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SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

ASSESSING FACTORS INFLUENCING UTILIZATION OF ADOLESCENT HEALTH SERVICES AT KPONE HEALTH CENTER, IN THE GREATER ACCRA REGION

BY

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DECLARATION

I, Helen Biney, declare that with the exception of quotations and references contained in published works which have all been identified and acknowledged, this thesis is entirely my own work, and it has not been submitted either in part or whole for another degree elsewhere.

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DEDICATION

To my dear loving husband, Mr. Isaac Kofi Biney, for supporting me greatly during the course of my study in school.

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ABSTRACT

Background: Reproductive health services that are adolescent-friendly have been found to be effective in addressing adolescent sexual and reproductive health needs. Notwithstanding the numerous sensitization campaigns conducted there have been no previous reported studies to understand why patronage remains low in Ghana. This study aimed to explore the knowledge, attitude and perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre.

Methods: A descriptive qualitative design was used in the study. A total of 10 adolescents at the Kpone Health Centre were purposively selected for the study. They were 3 males and 7 females from 17 to 19 years of age. Face-to-face in-depth interviews were conducted using semi-structured interview guide and transcribed verbatim. Thematic content analysis of data was done.

Results: Most of the adolescents knew that sexual and reproductive health services are provided at the adolescent corner and considered the adolescent corner as useful. However, patronage of the adolescent corner was poor because of previous bad experience, lack of time and unawareness of the existence of adolescent corners. General perception of services provided at the adolescent corner was good. Staffs at the unit were perceived to be nice and friendly. However, stigmatizing views of others made them uncomfortable accessing health care services at the adolescent corners.

Conclusion: Previous bad experience at the clinic, lack of time and unawareness of the existence of adolescent corners contributed in poor patronage of the adolescent friendly health services at the Kpone Health Centre. High intentionality to visit the

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unit and clear recognition of the importance of adolescent health corners and the need to maintain them are some positives for future interventions to increase patronage of adolescent corners in Kpone. It is recommended that the Ghana Health Service in collaboration with the media should make concerted efforts to address stigma associated with adolescent friendly health services to ensure better public understanding about the services provided.

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TABLE OF CONTENTS

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

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

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

LIST OF TABLES

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

LIST OF FIGURES

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LIST OF ABRREVIATIONS

ART:	Antiretroviral Treatment
ASRH:	Adolescent Sexual and Reproductive Health
CDC:	Centre for Disease Control and Prevention
EC:	Emergency Contraceptives
FGDs:	Focus Group Discussions
FP:	Family Planning
HIV:	Human Immunodeficiency Virus
ICPD:	International Conference on Population and Development
IPPF:	International Planned Parenthood Federation
IUD:	Intrauterine Device
RHS:	Reproductive Health Services
SRHS:	Sexual and Reproductive Health Skills
SSA:	Sub-Saharan Africa
STD:	Sexually Transmitted Diseases
STI:	Sexually Transmitted Infection
UNDPA:	United Nations Department of Political Affairs
UNFPA:	United Nations Population Fund
WHO:	World Health Organization
YFS:	Youth Friendly Services

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CHAPTER ONE

INTRODUCTION

1.1 Background

Adolescence is the transitional period between childhood and adulthood (WHO, 2019). Young people between the ages of 10 and 19 years are defined by the World Health Organization as adolescents. (WHO, 2010a). Most adolescents engage in risk-taking behaviours that sometimes expose them to many health hazards (Hale & Viner, 2016; WHO, 2014). It is estimated that about 15% of unsafe abortions recorded every year occur among female adolescents within the ages of 15 and 19 (WHO, 2011a).

The highest rate of sexually transmitted infections (STI) recorded worldwide every year occur among adolescents of 15 to 24 years (CDC, 2014). New cases of Human Immunodeficiency Virus (HIV) infections in developing countries have been found to be on the rise among this same age group (15-24 years) of adolescents (WHO, 2015). In Sub-Saharan Africa, an estimated 110 million new cases of sexually transmitted diseases (STD) are recorded each year (WHO, 2011b).

Among adolescents worldwide, sexually active girls who are married and unmarried adolescents are 23% and 3 % respectively (WHO, 2019). In Sub-Saharan Africa (SSA), millions of youth are at risk of poor reproductive outcomes. There is high adolescent birth rate of 120 per 1000 girls aged 15 to 19 years in SSA (WHO, 2011c). In Ghana, the rate of adolescent pregnancy since 2007 has remained always remained high with only 14% reduction (Enuameh et al., 2014). They are mostly vulnerable to peculiar health risk in relation to reproduction and sexuality yet their uptake of family planning services is low (Denoo, Hoopes, & Chandra-Mouli, 2015).

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Adolescents must have adequate information regarding sexual and reproductive health. The International Conference on Population and Development (ICPD) (1999) emphasized on specific recommendations. These include; access to universal and comprehensive sexual and reproductive health information, promoting respect and protection for sexual and reproductive rights through public education, universal access to sexuality education and abolishing domestic and public violence among women (ICPD, 1999).

Adolescent –friendly reproductive health services have been found to be very effective in addressing sexual and reproductive health needs of adolescents (UNFPA, 2003). However, according to the WHO, "most sub-Saharan African countries have a dearth of adolescent-friendly health services and inadequate policies to address adolescent health needs" (WHO, 2010b).

Globally, the use of FP among unmarried adolescents range from 21% to 64% and from 6% to 67% among married adolescents (WHO, 2012). In sub-Saharan Africa, the proportion of unmarried sexually active adolescents using FP ranges from 21% in Mali to 42% in Ghana with FP use among the married ones ranging from 8% in Mali to 36% in Zimbabwe (WHO, 2012; Bradley, Croft, & Fishel, 2012). This indicates low uptake of FP services among adolescents.

This is aggravated by negative attitude of FP service providers (Atuahene, Afari, Adjuik, & Obed, 2016; Michaels-Igbokweetet, Terris-Prestholt, Lagarde, Chipeta & Cairns, 2015). Easy access to and availability of wide range of FP methods can have greater influence on the uptake of such services by adolescents (Atuahene et al., 2016). According to Ahmed, Liu and Tsui (2012), use of adolescent friendly health

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services is affected by client, provider and facility characteristics including provider-client interactions, privacy, client waiting time and eligibility requirement.

1.2 Problem Statement

According to the WHO (2006), patronage of ASRH service could increase if service providers were well trained, health care facilities were adolescent friendly, efforts made to create demand for these services and community mobilization carried out to achieve community support. However, there is low patronage of adolescent friendly reproductive health services among adolescents in Ghana (Enuameh et al., 2014). Thus, particularly low patronage of sexual and reproductive health services for adolescents. Some sexually active adolescent girls in Ghana don't even know they could fall pregnant from engaging in sexual intercourse without the use of contraceptives (Gyesaw & Ankomah, 2013). Majority (41%) of sexually active adolescents in Ghana do not use modern contraceptives (Afenyadu & Goparaju, 2003). About 30% of them do not use any contraceptive methods at all during sexual intercourse (Afenyadu & Goparaju, 2003).

Staff of the adolescent friendly unit of the Kpone Health Centre complain that despite sensitization campaigns on the availability of adolescent friendly services at the Health Centre, patronage of these services remain low. Previous studies in Ghana, have looked into patronage of family planning services among adolescents (Gyesaw & Ankomah, 2013; Enuameh et al., 2014; Afenyadu & Goparaju, 2003), which is only a part of adolescent friendly services. However, there is dearth of studies into adolescent friendly services in general. Notwithstanding the numerous sensitization campaigns conducted there have been no previous reported studies to understand why patronage remains low in the Kpone Health Centre. This

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underscores the need to explore this behavioural phenomenon qualitatively by examining knowledge, attitudes, and perceptions about adolescent friendly health services as whole at the Kpone Health Centre using a well-designed qualitative study.

1.3 Research Questions

The study aimed at answering the following research questions;

1. What is the knowledge of adolescents on adolescent friendly health services at the adolescent unit of the Kpone Health Centre?
2. What is the attitude of adolescents towards adolescent friendly health services at the adolescent unit of the Kpone Health Centre?
3. What is the perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre?

1.4 Purpose of the Study

The purpose of the study was to assess the knowledge, attitude and perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre.

1.5 Objectives of the Study

The study was aimed at meeting the following objectives:

1. Assess the knowledge of adolescents on adolescent friendly health services at the adolescent unit of the Kpone Health Centre.
2. Explore the attitude of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre.

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3. Describe the perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre.

1.6 Conceptual Framework

Theory of Reasoned Action

The Theory of Reasoned Action (TRA) states that active behaviour depends on two elements (Fishbein, 2008). These include the evaluation of behaviour as observed to be positive or negative when performed (attitude) and perceived influences that other people have on behaviour performed (subjective norms) (Fishbein, 2008). These elements serve as the determinants to performing an intended behaviour or action (Fishbein, 2008).

Attitude is an individual's favourable or unfavourable feeling about performing a specific behaviour. These beliefs are called behavioural beliefs. Beliefs that underlie subjective norms are normative beliefs. An individual will intend to perform a certain behaviour when he or she evaluates it positively. Attitudes are determined by an individual's belief about the effects or results of performing the behaviour and the evaluation of the results or effects whether positive or negative (Fishbein & Cappella, 2006). Therefore, if the individual intends to achieve a positive result after performing a behaviour, then such a behaviour will be performed to achieve the desired positive outcome. Not all the times that behaviour is performed based on the natural effect of the performance of the behaviour. Subjective norms are based on normative influences that individuals approve or disapprove of the behaviour. The influence of other people to perform a behaviour in order to be accepted by those people is based on the element of subjective norm (Aronson, Wilson & Akert, 2005). Although an action may not be accepted or approved by an individual, an individual

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may be pressured to perform such an action in order to be favoured or to be liked by some social groups or individuals such as their spouse, close friends, community members, peers or significant others. If the reason for performing a behaviour is judged based on the fact that most people who are important to the person would approve or disapprove of such behaviour, then it is based on the normative influence that underlie subjective norm (Fishbein & Yzer, 2003).

The conceptual framework is an illustration of different perspectives of adolescents on adolescent friendly health care services. This comprises adolescents' knowledge about adolescent friendly health care services in addition to their attitude and perception about adolescent friendly health care services based on the theory of reasoned action.

Figure 1: Conceptual framework on Adolescent Knowledge, Attitude and Perception about Adolescent Friendly Health Services based on the theory of reasoned action.

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The knowledge component represents level of awareness of adolescent friendly health care services and the information or fact that adolescents have on adolescent-friendly health services (Abraham, Yitbarek, & Morankar, 2019). This however, may be poor or good knowledge (Schriver, Meagley, Norris, Geary, & Stein, 2014). With good knowledge representing better understanding of what adolescent friendly health care services entail and poor knowledge indicating less understanding of what adolescent friendly health care services entail.

Attitude comprises of feelings and behaviours of adolescents towards adolescent friendly health care services. This comprises patronage of adolescent friendly health services including sexual and reproductive health care seeking behaviour of adolescents (Woog, Singh, Browne & Philbin, 2015). This can be positive or negative. However, knowledge about adolescent friendly health care services also influences one's attitude towards adolescent friendly health care services.

Perception, however, comprises the views and opinions that adolescents have about adolescent friendly health care services. These depict their views about the services provided in general, kind of services provided and the quality of the services provided at the adolescent friendly unit (Biddlecom et al., 2007; Schriver et al, 2014). Perception may also be positive or negative. The kind of perception that one has about adolescent friendly health care services also influences one's attitude towards adolescent friendly health care services.

1.7 Operational Definition of Terms

Knowledge: Facts or information that adolescents have about adolescent friendly health care services

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Attitude: Feelings and actions of adolescents towards adolescent friendly health care services.

Perception: Opinion or views that adolescents have about adolescent friendly health care services.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Literature was accessed from full articles and abstracts from Google scholar, Science Direct, SCOPUS. Outline of literature review comprises the following:

- Overview of adolescent friendly health services
- Knowledge of adolescents on adolescent friendly health services
- Attitude of adolescents about adolescent friendly health services
- Perception of adolescents about adolescent friendly health services
- Summary of literature review

2.2 Overview of adolescent friendly health services

Adolescents have unique health needs as they transit from adolescence to adulthood. Within this period of their lives, they experience peculiar vulnerabilities with regard to their reproductive health (UNFPA, 2007). Therefore, services tailored towards meeting the Sexual and Reproductive Health (SRH) needs of adolescents must be appropriate, specific, easily accessible, user-friendly and effective for them (WHO, 2012). The consent of adolescents need to be sought before providing such services for them and, there is the need to ensure privacy and confidentiality in the provision of adolescent friendly health services. In the course of providing such services, service providers ought to respect the cultural value and religious beliefs of adolescents in conformity with internationally established conventions (UN, 1994).

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According to the International Conference on Population and Development (ICPD, 1999), national and international interventions need to the directed towards meeting the SRH needs of adolescents. These agreements include:

1. Providing information, education and counselling services for adolescents on their sexuality, reproductive health and parenthood.
2. Providing information, counselling services in addition to other services including prevention of pregnancy, HIV prevention and treatment services and the prevention and treatment of Sexually Transmitted Infections (STI's) to ameliorate the harmful effects of risky sexual behaviours among adolescents.
3. Provision of safe abortion services and abortion related services within the confines of the law.
4. Provision of prenatal, perinatal and postnatal services for adolescents (WHO, 2004).

In one study in South Africa, Geary *et al.* (2014) conducted semi-structured interviews with nurses from seven public primary health care clinic and a health centre in the Agincourt sub-district to explore the adolescent friendly health services provided. They found that services provided by all the health facilities included treatment for minor ailments, family planning services, HIV counselling and testing services, Antiretroviral Treatment (ART) services, pregnancy testing, antenatal care, abortion services from pregnancies not more than 12 weeks gestation and general health education services. Medical laboratory services including vaginal examination for STI diagnosis were also provided. Adolescents could access general health services, contraceptives and HIV testing and termination of pregnancy services

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without parental consent. However, some of the interviewees required those under 14 years and in one case, under 18 years, to come to the facility with an adult.

2.3 Knowledge of adolescents on adolescent friendly health services

Knowledge of adolescents on adolescent-friendly health services is very critical to their patronage of these health services (Abraham, Yitbarek, & Morankar, 2019). In a study aimed at examining the knowledge of adolescents on adolescent-friendly health services, (Schriver, Meagley, Norris, Geary, & Stein, 2014) carried out 23 interviews in urban Soweto in South Africa. Knowledge on adolescent-friendly health services was found to be low among the participants. Only three out of the 23 interviewees were aware about adolescent-friendly health services. However, none of them were able to give detail information about the services provided and how the adolescent-friendly health service programme was run. After participants were informed about the programme, most of them acknowledged that it may exist but admitted they had no idea about it. They all admitted to the fact that it was a good programme and that health service providers should be trained to ensure respect and maintain confidentiality, be dedicated to the youth and be sensitive to their needs. These included issues concerning adolescent sexual and reproductive health, STIs and HIV/ AIDS that were mentioned by the participants.

In Nepal, Tamang, Raynes-greenow, Mcgeechan and Black (2017) assessed the knowledge of adolescent reproductive health services among the youth of Nepal living in the Kathmandu Valley. This was a cross-sectional study involving a total of 720 female and 680 males from 15-19 years. In this study, majority of the youth lacked in-depth knowledge on adolescent sexual and reproductive health. Less than half (43%) of the respondents were aware of the possibility of a woman getting pregnant the first time of having sexual intercourse. This level of awareness was

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found to be significantly higher among the males compared to the females (p=0.018). The youths' knowledge on contraceptives was high however, less than half of them were aware about reversible and long acting contraceptives. Specifically, 47% of the respondents knew about implants and only 29% knew about the intrauterine device. There were varying ideas among male and female respondents concerning the most suitable contraceptive methods for the youth.

According to Tamang et al. (2017), more than half of the youth were aware that abortion was legal in Nepal but did not understand the circumstances under which abortion was considered as legal in Nepal. Among those who knew about this, about a quarter of them knew that the limit of legal abortion was a gestation period not more than 12 weeks. This knowledge was significantly higher among the females, compared to their male counterparts (p=0.011). Furthermore, majority of the youth knew about sexually transmitted infections. All of them knew about syphilis, followed by HIV, Hepatitis B and then Gonorrhoea. About 64% of the youth in this study knew that STIs may present with symptoms such as sore or an ulcer around the genitalia, swelling, pain or itching around the genitalia and abnormal discharge from the genitalia. More than 90% of the respondents also knew about ways of ensuring safe sex including the use of condoms and avoidance of multiple sexual partners.

2.4 Attitude of adolescents towards adolescent friendly health services

Reports on attitude of adolescents towards adolescent friendly health services vary despite some similarities between reports. A survey conducted in developing countries indicates that most adolescents do not fully utilise reproductive health services (Woog, Singh, Browne & Philbin, 2015). Further findings of the study revealed that use of modern contraceptives was low among married adolescents. Adolescents with STD who visited the health facility to seek care were only few.

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The percentage of adolescent women who had been tested for HIV for the past one year before this study ranged from 2% to 34% in Western and Southern African countries respectively.

Similarly, it is reported that most adolescents do not patronise RHS in Sub-Saharan African countries (Bankole, Biddlecom, Guiella, Singh & Zulu, 2007; Biddlecom, Munthali, Singh & Woog, 2007; IPPF, 2010).

Contraceptive needs of adolescents in Sub-Saharan Africa and South Asia that are unmet form about 60% of general needs of adolescents (UNFPA, 2013). About 50% of married adolescents in Sub-Saharan Africa do not use any contraceptive method (IPPF, 2010). Underuse of modern contraceptives among young married adolescents in all the regions in Sub- Sahara Africa has also been reported (UNFPA 2012). A study on adolescents in some selected Sub-Saharan African countries discovered that only minority (10%) of them used a modern contraceptive method from 1990-2011 (Kothari, Wang, Head & Abderrahim, 2012). Generally, the trend in the current use of contraceptives has shown higher usage among sexually active adolescents that are unmarried than among married adolescents (Blanc, 2009). Another study also reported that older women were more eager and determined to visit the health facilities for abortion services than adolescent girls (Woog et al., 2015).

One of the barriers to access to adolescent RHS reported by several studies was shyness or embarrassment associated with seeking the service (Regmi, Van Teijlingen, Simkhada & Acharya 2010; UNDPA, 2015). For instance, a study conducted in Nepal indicated that shyness was the commonest reason reported by adolescent boys and girls for not accessing RHS (UNFPA, 2015). From the study, it was observed that the adolescents were not willing to cooperate in discussing

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sensitive sexual and reproductive health issues especially when the provider available to offer the service was of the opposite sex or a known family member.

Other similar studies also pointed out that receiving RHS services from the opposite sex was a barrier to the use of the services (Ghafari, Shamsuddin & Amiri, 2014; Newton Levinson, Leichliter & Chandra-Mouli, 2016). For instance, a study in Malawi revealed that adolescents did not access adolescent friendly health services because they had problems with explaining genital issues to a provider of the opposite gender (Munthali & Zakeyo, 2011). In addition to that, a cross-sectional study in Nepal by Tamang et al. (2017) found that 77% of the youth did not seek Sexual and Reproductive Health (SRH) services or information.

Donadiki et al. (2013) assessed factors related to contraceptive methods among female higher education students in Greece. The study population was made up of 3,153 female college students between 18 and 26 years old in Greece. Tertiary students of 18-20 years formed a majority of the participants. Among these students, about 69% had sought services from a gynaecologist. The use of condoms was common among younger adolescents, non-smokers, those who had their first sexual intercourse at 17 years and those who have had at most two sexual partners in their lifetime. The use of use of Emergency Contraceptives (EC) was the second most used contraceptive method among these groups of people. The use of oral contraception was however common among participants who were older, have had more than two sexual partners in their lifetime and those who had visited the gynaecologist.

Biddlecom, Munthali, Singh and Woog (2007) assessed adolescents views of and preferences for sexual and reproductive health services in four West Africa countries comprising Burkina Faso, Ghana, Malawi and Uganda. This was a part of a national

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survey of adolescents, 12 to 19 years of age, in West Africa. Among the adolescents who were sexually active within the previous 12 months to the start of the study, at least 43% of the females had used a contraceptive method and at least 50% of the males had used a contraceptive method. The most commonly used contraceptive was the male condom. Apart from the male condom, use of other modern contraceptives among the adolescents was less common. This was even lower than the use of traditional methods of contraception in all the four countries used for the study. However, at least 16% of the sexually active female adolescents had ever used a traditional method of contraception compared to at least 7% of their male counterparts who were found to have at least ever used a traditional method of contraception. Most females in the countries in the study with the exception of Ghana reported the use of traditional method as a method of contraception than males.

Majority of the adolescents in these countries (Uganda- 81%, Malawi- 90%, Burkina Faso 97%, who were sexually active did not report Sexually Transmitted Infections (STI) and associated symptoms. The study indicated that only a small proportion minority (2-3%) who reported having STI in these three countries sought some care. In Ghana, more than 75% of the adolescents with STI obtained care from the hospital. Most adolescents who were infected and obtained treatment, sought care from clinics and hospitals. For instance, in Uganda, among the 11% who got infected, 9% sought care from a clinic or hospital while only 2% received treatment from other areas such as traditional healers. (Biddlecom et al., 2007).

Among adolescents of 14-19 years old, results from Biddlecom et al. (2007) indicated that these adolescents within this age group sought services from traditional healers and herbalists instead of hospitals or clinics. They reported that

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services received from these providers were confidential fast and effective. The patients also had the opportunity to pay the cost of treatment in instalments. It was only HIV testing that majority of all the adolescents in these countries visited a clinic or a hospital instead of other sources. According to the findings of the study, sexually- active adolescent girls went for HIV screening was more in Uganda and Malawi than Burkina Faso and Ghana. Most female adolescents who went through the HIV screening was probably related to pregnancy care, with more females receiving screening than males.

2.5 Factors influencing attitude of adolescents towards adolescent friendly health services

Attitude of adolescents towards adolescent friendly health services may be influenced by various factors. In a qualitative study conducted by Mbeba et al. (2012) in the Mtwara district in Tanzania, it was discovered that lack of facilities within the communities to visit and seek information on reproductive and sexuality education on sex, STI and HIV/AIDS resulted in girls within the district to have started sexual intercourse within ages of 9 to 12. Another barrier to seeking information on SRH by adolescents as reported by Tamang et al. (2017) was that over 90% of the youth in their study reported feelings of shame and around half (53.6%) described fear of society and family members. This fear was felt more acutely by the females compared to their male counterparts.

Mbeba et al. (2012) also had issues with availability of space or the designation of an office for the provision of adolescent friendly health services in health facilities in the Mtwara district, Tanzania. The findings from their study showed that, none of the 38 facilities in Mtwara district has designated areas for provision of Youth Friendly Services (YFS) since services provided were adult centered. Findings also showed

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limited number of service providers with Sexual and Reproductive Health Skills (SRHS). Facilities were found lacking privacy, bed examination screen. In addition, the community members and service providers in the district thought it was inappropriate for girls of age 10 - 18 to access SRHS especially the family planning. Stigma and discrimination to SRHS was also reported and confirmed by the adults and community members in the FGDs. There were also misconceptions about suitability of contraceptives to young people particularly the girls.

However, Geary et al. (2014) found that in South Africa, the most common barriers to providing health services to young people, and to providing adolescent friendly services was lack of staff who are skilled and trained to provide youth-friendly health services (YFS). From the study, only one facility had two nurses who were skilled to provide YFS. The second facility had also stopped the provision of YFS due to the death of a nurse that used to provide the YFS. Four of the facilities which have not implemented the YFS wished that their "own person" who would "work with them" and who has "trained a lot" would help them to provide health services to young people at the clinic and in schools. All clinics reported maintaining confidentiality for young people, however, breaches to parents emerged in the narratives at two facilities. Judgmental attitudes in relation to young people's sexual activity were present. They were branded as "naughty".

Sexually-active adolescents reported very similar perceptions of factors affecting their access to contraceptive methods as they do for STI diagnosis and treatment in the study carried out by Biddlecom et al. (2007) in Ghana, Malawi, Burkina Faso and Uganda. The main barriers to seeking RHS were the discomfort associated with the services especially when the provider is of the opposite sex. In Uganda and Malawi, it was reported most females felt more afraid and shy when receiving RHS

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than males. In Uganda, one of the factors that hindered the adolescents from receiving SRH were shortage of facilities across the country to receive contraceptive services and the cost of receiving the services. Apart from Ghana, significantly more males in all countries in these study reported that they had no idea where to go for contraceptive and STI services.

In a systematic review on "Determinants of adolescents reproductive health service utilization in Ethiopia" Abraham et al. (2019) assessed studies on patronage of adolescent-friendly health services among adolescents. Literature search was conducted in MEDLIE, CINAHL, EMBASE and Popline out of which 4 community-based cross-sectional studies were reviewed. Level of education, schooling status and discussion of reproductive health services with family or health workers were associated with utilisation of adolescent-friendly health services. Specifically, adolescents who have had primary level education were 57% less likely to adolescent-friendly reproductive health services compared to adolescents who have had secondary education and above.

Secondly, adolescents in school were 2.39 times more likely to patronise adolescent-friendly family planning services compared to adolescents who were out of school. Adolescents in school used HIV voluntary and counselling services more than adolescents who were out of school although this was not statistically significant (P=0.25). With regard to adolescents' discussion of reproductive health services with family or health workers, those who discussed reproductive health issues with family and health workers were found to be 3.63 times more likely to patronise adolescent-friendly health services compared to their counterparts how did not engage their families or health workers in any such a discussion (Abraham et al., 2019).

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2.6 Perception of adolescents about adolescent friendly health services

Smith et al. (2018) in their research project, set out to investigate adolescent perception about preferences for differentiated Sexual and Reproductive Health Services (SRHS) with the ultimate aim of finding innovative ways to incorporate adolescent-friendly services into already existing healthcare infrastructure in South Africa. Adolescents aged between 12 and 17 years were recruited for the Focus Group Discussions (FGDs). Participants had negative perceptions about the routine care young people experience at government clinic facilities, reporting that clinic opening times were inflexible, that staff could be unpleasant, stigmatising and often rude. They perceived that the staff did not respect confidentiality and gave inappropriate and misleading information to adolescents.

Participants universally opined that friendly adolescent services were needed. They were of the view that dedicated services for only adolescents only would result in the reduction or elimination of stigma towards adolescents when they seek RHS in the various public health facilities. The participants were happy about the introduction of dedicated adolescent health services. They had the perception that this concept will enhance the lives of adolescents since they will have the needed guidance. They also perceived that the dedicated adolescent health services will make them more comfortable and clearly understood when discussing their concerns with the providers (Smith et al., 2018).

Schriver et al. (2014) conducted a total of 25 interviews on 23 adolescents in South Africa, comprising14 female and 9 males. The aim of the study was to assess young people's perceptions of youth-oriented health services in urban Soweto, South Africa. In Soweto, the adolescents expressed disappointment in the public health services provided. Their dissatisfaction was related to limited resources, long waiting

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times and poor quality of care rendered. The adolescents perceived that antibiotics and analgesics dispensed at the clinics due to drug stock -outs were basic ones that can be purchased at over -the- counter drug stores. The youth perceived that going to a clinic was an unnecessary step that did not always result in better outcomes.

Furthermore, Schriver et al. (2014) found that the youth who visited local clinics had to wait for several minutes to hours to see a nurse or a doctor. Their perception that nurses take long tea breaks, and abandon their duties aggravated their disappointment associated with the long waiting times. The youth is also perceive that the nurses did not have any respect for their needs, were rude and did not maintain confidentiality of their information. Although doctors were scarce, the youth perceived that doctors were more attentive to their needs and committed to their work.

The perception of participants about private and public health care facilities were asses in this study. It was found that the youth perceived private facilities or clinics as trustworthy, reliable, clean, well stocked and better staffed than public health facilities. Those who had access to the private health services were happy with the satisfaction received and felt privileged to afford their services in order to avoid the public health services. Almost all the clinics the youth considered as good clinics were the ones having adequate resources, provided on-time and friendly services. However, there was limited access to public health facilities with his features (Schriver et al, 2014).

Biddlecom et al. (2007) pointed out some opinions that adolescents have about government clinic or hospital that provide adolescent-friendly services. Assessment of these facilities known to provide adolescent-friendly services were evaluated based on their accessibility, respect for their patients, cost and level of

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confidentiality. Generally, a majority of these adolescents had positive perception about the identified health facilities through the provision of their services based on the evaluation themes. It was reported in this study that, it was reported that 80% out of 85% female adolescents who are sexually active and knew of health facilities that provide confidential contraceptive services perceived that adolescents were likely to be respected there. Seventy-nine percent had positive perception about the physical accessibility of the facilities to adolescents. Sixty-six percent of them perceived that the cost of their contraceptive services was very affordable. The cost of general care provided by the facility was perceived to be affordable by 80% of the respondents. No significant gender inconsistencies in terms of views of government clinic and hospitals across the four countries based on these four dimensions was observed.

2.7 Summary of literature

In summary, the review of literature shows generally low level of knowledge and a lack of awareness on adolescent friendly health services among adolescents in Africa and within the sub-Saharan Africa sub-region. Secondly, there is a generally poor attitude of adolescents towards adolescent friendly health care services as shown in the literature. There is poor patronage of adolescent friendly health care services mostly in Saharan Africa and South Asia. Use of modern contraception is low and adolescents do not seek health care services for treatment of sexually transmitted infections. Negative perceptions about adolescent friendly health care services also exist which some adolescents questioning the relevance of such services. However, others also perceive the adolescent friendly health care services as a laudable idea.

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2.8 Gaps

Studies mainly done in other countries including Nepal, Greece and African countries such as South Africa, Malawi, Uganda, Burkina Faso. Only one in Ghana, which was even a joint study including three other West African countries. Studies are mainly of a quantitative approach devoid of the rich meaningful thick descriptions that qualitative reports provide. This study therefore sought to fill in this gap.

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CHAPTER THREE

METHOD

3.1 Introduction

This chapter presents the methodology for the study. The chapter includes a description of the research design to be applied to the research process to arrive at valid and useful findings. The chapter also describes the research setting, target population, sample size and sampling technique. It also includes an overview of the data collection instrument, data collection procedure, methodological rigour, data analysis and ethical considerations.

3.2 Research Design

This study employed a descriptive qualitative design to guide its enquiry into the knowledge, attitude and perception of adolescents about adolescent friendly health services.

3.3 Rationale for choice of design

Qualitative research is an inductive approach to discovering or expanding knowledge (Polit, Hungler, & Beck, 2001). More specifically, the qualitative approach to research provides one with the opportunity to acquire deeper understanding and rich descriptions of people's experiences of the phenomenon under study (Fain, 2013).

Rather than making observations and explanations about the phenomena under study, exploratory qualitative studies involve full investigation into the nature of the phenomenon under study. This provides a broader explanation and deeper understanding into the phenomenon of interest (Polit, Hungler & Beck, 2001). The flexibility of data sources such as the use of interviews and discussions, in addition to its focus on understanding a phenomenon under study rather that making definite

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conclusions are some of the advantages of exploratory approach to qualitative research. The descriptive research design helps the researcher to have an objective and accurate description of the phenomenon under study (Polit & Hungler, 2013). It provides a general overview of the concept and the way certain phenomenon occur, thus helping to describe and providing answers to certain life experiences.

This descriptive qualitative design helped the researcher to ascertain, explore and describe the knowledge, attitude and perception of adolescents about adolescent friendly health services at the Kpone Health Centre.

3.4 Research Setting

The research setting for this study was the adolescent friendly clinic of the Kpone Health Centre. The Kpone Health Centre is located within the Kpone sub-municipality of the Kpone Katamanso Municipality. The facility has a bed capacity of twenty (20). It has various units/ departments including Out-Patient Department, Male and Female ward, Laboratory, Anti-Natal Clinics, Post Natal Clinics, Labour ward, Psychiatry unit and Family planning unit. Services provided include treatment of major and minor diseases, wound dressing and suturing, health talk and counselling. The facility has an average weekly OPD attendance of fifty-three (53).

The adolescent friendly unit of the Kpone Health Centre provides services for adolescents. Services provided include counselling on sexual and reproductive health, mental health (drugs and substance abuse), nutrition, growth and development. The unit works Mondays to Fridays from eight (8) am to four (4) pm. The adolescent friendly unit has a staff strength of two (2). Thus, comprising one (1) public health nurses, and one (1) staff nurse. The unit has one consulting room, however medical cases are referred to the general out-patient department for further

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management. Services are targeted for adolescents from communities within the Kpone Katamanso Municipality including Gbetsile, Zenu, katamanso and Appolonia. The unit records an average of six (6) monthly attendance of adolescents to the health centre.

The Kpone Health Centre is a public health facility situated within the Kpone Katamanso Municipality. The facility has an adolescent friendly unit that provides general health and reproductive health services to adolescents. Services provided include, general health education, management of adolescent developmental problems, sexual and reproductive health education and counselling, nutrition services, mental health services, first aid services, non-communicable disease prevention and services and referral services for adolescents. The concept of adolescent friendly health service is about making existing reproductive health services more accessible, appealing and acceptable to young people. Five key dimensions of adolescent-friendly or youth-friendly health services indicated by the World Health Organization (WHO, 2009) are that, these services must be accessible, equitable, appropriate, acceptable and effective.

3.5 Target Population

The target population is referred to as the general aggregate of people or subjects with certain properties that are of particular interest to the investigator and for the research (Nieswiadomy, 2008). The target population for the study was adolescents accessing health care services at the Kpone Health Centre.

3.5.1 Inclusion Criteria

The following persons qualified for inclusion into the study:

1. Male and female adolescents 12 to 19 years of age

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2. Adolescents accessing health care services at the Kpone Health Centre.
3. Adolescents who willingly agreed to take part in the study

3.5.2 Exclusion Criteria

The criterion for exclusion in this study was;

Adolescents at the Kpone Health Centre who are severely ill and weak.

3.6 Sample Size

In qualitative research the number of participants cannot be determined a priory because it is an inherently problematic approach (Sim, Saunders, Waterfield & Kingstone, 2018). A total of 10 adolescents took part in the study. This was when saturation was achieved. The concept of data saturation is considered as important because it addresses whether a study is based on an adequate sample to demonstrate content validity (Francis et al., 2010).

3.7 Sampling Technique

The sampling technique is a means to determine how a sample is identified and recruited and the number of subjects involved in the sample (Polit & Beck, 2008). The study employed the purposive sampling technique to identify and select participants for the study. This is a form of non-probability sampling technique whereby only participants with properties that are of interest to the researcher are identified and selected for the study (Etikan, Musa & Alkassim, 2016).

This method was employed to allow sufficient recruitment of only participants who met the inclusion criteria for the study. Therefore, participants were selected on purpose. This was done with the assistance of the staff on duty. The staff served as contact persons and helped the researcher to identify adolescents who qualified for

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the inclusion criteria into the study and introduced them to the researcher. The purposive sampling technique adopted targeted male and female adolescents who were 12 to 19 years of age. However, those who were available for selection and also agreed to take part in the study were those aged 17 to 19 years and they were recruited for the study.

3.8 Data Collection Instrument

Data was collected through face-to-face in-depth interviews using a semi-structured interview guide. This is a tool in which open and direct questions are used to elicit detailed narratives and stories (DiCicco-Bloom & Crabtree, 2006). It is very flexible and provides the interviewees the opportunity to freely express themselves and provide in-depth information concerning their experiences of the phenomenon under study. Furthermore, it allows the researcher the opportunity to seek clarifications through follow up questions (Kusi, 2012). The interview guide was self-developed in consultation with the supervisor. This was designed using available literature and in accordance with the objectives of the study with the aim of answering the research questions.

The interview guide was in two sections. The first section covered demographic characteristics of respondents. These included their age, sex, religious affiliation, marital status, highest educational level. The second section comprised open-ended questions on adolescent friendly health services. This covered knowledge, attitude and perception aspects of adolescents relating to adolescent friendly health services with probing questions. Knowledge aspects covered adolescent friendly health services provided, how it is run, goal of adolescent friendly health services and advantages of the services provided at the individual, health care provider and community levels. Attitude aspects covered patronage of adolescent friendly health

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services and feelings about adolescent friendly health services. Aspects of perception about adolescent friendly health services assessed included views on the relevance of adolescent friendly health services, cost of services and issues around stigma.

3.9 Data Collection Procedure

Formal permission was sought from the management of the Kpone Health Centre and the head of the adolescent friendly unit before the data collection process. Informed consent was obtained from the selected participants and individual face-to-face interviews were scheduled according to their convenience. Interviews were conducted in an assigned office to ensure privacy.

Interviews were carried out in English and "Twi". Responses were probed or redirected where necessary to ensure full understanding of the participants' knowledge, attitude and perception about adolescent friendly health services. All the interviews lasted for about 30-45 minutes. This was recorded using a digital audio recorder. In addition to interviews, detailed field notes were kept.

3.10 Data Analysis

Data analysis was done concurrently with on-going interviews using thematic content analysis approach. Thematic content analysis is a type of qualitative analysis approach to analysing classifications and presents themes or patterns that relate to the data and using interpretations in dealing with diverse subjects in the data (Boyatzis, 1998). The thematic content analysis approach is more appropriate for this study because it provides flexibility in the use of both inductive and deductive approaches and the opportunity to code and categorize data into themes (Miles & Huberman, 1994) according to the themes of the conceptual framework.

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Interviews were then transcribed verbatim. Interview transcriptions were read several times to obtain full understanding of participants' accounts. The principles of thematic content analysis were employed to develop themes that emerge from the data. Thus, codes were attached to phrases, sentences or paragraphs. These are phrases or words used to represent verbatim narratives of the participants. These codes were then categorised by grouping them into similar ones and naming them as sub-themes. By so doing, words or phrases used as codes that have similar meaning or representing a similar theme were grouped together to form separate themes. These were then grouped into pre-determined themes indicated in the conceptual framework. Interpretations from the data were then discussed to ensure that themes are fully developed. Segments of data that best suit the themes identified were sorted appropriately and used to support the findings.

3.11 Methodological Rigour

The trustworthiness criteria recommended by Lincoln and Guba (1985) were employed in this study in order to ensure methodological rigor. This includes credibility, transferability, dependability and conformability.

Credibility refers to how congruent are the findings with reality (Carpenter & Speziale, 2007). This was ensured through prolonged engagement in the subject matter and through member checking by taking the final report back to the participants and to determine if it was an accurate representation of their report (Creswell, 2003).

Dependability of a research is the extent to which judgment about similarities and differences of content are consistent over time (Graneheim & Lundman, 2004). To ensure dependability, the researcher made detailed reporting of the processes

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involved in the study. This includes (1) a description of the research design and how it was implemented; (2) detail explanation of the data gathering process and (3) explaining what was done on the field.

The extent to which objectivity in qualitative research is ensured devoid of the researcher's biases is termed confirmability (Kusi, 2012). Confirmability involves triangulation of the methods and keeping of audit trail. Data triangulation was done through a combination of field notes and interviews during the data analysis phase.

Transferability refers to the extent to which findings can be applied to similar situations (Merriam, 1998). To ensure transferability, detailed descriptions was portrayed exactly as presented by the participants. This comprised sufficient contextual information about the fieldwork so as to enable readers to make such a transfer. Detail description of the research setting and the calibre of persons participating in the study, and methods involved were all presented.

3.12 Ethical Consideration

Ethical clearance: Ethical clearance was obtained from the Ghana Health Service Ethics Review Committee to conduct the study (GHS-ERC050/11/19).

Study area approval: An introductory letter from the school of public health, Legon, was also sent to the management of the Kpone Health Centre and the officer in-charge of the adolescent friendly unit at the Kpone Health Centre. This was to inform them about the study, seek approval for the study in the health centre and introduce the researcher to them.

Purpose of the study: To ascertain the knowledge, attitude and perception of adolescents about adolescent friendly health services at the Kpone Health Centre.

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Description of population: The study population included male and female adolescents 12 to 19 years of age accessing health care services at the adolescent friendly unit of the Kpone Health Centre.

Description of consenting process: The adolescents at the adolescent friendly unit were informed about the study. Those who agreed to take part in the study were asked to sign a consent form as evidence of their willingness to take part in the study. Participation was entirely voluntary and no one was coerced to take part in the study.

Voluntary withdrawal: Participants were informed that they were free to opt out of the study anytime they felt uncomfortable to continue, without any consequences to them.

Potential risks and benefits: Participants were informed that there was minimal risk associated with this study. They were assured that in case any of them felt upset during the process of the interview they would be referred to an experienced counsellor to discuss their concerns with them and reassure them. Although there were no direct benefits of participating in this study, participants were informed that indirectly, the outcome of the study would inform decision making and policies on interventions to effectively improve upon adolescent health care services at the Kpone Katamanso Municipality.

Compensation: No payments were made to participants for taking part in the study.

Privacy and confidentiality: Interviews were conducted individually to ensure privacy. Participant's names and other identifying data were not collected as part of the interview. Secondly, codes were assigned to quotes of the participants instead of their real names in order to ensure anonymity.

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Data storage, security and usage: All data collected have been stored and saved on a password protected computer. Field notes and consent forms have been safely kept in the custody of the researcher and placed under lock in order to ensure confidentiality of all information collected. Data collected were made accessible to the researcher and the supervisor.

Declaration of conflict of interest: There exist no conflicts of interest in this work.

Protocol funding information: This research work was solely funded by the researcher. No others funds were secured as sponsorship for this research.

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CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the study. Content analysis was done using the MAXQDA Plus 2020 software for qualitative data analysis. The findings of the analyzed data are presented in line with the study objectives. The presentation takes the following format; firstly, the demographic characteristics of respondent and secondly, the main findings are presented.

The three objectives of the study, are to gather empirical data by the knowledge, attitude and perception of adolescents about adolescent friendly health services. The study population was adolescents accessing health care services at the Kpone Health Centre. In all, ten participants took part in the study. For the sake of anonymity, the participants are; AF1, AF2, AF3, AF4, AF5, AF6, AF7, AM1, AM2 and AM3.

4.1 Demographic characteristics of respondents

The age, gender, level of education, marital status, occupation, religion and duration of accessing health care services at the Kpone Health Centre were the demographic details obtained from the participants. The age range of the participants was 17 to 19 years. Two of them were 17 years old and three were19 years old. However, five of them were 18 years old. They comprised three males and seven females and they were all single. One of the girls, however, had a child. All the ten participants were secondary school students. Nine of them were Christians and one a Muslim. Average duration of patronizing health care services from the Kpone Health Centre was 3 years, thus, ranging from 1 to five years. Two of them had accessed health care from

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the Kpone Health Centre for 5 years and three have patronized Kpone Health Centre for 4 years. The remaining five however, have been visiting the facility for a year.

Table 4.1: Demographic characteristics of participants

ID	Age (Years)	Gender	Level of education	Marital status	Religion
AF1	17	Female	Secondary education	Single	Christian
AM1	17	Male	Secondary education	Single	Christian
AM2	18	Female	Secondary education	Single	Christian
AF2	18	Male	Secondary education	Single	Christian
AF3	18	Male	Secondary education	Single	Christian
AM3	18	Female	Secondary education	Single	Christian
AF4	18	Female	Secondary education	Single	Christian
AF5	19	Female	Secondary education	Single	Muslim
AF6	19	Female	Secondary education	Single	Christian
AF7	19	Female	Secondary education	Single	Christian

4.2 Themes and categories

The outcome of the analysis had three main themes and 10 sub-themes. The three main themes were predetermined themes based on the study objectives.

Objective one, theme one: Knowledge on adolescent health services;

Objective two, theme two: Attitude towards adolescent health services and;

Objective three, theme three: Perception about adolescent health services.

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Table 4.2: Themes and sub-themes

Themes	Sub-themes
Knowledge on adolescent health services	(1) Meaning of adolescent health service (2) Services provided (3) Knowledge gained
Attitude towards adolescent health services	(1) Usefulness of adolescent corner (2) Visit to adolescent corner (3) Educating friends on adolescent corner
Perception about adolescent health services	(1) Perception of services provided (2) Cost of care (3) Perception of staff (4) Stigma

The first theme, 'Knowledge on adolescent health services' had three sub themes arising from the data namely; Meaning of adolescent health service, Services provided and Knowledge gained.

The second theme, 'Attitude towards adolescent health services', also had three sub themes arising from the data namely; 'Usefulness of adolescent corner', 'Visit to adolescent corner' and 'Educating friends on adolescent corner'.

The third main theme, 'Perception about adolescent health services' had with five sub themes arising from the data namely; Perception of services provided, Cost of care, Perception of staff, and Stigma.

4.3 Knowledge on adolescent health services

Knowledge on adolescent health services was one of the themes from the study. This represents information or facts that the adolescents knew about adolescent health

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service. Knowledge on adolescent health service was had three sub-themes: 'meaning of adolescent health service', 'services provided' and 'knowledge gained'.

4.3.1 Meaning of adolescent health service

Meaning of adolescent health service was described in terms of the understanding that the adolescents have about what an adolescent corner is and what the unit stands for. Three participants described their meaning of adolescent health service as an organisation that protects adolescents from illness and promotes their hygiene practices.

> *'Okay, adolescent health service is an organization and that they organize the youth and help them to take care of themselves and how to protect themselves from some diseases as they grow'.* (AF5 18y)

> *'Adolescent health services are a group of people who teaches the young about how to make themselves hygienic.'* (AF6 18y)

> *'Okay, they* (Staff at the adolescent corner) *help adolescents on how to take care of themselves in terms of personal hygiene, food hygiene and stuffs.'* (AM1 17y)

To some other participants, adolescent health services meant a unit that helps adolescent to avoid sexually transmitted infections, engage them with knowledge on healthy sexual practices including abstinence from sex and the consequences of unhealthy sexual practices.

> *'What I know about them is that they teach you how to stay chaste and how to protect yourself from sexually transmitted infections.'* (AF7 19y)
> *'...And also, they help you have to avoid any sexual intercourse so that you can't be pregnant and also you avoid bad friends because they can influence and also avoid early marriage.'* (AF4 18y)

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'They teach us how to avoid sexual activities such as a boy and girl having sexual intercourse.' (AF7 19y)

Two other participants considered adolescent health service as a unit that helps ensures adolescent reproductive health.

'I know that they're responsible for the safety and health of adolescents, in terms of reproduction and growth.' (AM1 17y)

'I also know that they teach adolescents how to take care of themselves and also they teach them how to take care of their reproductive system'. (AM1 17y)

4.3.2 Services provided

Services provided represent accounts of knowledge that adolescents have about adolescent health services provided by the adolescent friendly unit. These were either account of their experiences with adolescent health service staff or what they learnt from colleagues and others about adolescent health services. The known services provided are mainly education on prevention of illnesses common to adolescents, prevention of unwanted pregnancies, and hygiene practices.

'They told me about some killer diseases that if you don't protect yourself from, they can kill you. They said that when those diseases get into your system, you may not know it instantly. It will take a time, before you get to know that you have this disease. So, they told us to take good care of ourselves.' (AF5 18y)
'They teach us about how to protect ourselves from certain diseases and unwanted pregnancies.' (AF6 18y)

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A nineteen-year-old female adolescent specifically mentioned health education on vaginal health, personal hygiene and education sexually transmitted infections as some of the adolescent health services provided at the adolescent friendly units.

> *'They teach you about the health of the vagina and how to keep the vagina ... How to keep the armpit, the vagina clean to prevent diseases such as HIV/AIDS, gonorrhoea and syphilis'.* (AF3 19y)

Others also reported what they learnt from others about services provided by the adolescent health service staff including education of adolescents on unhealthy lifestyle, avoiding of use of illicit drugs and how to stay safe from sexually transmitted infections.

> *'They are known for educating adolescents to help them stay safe from sexually transmitted diseases, drug abuse and bad activities.'* (AF7 19y)

A nineteen-year-old female adolescent mentioned abortion and family planning services as services provided at the adolescent friendly unit.

> *'They will help you to do abortion and how to do family planning.'* (AF3 19y)

4.3.3 Knowledge gained

Knowledge gained is one of the sub-themes of the theme 'knowledge on adolescent health services' that emerged from the data. These are personal accounts of health tips the adolescents get to know after visiting the adolescent corners for adolescent health services. Participants recounted knowledge they gained on sexually transmitted infections.

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'I got to know more about sexually transmitted diseases like HIV/AIDS, a killer disease that mostly affects the youth.' (AF5 18y)

I got to know about some sexually transmitted diseases you can prevent yourself from... the diseases such as HIV, gonorrhoea and candidiasis and a whole lot.' (AF6 18y)

'Me personally, I got to know how sexually transmitted diseases are being gotten from our friends or sexual partners and how we can share items with our friends without being infected if they're carriers... Some of the sexually transmitted infections I got to know were gonorrhoea, syphilis, aids and many more.' (AF2 19y)

Participant's recounted knowledge they gained from the adolescent friendly unit on how to protect oneself from sexually transmitted infections and how to use condoms.

'They've shown me how to protect myself so I'm not going to get sexually transmitted diseases and, they've shown me how to use condoms.' (AF3 19y)

'As you're getting to adolescence, by all means you'll feel. You'll get feelings for the opposite sex. So, they taught us something that we use to protect ourselves from sexually transmitted infections and unwanted pregnancies, like the use of condoms.' (AF5 18y)
'I was also taught how to use condom to prevent unwanted pregnancies. I got to know that if you're an adolescent, your hormones are active, so I have to protect myself ... and a whole lot.' (AF6 18y)

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Two of the participants mentioned what they learnt about the consequences of unhealthy sexual practices and the need to stay away from them.

> *'I learnt that when adolescents engage into such bad sexual activities, it will lead some of them to drop out of school and unwanted pregnancies.'* (AF7 19y)

> *'They told us that if we engage ourselves in these immoral sexual practices it will lead us into trouble.'* (AF7 19y)

Some of them described how knowledge gained on safe sexual practices from the adolescent health friendly unit has guided their attitude towards sex.

> *'As for me up to now I have not had sex. They told me reason why we have sex and the reason why we don't have to have sex. I have learnt a lot- the age to have sex and the age not involve yourself in any relationship. Due to this, I have not had sex till now.'* (AF5 18y)

One 18-year-old female adolescent described how she learnt about adolescence and the signs that show that one is in the adolescence stage.

> *'Okay, okay. I learnt about adolescence. The age that shows I'm adolescent and some of the signs to show that I'm an adolescent.'* (AF5 18y)

4.4 Attitude towards adolescent health services

The attitude of adolescents towards adolescent health services represents the feelings or behaviours of adolescents towards adolescent friendly health care services. Three sub-themes namely; 'Importance of adolescent corner', 'Visit to adolescent corner' and 'Educating friends on adolescent corner' emerged from the data under the theme attitude towards adolescent health services.

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4.4.1 Usefulness of adolescent corner

The sub-theme, usefulness of adolescent corner represents the significance or value that adolescents place on adolescent health services. Participants explained that the adolescent corner is useful and that it protects adolescents, especially adolescent girls, from unwanted pregnancy and from sexual immorality.

> *'Adolescent health services are very necessary for every individual but for the females I think when they go to this organization, it helps them to move away from men and other friends. It helps them to avoid teenage pregnancy and teenage parenting.'* (AF2 19y)

> *'When adolescents go there for sexual health services, I think it will help them ... So that they can prevent themselves from diseases such as syphilis, gonorrhoea and HIV/ AIDS.'* (AF3 19y)

> *'Yes, it is very very necessary. For me as I said earlier, it has helped me a whole lot. It helped me to protect myself from having sex and doing a lot of things which is not acceptable in my age. The benefits I get from it, if those adolescents go there, they'll get same.'* (AF6 18y)

The adolescent corner concept is also seen as useful because services provided guide adolescents to avoid problems that may jeopardize their lives in the future. Two participants explained that the adolescent corner is important and that it helps adolescents to avoid unwanted pregnancies and school drop outs.

> *'Those who don't access adolescent health services may drop out from school after pregnancy which will create impediment in their lives. ... One may be rejected by his or her parents and in this case, you find it difficult and will also be a burden on the country as a whole.'* (AF2 19y)

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'...Because going there encourages me to avoid such activities which will lead me to school dropout and other stuffs.' (AF7 19y)

Thus, adolescent health services provided at the adolescent corner is considered useful because it ensures continuous and uninterrupted course in education and guarantees safe future love relationship and marriage.

'Most of the people want to grow up and become great persons in future. But because of the lack of education and lack of adolescent health services, most of the youth get pregnant and they are not able to attain their dream in life. So, it will be very important to provide have more adolescent corners to provide adolescent friendly health services.' (AF6 18y)

'It will help them in their marriage in future. Because no one wants to marry born one or born two women. Because without the knowledge about adolescents or sexual health, most of the youth have given birth in their earlier ages and their lives are miserable and you see them walking around miserably.' (AF6 18y)

As a result of this, three adolescents stressed the need to visit the adolescent corner.

'Okay, but I think it's necessary to go there.' (AF7 19y)

'It's very necessary. When you go there, they'll teach you how to go about a lot of things so it's very necessary.' (AM3 18y)
'So, I think it was necessary for me to go there.' (AM2 18y)

A 19-year-old female adolescent reiterated its importance and the need for all adolescents to patronise the adolescent health services.

'This is a program for all adolescents which I think those in charge of adolescent health services should put in much effort to make sure every adolescent benefits ... so, I think the government must enforce it

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on every adolescent so that we will all benefit.' (AF2 19y)

One 17-year-old female adolescent mentioned that going to the adolescent corner is important because it motivates her to encourage her peers and colleagues.

'It is important because it will help me to encourage the adolescents in life.' (AF1 17y)

Consequently, most of the participants stressed the need for the adolescent friendly health care programme to be sustained. Thus, to help adolescents who are in need of their services such. This includes continuous education of adolescents on adolescence, provision of family planning services to adolescents who need it,

'This program should be continued because many of the adolescents, though we know we are adolescents, we don't know more about ourselves ... the program teaches us may secrets about adolescence that we don't know ourselves. And as adolescents we need to know about ourselves.' (AF2 19y)

'It is important because there, you get to know more about yourself. As an adolescent, you have to know more about adolescent behaviour. They won't teach you all in the school so you have to go there (Adolescent corner) *and know more about that so it is very very important.'* (AF4 18y)

'It should be continued because maybe an adolescent is giving birth always and maybe the person doesn't have enough money so she wants to stop. The person will need family planning from the adolescent corner.' (AF3 19y)

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4.4.2 Visit to adolescent corner

Visits to the adolescent corner is the second sub-theme that emerged from the data under the theme attitude of adolescents towards adolescent health services. This sub-theme describes number of visits to the adolescent corner, reasons for visiting, reasons for not visiting and intention to visit the adolescent corner. Half of them have never visited the adolescent corner whilst the other half have ever been to the adolescent corner once or twice.

Reasons for visit to the adolescent corner

Most of the participants who visit the adolescent corner wen there because they thought it was necessary for them to go there to access their services.

> *'Yes, sure. I went there because I thought it was necessary for me to go there'.* (AF1 17y)

> *'So, I think it is necessary to go to the adolescent health unit. That's why I went there.'* (AF3 19y)

Some explanations provided for the need for adolescents to visit the adolescent corner were for the purposes of health education on adolescent health in general so that they can practice it and stay healthy.

> *'My reason for visiting is to also get some healthy education so that I will also be healthy.'* (AF7 19y)

> *'I visited the adolescent corner because I want to know more about myself. Even though I'm an adolescent, there are certain things that I do that I think that's right but at the sight of the society, it is not right. So, I'll go there to know more about adolescents and how to keep myself as an adolescent.'* (AF1 17y)

> *'... I just want to know more about adolescents' health service and then how adolescents can maintain their*

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> *health.... Maybe you have a doubt about something that you want to clear and then you're giving information on it and you're okay'.* (AF2 19y)

Others were motivated to visit the adolescent corner to learn more about the services provided, how to protect oneself from sexually transmitted infections and to learn about hygiene practices for adolescents.

> *'The reasons for going to the adolescent corner was to put myself clean and protect myself from diseases because that's what they have been teaching and if you follow their rules or steps, you'll protect yourself from diseases as I earlier on mentioned such as AIDS, candidiasis, syphilis and whole lot.'* (AF6 18y)

> *'Because they teach you about abortion, family planning, vaginal hygiene and armpit cleaning.'* (AF3 19y)

> *'Yes, I went there because I wish to learn such things about the menstrual cycle and personal hygiene.'* (AF1 17y)

However, one 18-year-old male adolescent was directed to go to the adolescent corner after reporting to the general out-patient department for health care.

> *'I came to the OPD* (Out-Patient Department) *and they told me to go there.... Because I'm an adolescent and they know the reason why they told me to go there.'* (AM2 18y)

Reasons for not visiting the adolescent corner

Among the participants with no history of visits to the adolescent corner, common reasons given for not visiting the unit were poor treatment from health workers and no time to visit the unit.

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'Some of the way that health workers treat adolescents when they go to the hospital is not good. That is the reason why I have not been to the adolescent corner.' (AF3 19y)

'Because of the school, I don't get time to even visit the adolescent corner.' (AF4 18y)

A 17-year-old female adolescent mentioned that she never visited the adolescent corner because she was not aware about its existence in the health facility.

'I haven't been to the adolescent health unit before because no one has ever spoken about it to me.' (AF1 17y)

One 19-year-old female participant explained that she had never been to the adolescent corner because of no apparent reason.

'I don't know why I have not been there... I actually don't have any reason.' (AF3 19y)

Intention to visit

However, most of the participants, including those who have not been to the adolescent corner, have the intention of visiting the adolescent corner in the future.

'Yes, I intend to go there (Adolescent corner) in the future.' (AF2 19y)

'Yes, I would like to go there in future.' (AM1 17y)

'Although I have not been there before, I think in future I will go to the adolescent health unit.' (AF7 19y)

Most of the participants expressed their desire to frequently visit the adolescent corner in the future in order to keep themselves abreast with health issues concerning adolescence and reproductive health so as to remain healthy.

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> *'I want to go there in the future to learn more about reproductive health.'* (AF3 19y)

> *'Yeah I will like to go there (Adolescent corner) because I'll know more of the advice and health tips they give to adolescents.'* (AM2 18y)

> *'I will like to go there to be educated. There are certain things I don't know about my teenage or adolescence so that I go there to know more about the changes and to be equipped in order to face any challenges that come my way.'* (AM3 18y)

One 19-year-old female adolescent mentioned that she would like to go to the adolescent corner in the future to improve upon what she already knows about adolescent reproductive health.

> *'I want to go there in future so that I can improve on what I know already. Day in day out many health conditions come out so I want to learn more and improve on my life.'* (AF2 19y)

One participant, a 19-year-old female adolescent, also expressed her desire to visit the adolescent corner because now sees it as necessary.

> *'Now that I see it* (Adolescent friendly health service) *as necessary, I will like to go there in future.'* (AF3 19y)

Two male adolescents expressed their desire to visit the unit out of curiosity to abreast themselves with services provided at the unit and to encourage others to visit the unit.

> *'Erm I'll like to go there in order to know more about the service ... and when I know that I can also tell my friends in order to visit the place.'* (AM1 17y)

> *'Yeah now that there's something like that. So, I will try and go there.'* (AM3 18y)

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4.4.3 Educating friends on adolescent corner

The third sub-theme under the theme 'Attitude towards adolescent health services' is 'educating friends on adolescent corner'. This describes the actions and intentions of the participants to impart knowledge gained from accessing adolescent health services to their colleagues and friends. They usually educate with the intention to inform their friends about their experiences at the adolescent corner.

> *'Now that I have been there and have some experiences, I will like to tell my friends about it.'* (AF5 18y)

One 18-year-old female adolescent explained that she will educate her friends about services provided at the adolescent corner and go on to invite them to come and listen to the staff at the adolescent corner to confirm all that she tells them.

> *'Oh, anytime I will like to invite some of my friends who are not around so that they can come and learn more... I will invite them to hear from the nurses and doctors, so that they'll know that what I explained to them is true and also know how to take care of themselves.'* (AF5 18y)

Another 18-year-old female adolescent said she explains to friends who ask her about what she goes to do at the adolescent corner.

> *'Some of my friends who don't know why I'm going there asks me why I have been going there and I tell them what had been going on there* (Adolescent corner).' (AF6 18y)

One 19-year old female adolescent specifically said she educates her friends on good hygiene practices learned from the adolescent corner.

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'Yeah I like to educate my friends so that we will all know how to live positive and then maintain good hygiene.' (AF2 19y)

One participant explained she educates her friends with the intention of getting them to also visit the adolescent corner to also access adolescent friendly health services.

'...I will give them a brief information about what I gained from going to the adolescent corner and I'm sure after that they'll visit there.' (AF2 19y)

4.5 Perception about adolescent health services

Adolescent perceptions about health care services represent their opinion or views that about adolescent friendly health care services provided at the adolescent corners. These have been presented under the sub-themes 'perception of services provided', 'cost of care', 'perception of staff', and 'stigma'.

4.5.1 Perception of services provided

The sub-theme perception of services provided describes participants views on types of services provided and their opinion about the usefulness of such services. Participants perceived that staff at the adolescent corners provide health screening for adolescents and educate them on positive sexual practices and menstrual hygiene.

'When we went to there (adolescent corner), *we had free health screening and free scanning of the eye'.* (AF2 19y)

'I think the unit is also there to teach us how to live in the society as an adolescent and how to take care of ourselves, especially we the girls from the opposite sex and also of our menstrual cycle and how to take care of ourselves when we are in our period.' (AM1 17y)

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General opinion was that the services provided at the adolescent corners were okay and that they get to learn about how to protect themselves from sexually transmitted infections. However, others were of the view that it every secondary school should have an adolescent corner.

> *'Please I think the service is okay. But I think some years to come since technology is improving maybe there may be changes but for now, I think everything is okay.'* (AF2 19y)

> *'I can say it is good. We get to know some things that we use to protect ourselves. Like, you're going to have sex or something like that you have to protect yourself.'* (AF5 18y)

> *'Yes, I think so far I've not seen the service moving from school to school. So, I think the job should be done fast and also move from school to school.'* (AM1 17y)

4.5.2 Cost of care

Participants described cost of care based on their experience on charges at the adolescent corner and their views on the cost of care at the unit. Those who visited the adolescent corner mentioned that they did not spend any money for services accessed at the unit.

> *'When I went there, I did not spend any money or incur any cost ... No. It was totally free.' (AF2 19y)*
> *No, I did not spend any money when I went there.'* (AF5 18y)

Three participants who had not been to the adolescent corner were not sure as to whether services provided at the unit will be paid for or free of charge.

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'As for that one I don't know. Maybe some of them will take money and some of them will not take money.' (AF4 18y)

'No, I don't know if I will spend any money when I go there. Maybe.' (AM3 18y)

'From the look of things, I think maybe I will spend some money when I visit the adolescent corner.' (AM1 17y)

4.5.3 Perception of staff

Perception of staff represented views held by participants about the attitude of nurses at the adolescent corners whilst providing them with adolescent health services. Participants perceived staff at the adolescent corner as good, polite, gentle and friendly towards them.

'They were good. They, were polite. They talked to the patients as they talk to the normal people. They don't talk rudely. They don't use abusive words too.' (AF2 19y)

'Yes, the nurses were all friendly'. (AF5 18y)

'They are very very good. They tolerate every view of every individual. No matter who you are. They are patient with you any time you bring any concern for discussion. They help you to achieve whatever you want.' (AF6 18y)

Others who had not been to the adolescent corner expressed their views on how they perceive staff at such a unit will behave. They perceived the staff would be nice to them and treat them well.

'... I don't think they'll be harsh or something like they may be good or nice. I think they will be calm.' (AF1 17y)

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'I think they will treat you well because you are a student and you don't know anything so I hope they will treat you well' (AF4 18y)

'I think they're going to be nice. I think if they see I'm an adolescent, they'll be more understanding.' (AM1 17y)

However, other's perceived not all would be nice to them.

'Some of them will behave well, but others will also not behave well.' (AF3 19y)

4.5.4 Stigma

Stigma also emerged as one of the sub-themes under perception about adolescent health services. This however represented negative perceptions that others held about adolescents who visit the adolescent corner. Most of the participants mentioned gossips and stigmatizing views held by people about them. They are labelled as bad or spoilt adolescents who visit the adolescent corner to learn about sex or to have abortion.

'You know Ghanaians, the adults when they see you going for sexual health may think that they're going to spoil you or something.' (AF1 17y)
'When people see you going to the unit, they say bad things about you... they'll think that you're going there for abortion or to learn about sex.' (AF3 19y)

'Someone will say look at this girl. Some people will also gossip about you but it's not anything bad that you go to do there... They may think as for this girl she has gone to get pregnant and wants to abort it.' (AF4 18y)

'Hmm most Ghanaians, when they see an adolescent girl visit the hospital more than twice, they think it's obvious that the girl is pregnant or the person is facing sexually transmitted disease, which I think is a misconception.' (AM1 17y)

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Those who have not been to the adolescent corner anticipated some negative views that some persons may have about them when they visit the adolescent corner.

> *'I don't know. But I think some of the people will think negatively.'* (AM3 18y)

> *'With human beings, it's not all of them that will know how those services are essential. Some may criticize you out of ignorance. So, it depends on the person.'* (AM3 18y)

This subsequently made it uncomfortable to participants to visit the adolescent to access adolescent friendly health services.

> *'Yes because of what people will think, you'll not feel comfortable when going there.'* (AF3 19y)

One 18-year-old male adolescent mentioned both negative and positive views that people have about adolescents who visit the unit.

> *'Some will think that maybe the girl is pregnant and going there to do abortion or some will think that the girl is going to seek education or reproductive and adolescent health.'* (AM3 18y)

One 18-year old female adolescent however, reportedly experienced no stigma whilst accessing health care services at the adolescent corner. This she attributed to the fact that those who know that she visits the adolescent corner understand the services provided there.

> *'When I'm going there and they see me, they don't feel anything. They don't think negative. When I come out or when I finish the service, they don't say anything. I think they also know the reason why I went there.'* (AF5 18y)

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CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter presents a discussion of the findings presented in chapter four. This study aimed at exploring the knowledge, attitude and perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre. A critical analysis of the findings and comparison of the findings with existing literature from previous studies have been carried out in this chapter. A discussion of the demographic characteristics of the respondents is presented followed by discussion of the results under the themes that from the data – knowledge on adolescent health services, attitude towards adolescent health services and, perception about adolescent health services.

5.1 Demographic characteristics of respondents

Among the ten adolescents that took part in the study, seven out of the ten were females and all of them have on the average accessed health care from the Kpone Health Centre for 3 years. This suggests that most female adolescents access health care services compared to male adolescents. The participants are old adolescents with age range from 17 to 19 years which indicates their transition from childhood to adulthood (WHO, 2019). This also falls within the WHO (2010a) criteria for defining adolescents. This explains why all of them were not married. However, one of the seven girls, making about 14% of the girls, had a child. Thus, an indication of early sexual activity among the adolescents. This confirms Enuameh et al. (2014) that the rate of pregnancy among adolescents aged 15 to 19 years have remained high in Ghana in spite of a slight decline from 14% in 2000 to 12.2%. This might

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also be linked to some risky sexual behaviours among adolescents that may expose them to many health risks (Hale & Viner, 2016). All the ten participants were secondary school students. This indicates that 17 to 19 years of age are mainly secondary school going age range for adolescents in Ghana. Nine of them were Christians and one a Muslim which suggests that the settlements served by the Kpone Health Centre are predominantly Christians.

5.2 Knowledge on adolescent health services

Knowledge on adolescent health services was described in terms of the meaning of adolescent health service to the adolescents, their knowledge on services provided at the adolescent corner and the knowledge they gained from visiting the unit. To the adolescents, an adolescent corner is an organisation that protects adolescents from illness and promotes their hygiene practices. They described the adolescent corner as a unit that promote reproductive health and helps adolescents to avoid sexually transmitted infections, engage them with knowledge on healthy sexual practices including abstinence from sex and the consequences of unhealthy sexual practices. Thus, an adolescent corner meant a place for adolescents are protected from sexual and reproductive health problems through education. This represents the goal of the ICPD (1999) to help adolescents achieve access to universal, comprehensive and integrated sexual and reproductive health information, education and services. An understanding of what adolescent friendly health services mean to adolescents is very critical to their patronage of these health services (Abraham et al., 2019).

In this current study the adolescents got to know about adolescent health services provided by the adolescent friendly unit from their personal experiences with staff at the unit or through what they learnt from colleagues and others about adolescent

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health services. Commonly known services provided at the adolescent corner included education on prevention of illnesses common to adolescents, sexual and reproductive health, prevention of unwanted pregnancies, in addition to abortion and family planning services and hygiene practices. These are mainly Reproductive Health Services (RHS) which are very important for adolescents in the 21st century. According to the UNFPA (2003), RHS that are adolescent-friendly have been found to be effective in addressing adolescent sexual and reproductive health needs. This suggests that the adolescents are aware of the services take can access from the adolescent corners. This is likely to motivate them to go to the adolescent corners for such services when the need arises for them. This can be linked to the ICPD's (1999) aim of achieving access to universal, comprehensive and integrated sexual and reproductive health information, education and services.

The adolescents who ever visited the adolescent corner described the knowledge they gained when they visited the unit. They got to know about sexually transmitted infections, to use condoms and the consequences of unhealthy sexual practices. This suggests that the staff at the adolescent corner make concerted efforts to provide some of sexual and reproductive health education for their clients. Earlier studies in Ghana showed that 41% of sexually active adolescents do not use condom, 34% did not use any modern contraceptive and 30% did not use any family planning method (Afenyadu & Goparaju, 2003) whilst others had no idea that they could get pregnant from engaging in sexual intercourse (Gyesaw & Ankomah, 2013). As a result of this, the knowledge gained by the adolescents in this current study on safe sexual practices from the adolescent health friendly unit reportedly guided the attitude of the adolescents towards sex.

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5.3 Attitude towards adolescent health services

Findings from the study on the attitude of adolescents towards adolescent health services included usefulness of adolescent corner to the adolescents, visits to adolescent corner and education of friends on adolescent corner. The adolescents in the current study considered the adolescent corner as useful because to them, it protects adolescents from sexual immorality, unwanted pregnancy in order to ensure their continuous and uninterrupted schooling whilst guaranteeing their safe future love relationship and marriage. Thus, an indication that some of them are aware of the import of the adolescent friendly health care service. Due to the fact that the adolescents realized the adolescent corner was important and useful, they stressed the need for colleagues to visit the adolescent corner. This confirms the finding of Smith et al. (2018) in South Africa where adolescents universally opined that friendly adolescent services were needed.

In addition, the adolescents in the current study, demanded that the adolescent friendly health care programme should be sustained. This would help ensure that health care services provided in a way that meet specific needs of adolescents remain available to them. This can be linked to another study in Soweto, South Africa by Schriver et al. (2014) where adolescent participants admitted to the fact that friendly adolescent services was a good programme and that health service providers should be trained to ensure respect and maintain confidentiality, be dedicated to the youth and be sensitive to their needs.

Half of the adolescents in this current study never visited the adolescent corner whilst the other half have ever been to the adolescent corner once or twice. Thus, an indication of relatively low patronage of adolescent friendly health services among

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the participants. This confirms the low patronage of adolescent friendly reproductive health services among adolescents in Ghana (Enuameh et al., 2014). Similarly, studies from other sub-Saharan African countries also reveal that many adolescents underuse RHS (Bankole, Biddlecom, Guiella, Singh & Zulu, 2007; Biddlecom, Munthali, Singh & Woog, 2007; IPPF, 2010). This underscores the need for concerted efforts to address this low patronage of adolescent friendly health services since they are mostly vulnerable to peculiar health risk in relation to reproduction and sexuality (Denoo et al., 2015).

The adolescents who visited the adolescent corner went there to learn more about the services provided, to get some health education on adolescent health in general, to learn about how to protect oneself from sexually transmitted infections and to learn about hygiene practices for adolescents. This suggests some sense of eagerness in the adolescents to learn more about health issues concerning them, especially their reproductive health. Others thought it was necessary for them to go there to access their services whilst one was directed there after visiting the general out-patient department of the facility for health care. As a result of this, the adolescent friendly health care programme provides the right environment for these adolescents.

Non-visit to the adolescent corner was due to previous experience of poor treatment from health workers and no time to visit the unit. Some did not visit because they were not aware about its existence in the health facility and others for no apparent reason. This can be linked to the findings from Schriver et al. (2014) in South Africa where only three out of the 23 interviewees were aware about adolescent-friendly health services. This underscores the need for more education and sensitization of adolescents on the existence of adolescent corners and the services provided so as to motivate them to patronize the unit.

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Most of the adolescents, including those who have not been to the adolescent corner, have the intention of visiting the adolescent corner in the future. Reasons given were to keep themselves abreast with health issues concerning adolescence and reproductive health so as to remain healthy. Some are motivated to visit the unit in the future out of curiosity whilst others see the need to do so. This indicates that the adolescents in this current study appreciate the adolescent friendly health care concept as reported in a similar study in South Africa (Schriver et al., 2014). It also indicates acceptability which is good for future adolescent health interventions.

This motivated the adolescents to educate others with the intention to inform their friends about their experiences at the adolescent corner. Others invite their friends to come and access adolescent friendly health services, to listen to the staff at the adolescent and also explain to friends who ask about what they go to do at the adolescent corner. This underscores the importance that adolescents who visit the adolescent corner see in the adolescent friendly health care based on their experience with the services they access at the adolescent corner.

5.4 Perception about adolescent health services

Adolescents also expressed their perception about adolescent health services. These include their perception of the services provided, perception about the cost of care, perception of staff at the adolescent corner and stigma. With regard to services provided, the adolescents perceived that staff at the adolescent corners provide health screening for adolescents and educate them on positive sexual practices and menstrual hygiene. These services will aid adolescents in achieving access to universal, comprehensive and integrated sexual and reproductive health information, education and services (ICPD, 1999).

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The adolescents in this current study perceive that the services provided at the adolescent corner are okay and that every secondary school should have an adolescent corner. According to the WHO (2201b), most sub-Saharan African countries have a dearth of adolescent-friendly health services and inadequate policies to address adolescent health needs. This suggests the need for government, non-governmental organizations and all stake holders to help in the establishment of more adolescent corners in secondary schools in Ghana to cater for the specific health needs of the Ghanaian adolescent.

Participants who visited the adolescent corner observed that they did not spend any money for services accessed at the unit. On the contrary, Biddlecom et al. (2007), in their study in Ghana found that 66% of the adolescents in their study thought they would pay for the cost of adolescent friendly health services. The free health care for adolescents is expected to motivate them to access these health care services. However, more sensitization needs to be done to create more awareness of the existence of these services.

Participants perceived staff at the adolescent corner as good, polite, gentle and friendly towards them. This suggests that staff at the adolescent corner are professional in the dispensation of their duties towards their clients. Those who had not been to the unit perceived the staff would be nice to them and treat them well. Other's perceived not all would be nice to them. This might be linked to previous bad experiences some of them might have gone through whilst accessing health care services in a health facility.

This confirms the findings of Biddlecom et al. (2007) in Ghana, where 85% of sexually-active female adolescents felt staff who provided adolescent reproductive

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health services maintained confidentiality and, 80% felt that young people were likely to be respected there. However, this contradicts the findings of Smith et al. (2018) in South Africa where participants had negative perceptions about the routine care young people experience at government clinic facilities, reporting that staff could be unpleasant, stigmatising, often rude and disrespected confidentiality of adolescents.

Furthermore, most of the participants perceived gossips and stigmatizing views held by people about them because they were spotted accessing health care from the adolescent corner. They are labelled as bad or spoilt adolescents with the notion that they visited the adolescent corner to learn about sex or to have abortion. These misconceptions and stigmatizing views are likely to damage the reputation of the adolescent friendly health care concept and deter adolescents from accessing these health care services.

Similarly, Mbeba et al. (2012) found that in Tanzania, the community members and service providers in the district perceived it as inappropriate for adolescent girls to access sexual and reproductive health services leading to stigma and discrimination of those who patronised such services. Similarly, Geary et al. (2014) found that in South Africa, judgmental attitudes in relation to young people's sexual activity were present.

This subsequently made it uncomfortable to the adolescents in this current study to visit the adolescent corners to access adolescent friendly health services. This is because shyness is known to be the most commonly reported reason among adolescent boys and girls for not accessing RHS (UNFPA, 2015).

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CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.0 Introduction

This chapter presents the conclusions of the findings from the study. Recommendations based on the findings from the study are also outlined in this chapter.

6.1 Conclusion

The study shows that general knowledge and understanding of the adolescents about adolescent friendly health care services was good. Sources of information about adolescent health services were from their personal experiences with adolescent health service staff or what they learnt from colleagues and others about adolescent health services. They mainly knew about sexual and reproductive health services provided at the adolescent corner.

The adolescents considered the adolescent corner as useful in addressing issues of sexual immorality among them and showed interest in the need for the programme to be sustained. Poor patronage of the adolescent friendly health services was due to lack of awareness and poor previous experience of visiting the unit.

General perception of services provided at the adolescent corner was good. Staff at the unit were perceived to be good, polite, gentle and friendly and cost of care known to be free. They perceived the services provided were okay and suggested that every secondary school should have an adolescent corner. However, stigmatizing views of others made them uncomfortable accessing health care services at the adolescent corners.

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6.2 Recommendations

Based on the findings from the study, it is recommended that:

1. Stigma was a major concern for the uptake of adolescent health services. This could be addressed by sensitization programmes aimed at educating people about adolescent friendly health services. The Ghana Health Service in collaboration with the media should make concerted efforts to address stigma associated with adolescent friendly health services by educating the general public on the concept of adolescent friendly health services. This will help ensure better public, including parents', understanding about the services provided so they don't think that children who access these services are bad.
2. One of the barriers to patronage of adolescent health services was lack of awareness of the existence of the adolescent corners. This underscores the need for intense sensitization of adolescents on the existence of adolescent corners. Coordinators in the municipal health directorate of the Kpone Katamanso Municipality should collaborate with the school health education programme coordinator in their communities and involving them in the creation of more awareness to adolescents in their communities and schools on the existence of adolescent corners in the form of school talks and community durbars.
3. Patronage of the adolescent corner in this study was poor as only half of the adolescents ever visited the adolescent corner. Therefore, adolescents need to be motivated to access adolescent health services in their communities. The municipal public health nurses in the Kpone Katamanso Municipality should collaborate with the school the municipal health education programme coordinator in their communities to encourage adolescents to patronize the

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service by establishing peer educator clubs to train adolescents to encourage and support each other to access adolescent friendly health services.

4. Adolescents in this current study had high intentionality to visit the adolescent corner suggested the need for the programme to be sustained. The Ghana Health Service in collaboration with the district and municipal assemblies should establish more adolescent corners in schools and health facilities in their communities to ensure that adolescent friendly health services are readily available to adolescents and, to guarantee the sustainability of the programme.
5. Although the study aimed at exploring the experience of both male and female adolescents from 12-19 years of age, only old adolescents, 17-19 years of age, comprising just 3 males and 7 females availed themselves for the study. This skews the study to more of female adolescent perspective and denies the study the perspectives of younger adolescents. Future researchers should endeavour to involve equal numbers of male and female, young and old adolescents so as to show any differences in their perspectives about adolescent friendly health services.
6. This study focused on knowledge, attitude and perception about adolescent health services. Future outcome studies should also be carried out to assess the impact of the adolescent friendly health care programme on the reproductive health of adolescents in Ghana. This will help determine the usefulness on the programme and gaps that need to be filled to make it more effective and efficient.

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APPENDIX I: PARTICIPANT INFORMATION SHEET

Title: Assessing factors influencing utilization of Adolescent Health Services at Kpone Health Centre, in the Greater Accra Region.

Hello

I am Helen Biney, a Masters student from the Public Health School, University of Ghana. I would like to request your participation in my study on the knowledge, attitude and perception of adolescents about Adolescent Friendly Health Services. This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part.

Background

In most sub-Saharan African countries, there are limited adolescent-friendly health services co upled with inadequate policies to address adolescent health needs. Reproductive health services that are adolescent-friendly have been found to be effective in addressing adolescent sexual and reproductive health needs.

What is the purpose of this study?

The purpose of the study is to explore the knowledge, attitude and perception of adolescents about adolescent friendly health services at the adolescent unit of the Kpone Health Centre. This will help me to understand the perspectives of adolescents about adolescent friendly health care services.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. An interview will be conducted with you. This interview will last for forty-five (45) to ninety (90) minutes. With your permission, the interview will be recorded with a voice recorder and the conversation will be typed. I will ask questions about your gender, age, religion, marital and educational, to know a little about yourself. After that, I will ask questions about your knowledge, attitude and perception about adolescent friendly health services

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What are the conditions that qualify me for the study?

You have to be an adolescent; thus, either a male or female adolescent from 12 to 19 years of age at Kpone Health Centre.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. In this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you at no cost. However, you reserve the right to withdraw from the study anytime. Your withdrawal from the study will not affect your treatment at Kpone Health Centre.

What are the benefits of participating in this study?

There are no direct benefits for participating in this study, however, the information you provide will help health workers and the general population appreciate the perspectives of adolescents about adolescent friendly health services. This will drive changes and reforms in policy that will influence interventions and practices to improve the knowledge, attitude and perception of adolescents about adolescent friendly health services.

Who is funding the study?

The principal investigator is funding the study

Feedback to participant?

Study results will be made available to participant

What rights do you have as a participant in this study?

Participation in this study is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview.

Is there reimbursement for taking part in the study?

No payment to take part in this study.

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How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Who can I call for enquires?

A copy of the information sheet and the consent form will be made available to you after it has been signed. For further clarification about the study, you may contact me on telephone number +233 244109508 or Email: adjeleybiney370.gmail.com

Or my supervisor on telephone number +233 200827195 or Email: bweobong@ug.edu.gh

With regard to concerns over the conduct of the study, please contact Nana Abena Apatu, the administrator of the Ghana Health Service Research Ethics Committee, on telephone number 050353869

Thank you

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APPENDIX II: CONSENT FORM FOR PARTICIPANTS

Title: Assessing factors affecting utilization of Adolescent Health Services at Kpone Health Centre, in the Greater Accra Region

Participant statement

I confirm that I have been informed by the researcher about the nature, conduct, benefits and risks of the study. I have read/it, was read to me (English, ☐ Ga ☐ or Akan ☐), and I understood the information on the information sheet and have had the opportunity to ask questions. I understand that the interviews will be audio recorded. I also understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care and legal rights being affected. I also understand that copies of the information sheet and signed consent form will be given to me for my personal records before the interview.

I agree to take part in the above-mentioned study. I hereby give consent for my personal information and my perspective about adolescent friendly health services should be used as data for this study.

---------- ---------- ----------

Name and Surname Signature/ Thumb Print Date

Consent for audio recording of interview

Do I have your permission to record the interview? Yes [ ] No [ ]

Interpreters' Statement

I interpreted the purpose and contents of the participants' Information Sheet to the afore named participant to the best of my ability in the (Ga ☐ Akan ☐) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter..... Date.....

Contact Details.....

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Statement of Witness

I was present when the purpose and contents of the participation Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (Ga ☐ Akan ☐ language)

I confirm that he/she was given the opportunity to ask questions/ seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name.....

Signature.....OR Thumb Print

Date.....

Investigator statement and Signature

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

Name and Surname	Signature	Date

Should you wish to contact me at any stage regarding consent you can contact me at Cell +233 244109508 or Email: adjeleybiney370.gmail.com

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APPENDIX III PARENTAL CONSENT FORM

I ..... (Parent/ guardian), give consent for my ward to participate in the study with the title "assessing factors influencing utilization of adolescent health services at Kpone Health Centre"

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Name and Surname Signature/ Thumb Print Date

Should you wish to contact me at any stage regarding consent you can contact me at Cell +233 244109508 or Email: adjeleybiney370.gmail.com

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APPENDIX IV: SEMI STRUCTURED INTERVIEW GUIDE

Dear Sir/ Madam, I invite you to participate in a study on the knowledge, attitude and perception of adolescents about adolescent friendly health services received at the adolescent unit of Kpone Health Centre. This will help us identify areas of adolescent health service provision that need to be addressed in order to improve upon the quality of health services provided at the adolescent unit of Kpone Health Centre. This interview is expected to last for forty-five (45) to ninety (90) minutes and it will be recorded. Thank you.

SECTION A: DEMOGRAPHIC DATA

Could you please tell me about yourself?

1. How old are you? _____ years
2. What is your gender? Male [ ] Female[ ]
3. What is your highest level of education?
   No Formal education [ ] Basic education (Primary/ JHS) [ ]
   Secondary education [ ] Tertiary education [ ]
4. What is your marital status? Not married [ ] Married [ ]
   Divorced [ ] Widowed [ ] Cohabiting [ ]
5. What is your religious denomination? _____
6. How long have you been accessing health care from this Health Centre? _____ years.

SECTION B: Knowledge on adolescent friendly health services

What do you know about adolescent friendly health services?

Probes

- What it comprises of,
- Services provided (Counselling, HIV Testing, Family planning services, abortion care, STI treatment, etc)
- How it is run
- Goal of adolescent friendly health services,
- Advantages of services provided (Adolescent/ Health care provider/ Community)

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SECTION C: Attitude towards adolescent friendly health services

Tell me about your patronage of adolescent friendly health services.

Probes

- Frequency of patronage
- Reasons for patronizing adolescent friendly health services
- Services accessed (Counselling, HIV Testing, Family planning services, abortion care, STI treatment, etc)
- Feeling about accessing adolescent friendly health services (Shy, embarrassed, insecure, confident, etc.)
- Usefulness
- Future patronage of adolescent friendly health services

SECTION D: Perception about adolescent friendly health services

What do you think about adolescent friendly health services?

Probes

- Necessity or relevance of providing adolescent friendly health services
- Involvement of all adolescents
- Stigma
- Cost of services
- Staff attitude
- Quality of services
- Sustainability
- Outcome

Is there any other thing you would like to say about adolescent friendly health services?

THANK YOU!!!

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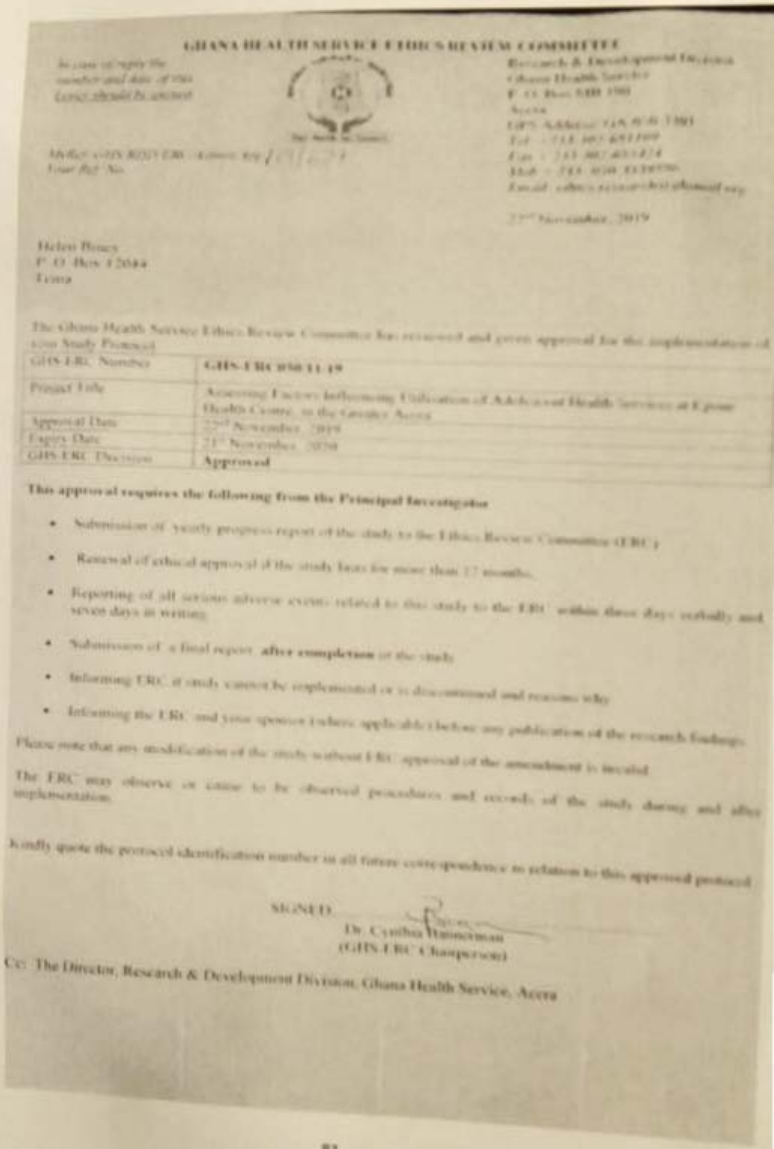
APPENDIX V: APPROVAL LETTER FROM ETHICS



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

Helen Boaey
P. O. Box 12044
Legon

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

GHS-ERC Number	**GHS-ERC 050 11 19**
Project Title	Assessing Factors Influencing Utilization of Adolescent Health Services at Kpone Health Centre, in the Greater Accra
Approval Date	22nd November, 2019
Expiry Date	21st November, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months.
- Reporting of all serious adverse events related to the study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

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

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

SIGNED
Dr. Cynthia Hanneman
(GHS-ERC Chairperson)

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