EXCELLENCE
DISCIPLINE
INTEGRITY



Volta Regional Health Directorate
GHANA HEALTH SERVICE
P. O. BOX 72
HO, V/R.
Tel: (03620) 28210
Fax: (03620) 28244
volta-health@4u.com.gh

April 9, 2015

LETTER OF INTRODUCTION- LIVIA LIKE ATIKU

This is to introduce to you Ms Livia Like Atiku (ID 10268196), a post graduate student of the Department of Population Family and Reproductive Health of University of Ghana, offering a Masters programme in Public Health.

As an academic requirement, she is conducting a research on the topic: An Assessment of Youth Friendly Sexual and Reproductive Health Service in the region.

I would be very happy if you could accord her the necessary assistance.

Thank you.

[DR JOSEPH TEYE NUERTEY]
REGIONAL DIRECTOR OF HEALTH SERVICES
VOLTA REGION

DISTRIBUTION

THE MUNICIPAL DIRECTORS OF HEALTH SERVICES;
HO MUNICIPAL HEALTH DIRECTORATE
HOHOE MUNICIPAL HEALTH DIRECTORATE
KPANDO MUNICIPAL HEALTH DIRECTORATE

Cc: Ms Livia Like Atiku ✓

Appendix B: Ethical Approval

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

Tel: +233-302-681109

Fax + 233-302-685424

Email: Frimpong@ghsmail.org

Hannah.

My Ref. :GHS-ERC: 3
Your Ref. No.

12th May, 2015

Atiku Livia Like
School of Public Health
University of Ghana
Legon, Accra

ETHICS APPROVAL - ID NO: GHS-ERC: 92/02/15

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

“An Assessment of Adolescent Youth-Friendly Sexual and Reproductive Health in Three Health Facilities in the Volta Region of Ghana”

This approval requires that you inform the Ethics Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethics Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

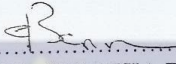
You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please note that this approval is given for a period of 12 months, beginning May 12th 2015 to 11th May 2016.

However, you are required to request for renewal of your study if it lasts for more than 12 months.

Please always 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



Appendix C

PARTICIPANT'S CONSENT FORM

Research Topic

An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana.

Introduction

I am a student from the School of Public Health, University of Ghana, Legon, carrying out a study titled “an assessment of adolescent/youth-friendly sexual and reproductive health services in three health facilities in the Volta region of Ghana.”

You are warmly invited to participate in this study by signing the consent form voluntarily.

Study Procedure

This study will be conducted in the reproductive health units of the municipal health directorates of Ho, Hohoe and Kpando, all in the Volta region of Ghana and a total of 42 participants (14 from each municipal) with a mix of service providers, clients and community members. The methods of obtaining the information are through interviews, facility observation checklist and focus group discussions. Participants will be required to give candid opinions about a series of issues concerning the services provided by the youth-friendly sexual and reproductive health facility. The interview is expected to last for forty five minutes. This consent form contains information about the research. We are asking you to read this consent form carefully before you decide to participate in this study. You will also be required to sign it if you agree to be part of the study. In that regard, you will be given a copy of this form to fill. This consent form might have some words that are unfamiliar to you. Please request for us to explain to you anything you might not understand.

Benefits

There are no personal gains in participating in this study. It is expected however, that the findings from this research will contribute to improving upon the existing facilities and the services they provide.

Discomforts

This study will involve a total of 30 respondents who will answer a series of questions. Accepting to take part in this study will take about 45 minutes of your time and we need you to answer the questions. The questions are basically about the youth-friendly sexual and reproductive health services and what you would want to see about it. Also, if there are any questions you would rather not answer or that you do not feel comfortable answering, please say so and we will stop the interview or move on to the next question as preferred by you. In accepting to take part in this study the discomfort that you may experience is mainly your time taken to answer the questions.

Privacy and Confidentiality

Your participation in this study is voluntary and safe. All data collected is for only research purposes and will be held in confidence. Information will be stored with passwords on electronic media and in safely locked boxes.

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. This study has been reviewed and approved by Ghana Health Service Ethical Review Committee (GH-ERC) which is committee whose task is to make sure that research participants are protected from harm and their rights respected.

If you have any questions or concerns kindly contact the Ethical Review Committee administrator **Hannah Frimpong on the following lines 0243235225 or 0507041223 for further clarification.**

Voluntary Participation

Part-taking in this study is completely voluntary. You may refuse to answer any question we ask you and you may stop or end the interview at any point in time. You may also withdraw your participation should you decide to after you have consented to participate.

Withdrawal from the Study

You can voluntarily withdraw from participating in this research at any point in time without any adverse reaction from the researcher towards you.

Potential Risks and Benefits

The researcher does not foresee any risks associated with your participation in the research. There will be no direct benefit to respondents. However, the information provided is expected to guide policy makers to address concerns raised in improving upon the existing facilities and the provision of services.

Recording

The interviews will be recorded. This will allow the researcher to clearly understand the points that are raised in the interview. You can request that the recording be stopped at any time during the interview, either temporarily or permanently as appropriate. The researcher and her research assistants and project supervisor will be the only ones who will have access to the recordings. The recordings will be stored in a locked cabinet and will be destroyed two months after the study. The recordings will be transcribed for the purposes of analyzing this work. Your name and other information that could be used to identify you will not be included in the type-written version.

Compensation

Study participants who consent to be part of this study will not receive any monetary or non-monetary compensation.

Declaration of conflict of interest

I, the researcher, hereby declare that there is no conflict of interest as far as this research work is concerned.

Your Right as a Participant

If you have questions about the research in general or about your role in the study, please feel comfortable to contact the principal investigator on this address: Livia Like Atiku, cell phone number **024 3617 446** or email **liviaak1@yahoo.com**

You could also contact the administrator of the Ethical Review Committee of the Ghana Health Service on this address: **Hannah Frimpong, cell phone numbers 024 323 5225/ 050 704 1223.**

Volunteer Agreement

The above document describing an assessment of adolescent/youth friendly sexual and reproductive health service for the above named research has been read and explained to me. I have been given the opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

.....
Date

.....
Signature/Thumb print of
Participant

Interviewer's statement

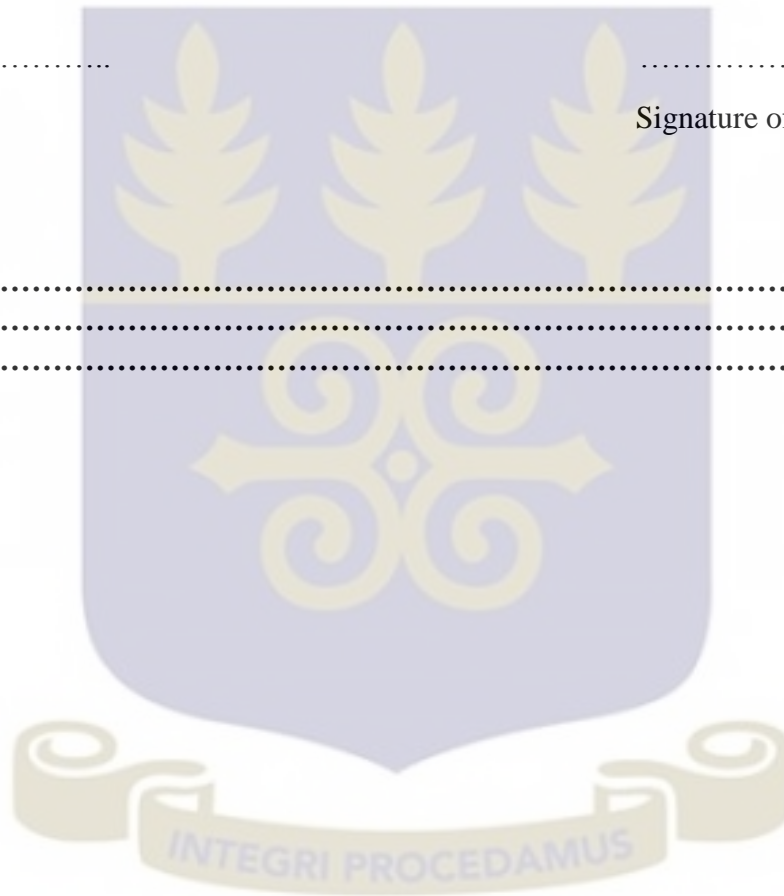
I, the undersigned, have explained the details of this consent form to the participant in the language that s/he understands, the purpose of the study, procedures to be followed as well as risks and benefits involved. The participant has freely agreed to participate in the study.

.....
Date

.....
Signature of Interviewer

Address

.....
.....
.....



**APPENDIX D
PARENTAL CONSENT FORM**

I agree to the document that described the benefits, risks and procedure, for the study;
“An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana” that have been read and explained to me. And I agree that my ward should be a volunteer.

Date

Signature or thumbprint

If volunteer’s parent/guardian cannot read and witness is involved:

I was present while the benefits, risk and procedures were read and explained to the volunteer’s parent/guardian and he/she has agreed to participate in the study.

Date

Signature or thumbprint of witness



APPENDIX E**Profile of Respondents**

Entry number	Age (years)	Sex	Marital status	Level of education	Language spoken for interview	Study site
HSP KHC 1	49	Male	Married	Tertiary	English	Kpando
HSP KHC 2	42	Female	Married	Middle School	English	Kpando
HSP KHC 3	26	Female	Single	Tertiary	English	Kpando
ADC KHC 1	18	Female	Single	SHS	Ewe	Kpando
ADC KHC 2	20	Female	Single	SHS	Ewe	Kpando
ADC KHC 3	17	Female	Single	JHS	English	Kpando
ADC KHC 4	20	Female	Single	SHS	Ewe	Kpando
ADC KHC 5	18	Female	Single	SHS	Ewe	Kpando
HSP HCH 1	54	Female	Married	Tertiary	English	Ho
HSP HCH 2	26	Female	Single	Tertiary	English	Ho
HSP HCH 3	24	Female	Single	Tertiary	English	Ho
ADC HCH 1	17	Female	Single	JHS	Ewe	Ho
ADC HCH 2	20	Female	Single	SHS	English	Ho
ADC HCH 3	18	Female	Single	Tertiary	English	Ho

ADC HCH 4	18	Female	Single	SHS	Ewe	Ho
ADC HCH 5	19	Female	Single	JHS	Ewe	Ho
HSP HH 1	44	Male	Married	Tertiary	English	Hohoe
HSP HH 2	56	Female	Married	Middle School	English	Hohoe
HSP HH 3	24	Female	Single	Tertiary	English	Hohoe
ADC HHZ 1	18	Female	Single	JHS	English	Hohoe
ADC HHZ 2	20	Female	Single	JHS	Ewe	Hohoe
ADC HHZ 3	22	Female	Single	JHS	Ewe	Hohoe
ADC HHZ 4	20	Female	Single	JHS	Ewe	Hohoe
ADC HHZ 5	18	Female	Single	JHS	Ewe	Hohoe
FGD ADC HR1	16	Female	Single	JHS	Ewe	Ho
FGD ADC HR 2	19	Female	Single	JHS	Ewe	Ho
FGD ADC HR 3	21	Female	Single	JHS	Ewe	Ho
FGD ADC HR 4	17	Female	Single	JHS	Ewe	Ho
Entry number	Age (years)	Sex	Marital status	Level of education	Language spoken for interview	Study site
FGD ADC HR 5	17	Female	Single	JHS	Ewe	Ho
FGD ADC HR 6	22	Female	Single	JHS	Ewe	Ho
FGD PIC	38	Female	Single	SHS	Ewe	Hohoe

HH R1						
FGD PIC HH R2	35	Female	Married	Tertiary	Ewe	Hohoe
FGD PIC HH R3	40	Male	Married	Tertiary	Ewe	Hohoe
FGD PIC HH R4	42	Female	Married	SHS	Ewe	Hohoe
FGD PIC HH R5	36	Male	Married	Tertiary	Ewe	Hohoe
FGD PIC HH R6	33	Female	Married	Tertiary	Ewe	Hohoe
FGD PIC K R1	39	Female	Married	SHS	Ewe	Kpando
FGD PIC K R2	31	Female	Married	Tertiary	Ewe	Kpando
FGD PIC K R3	40	Female	Married	Tertiary	Ewe	Kpando
FGD PIC K R4	34	Female	Married	Tertiary	Ewe	Kpando
FGD PIC K R5	37	Female	Married	Tertiary	Ewe	Kpando
FGD PIC K R6	41	Male	Married	SHS	Ewe	Kpando

APPENDIX F 'A'

A. Interview Guide (Adolescent/ Youth Client)

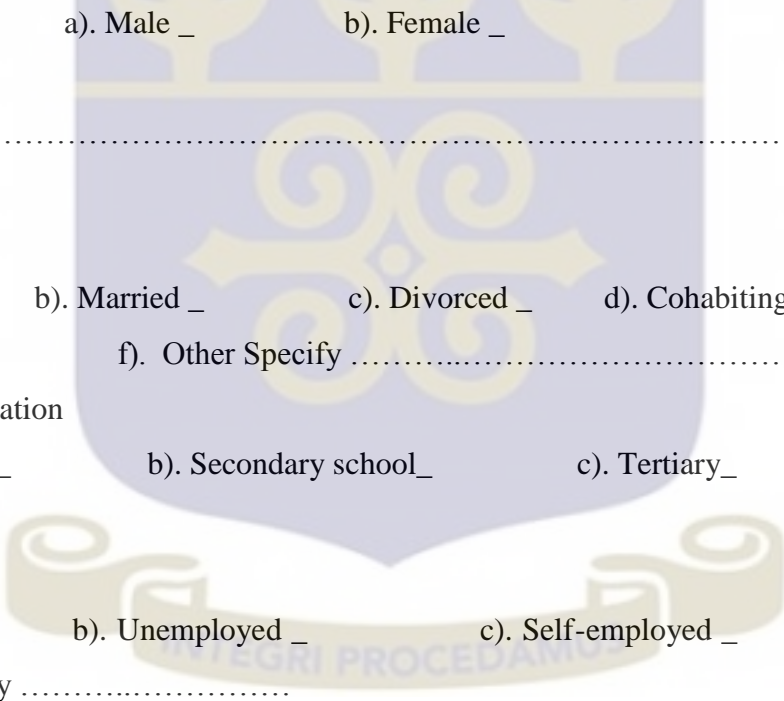
An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana.

ID No.....

Time started..... Time ended.....

SECTION A

DEMOGRAPHIC DATA

- 
1. Sex: a). Male _ b). Female _
2. Age
3. Marital status
- a). Single _ b). Married _ c). Divorced _ d). Cohabiting _
- e). Widowed _ f). Other Specify
4. Level of education
- a). Basic school_ b). Secondary school_ c). Tertiary_ d). Others_
5. Occupation
- a). Student _ b). Unemployed _ c). Self-employed _ d). Public Servant _
- e). Other Specify
6. Language spoken for interview

SECTION B

Friendliness of Service Delivery

1. Please tell me, do health-care providers and support staff in this facility treat adolescent/youth client with equal care and respect, regardless of status?
2. Are health services delivered here either free or offered at affordable to adolescents/youth?
3. Is client privacy and confidentiality ensured and guaranteed respectively during service delivery?
4. Are health services delivered at convenient hours?
5. How about the facility environment, would you say it is appealing and clean?

Range of Services Provided

6. Would you say adolescents are well informed about the range of available reproductive health services and how to obtain them e.g. STIs management, VCT, Vaginal discharges?
7. Are health-care providers using evidence- based protocols and guidelines to provide health services e.g. the use of posters, handbooks and treatment guidelines?
8. Are the youth actively involved in designing, assessing and providing health services?

Service Provider Attributes

9. What competencies would you expect to be exhibited by the health service provider? In your own assessment, do you think health-care workers demonstrate this?
10. Would you say the facility has the required equipment and supplies necessary to deliver the required health services?

Packaging of Health Services

11. How would you want these services to be packaged to make them appealing and attractive to adolescents, youth and young people in general e.g. friendliness as in working hours, waiting time, etc.?

APPENDIX F 'B'

Interview Guide (Manager)

Research Topic

An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana.

ID No.....

Time started..... Time ended.....

SECTION A

DEMOGRAPHIC DATA

1. Sex: a). Male _ b). Female _

2. Age

3. Marital status
a). Single _ b). Married _ c). Divorced _ d). Cohabiting _
e). Widowed _ f). Other Specify

4. Level of education

5. Occupation/Rank

6. Language spoken for interview.....

SECTION B

Friendliness of Service Delivery

1. May I please know from you if there are policies and procedures in place that ensure and guarantee client's privacy and confidentiality?
2. Does the health service delivery ensure and guarantee client privacy and confidentiality?

Range of Services Provided

3. Does management have in place a variety of channels to inform and educate the community on the services provided by the facility?
4. Are the adolescent and youth actively involved in designing, assessing and providing health services?

Packaging of Health Services

5. Is there a required package of health care provided to fulfil the needs of all adolescents either at the point of health service delivery or through referral linkages e.g. education on SRH matters, information leaflets, contact number of focus care provider, timing etc. ?

Health Service Provider Attributes

6. Would you say the health-care workers have the required competencies to work with the youth and provide them with the required health services? What are the competencies?



APPENDIX F ‘C’

Interview Guide (Health Service Provider)

Research Topic

An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana.

ID No.....

Time started..... Time ended.....

SECTION A

DEMOGRAPHIC DATA

1. Sex: a). Male _ b). Female _

2. Age

3. Marital status
a). Single _ b). Married _ c). Divorced _ d). Cohabiting _
e). Widowed _ f). Other Specify

4. Level of education

5. Occupation/Rank

6. Language spoken for interview

SECTION B

Friendliness of Service Delivery

1. Please tell me, are there policies in place that do not restrict the provision of health services on any terms?
2. Do health-care providers treat all clients with equal care and respect regardless of status? How do you ensure that?
3. What policies and procedures do you have in place to ensure and guarantee client privacy and confidentiality?
4. May I know if you provide care using evidence-based protocols and guidelines (e.g. posters, models etc)
5. Are you well-resourced with the required equipment and supplies to facilitate the provision of health services?

Service Provider Attributes

6. Are you, as a provider of service non-judgmental, considerate and easy to relate to? In what ways?
7. Do you observe short waiting times for consultations and do you attend to clients with/without appointment and where necessary refer appropriately?
8. How about competency, have you received any special training in delivering adolescent and youth sexual and reproductive health services.

INTEGRI PROCEDAMUS

APPENDIX F ‘D’

Focus Group Discussion Guide (Community Member)

Research Topic

An assessment of adolescent/youth friendly sexual and reproductive health services in the Volta region of Ghana.

ID No.....

Time started..... Time ended.....

SECTION A

DEMOGRAPHIC DATA

1. Sex: a). Male _ b). Female _

2. Age

3. Marital status
a). Single _ b). Married _ c). Divorced _ d). Cohabiting _
e). Widowed _ f). Other Specify

4. Level of education
a). Basic school_ b). Secondary school_ (c) Tertiary_

5. Occupation
a). Student _ b). Unemployed _ c). Self-employed _ d). Public Servant _
e). Other Specify

6. Language spoken for interview

SECTION B

Awareness and Perception of Services Provided

1. Who is an adolescent?
2. Please tell me, are you aware of the existence of a youth friendly sexual and reproductive health service facility in this community?
3. Does your culture in any way oppose the patronage of services provided at this clinic?
4. Do community members understand the benefits of the adolescent/youth friendly sexual and reproductive health services?



APPENDIX G

FACILITY OBSERVATION ASSESSMENT CHECKLIST

Adopted from African Youth Alliance/Pathfinder International

..	Characteristics	Facility 1	Facility 2	Facility 3	Feasible suggestions for improvements
	Health facilities Characteristics				
1.	Is the facility located near a place where adolescents – both male and female congregate (youth centre, school, market etc.)?	x	x	✓	
2.	Is the facility open during hours that are convenient for adolescents –both male and female (particularly in the evenings or at weekends)?	✓	x	✓	
3.	Are there specific clinic times or spaces set aside for adolescents?	✓	✓	✓	
4.	Are RH services offered for free are at rates affordable to adolescents?	✓*	✓*	✓	
5.	Are waiting times short?	✓	✓	✓	
6.	If both adults and adolescents are treated in the facility, is there a separate, discreet, entrance for adolescents to ensure their privacy?	✓		✓	
7.	Do counselling and treatment rooms allow for privacy	✓	✓	✓	
8.	Is there a code of conduct in place for the staff at the health facility	✓	✓	✓	
9.	Is there a suggestion box for the youth to submit complaints or feedback about services?	x	x	✓	
	Provider characteristics				
1.	Have providers been trained to provide adolescent-friendly services?	✓	x	✓	
2.	Have all staff been oriented to provide confidential services? (including receptionists, security guards, cleaners etc.)?	✓	x	✓	

5.	Do staff demonstrate respect when interacting with adolescents?	✓	✓	✓	
9.	Do the providers ensure the client's privacy and confidentiality?	✓	✓	✓	
10.	Do the providers set aside sufficient time for client provider interaction?	✓	✓	✓	
11.	Are peer educators or counsellors available?	x	x	✓	
12.	Are health providers assessed using quality standardized checklists?	✓	x	✓	
Program characteristics					
1.	Do adolescents (male or female) play a role in the operation of the health facilities?	x	✓	✓	
2.	Are adolescents involved in monitoring the quality of SRH service provision?	x	x	✓	
3.	Can adolescents be seen in the facility without the consent of their parents or spouses	✓	✓	✓	
4.	Is a wide range of services available? (Including Family Planning, STI treatment and prevention, HIV counselling and testing, ante and post-natal care, delivery care)	✓	✓*	✓	
5.	Are there written guidelines for providing adolescents services?	✓	✓	✓	
6.	Are condoms available to both young men and young women?	✓	✓	✓	
7.	Are there RH educational materials, posters or job ads on site, which are designed to reach adolescents?	✓	✓	✓	
8.	Are there referral mechanism (for medical emergencies, for mental health and psychosocial support etc.)	✓	✓	✓	
9.	Monitoring of attendance by age, sex	✓	✓	✓	

Key: ✓ = Item present x = Item absent ✓* = Item present but limited



APPENDIX H
FINDINGS

THEMES	CATEGORIES
Privacy and confidentiality	<ul style="list-style-type: none"> - Professionalism - Structural privacy - Informational confidentiality - One-on –one, face to face service provision - Professional adherence to policies on confidentiality - Timing of consultation
Competence of staff	<ul style="list-style-type: none"> - Strong perception of competence - Counseling skills - In-service and special training - Knowledge on policies - Broad competency areas - Teaching methods - Feedback - Referral - Error-free performance - Satisfaction with service - Ignorance of standards
Range of services	<ul style="list-style-type: none"> - Counseling - Guidance - Ante-natal services - Post-natal services - STIs management - Child welfare clinics - Hygiene education - Sex and sexuality education - Family planning services - Video and printed material education - Laboratory services - Child circumcision - Immunizations - Medications and minor treatment - Home and nutritional care education - Outreach services - After closing hours services - Health educational talk - Pregnancy testing

	<ul style="list-style-type: none"> - Adolescent health clubs - Follow-up care - Referral services - Recreational services
Youth involvement	<ul style="list-style-type: none"> - Consulting youth on facilities - Consulting youth on services and planning - Involving youth on assessment of services - Involving youth in provision of services
Equipment and infrastructure	<ul style="list-style-type: none"> - Adequacy of supplies - Provision of educational materials - Use of teaching aids - Availability of family planning methods and medications - Use of available equipment - Recreational facilities - Models - Sufficiency of equipment - Audio-visual materials - Screens
Staff friendliness	<ul style="list-style-type: none"> - Non-judgmental - Empathy - Equal treatment - Relation as peer - Staff guidance - Patience - Friendliness - Tolerance of client's view points - Generosity - Cordiality - Effectiveness of communication - Consent seeking from clients - Criticism - Consistent availability - Lack of feedback from clients - Prompt and respectful treatment - Interactive learning - Welcoming appearance - Polite - Result-oriented
Sexual health education	<ul style="list-style-type: none"> - Having sexual intercourse - Procreation - Disease prevention

	<ul style="list-style-type: none"> - Practical demonstration - Community outreach programmes - Information on side effects of family planning methods - Video and printed materials education - Self-care - Male/female friendships - Family planning - STIs prevention - Antenatal and baby care
Future plans and desires	<ul style="list-style-type: none"> - Space expansion - Increased educational and recreational facility - Improved coverage - Increased number of equipment - Increased treatment and medication - Improved worker attitude - Increased awareness creation - Donor support - Improved services at the facility - Youth involvement - Improved training for staff - Improved infrastructure - Increased access to funding - Improving accessibility
Perception of what AFSRH is	<ul style="list-style-type: none"> - Giving educational talk - Giving care to adolescents - Parental viewpoint - Family planning and STIs prevention - Addressing reproductive health problems - Menstrual hygiene - Perception of adolescence - Perception of adolescent sexuality - Responsibility for actions - Secondary sexual characteristics development - Physical and sexual maturation - Increased questioning - Adolescent perspective - Psychological development
Facility operation	<ul style="list-style-type: none"> - Working hours - Waiting time - Time convenience to students - Time convenience to non-students

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