

*A Comparative Analysis of Adolescent Sexual and Reproductive Health  
Programmes in Two African Countries: Ghana and South Africa*

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**A Comparative Analysis of Adolescent Sexual and Reproductive Health  
Programmes in Two African Countries: Ghana and South Africa**

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**A Dissertation Submitted to the Faculty of Health Sciences  
School of Nursing  
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Doctor of Philosophy (Nursing)**

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by

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**January 2007**

## DEDICATION

*“A lot of effort and time was spent in putting this work together. In recognition of those special moments when thoughts of special ones kept me pressing forward and hopeful with the determination to succeed, I hereby dedicate this work to loved ones who have a special place in my heart that cannot be replaced under whatever circumstances”.*

*“My adolescent days went by smoothly without giving my parents heartache and pain or youthful rebellion associated with young people. To my late Mum, Esther Victoria and Dad, Charles Augustus Elba for instilling in me values that ever remain with me even in my adult years. I know you are safe in God’s keeping and smiling from yonder at my achievements. Though a vacuum was created by your absence, it is still filled up with sweet and fondest memories of you both”*

RIP.

## DECLARATION

*I hereby declare sole ownership of this dissertation*  
*“A Comparative Analysis of Adolescent Sexual and Reproductive Health Programmes*  
*in Two African Countries: Ghana and South Africa”*  
*on the merits of its originality through observation of the scientific process and*  
*academic writings and inputs from my supervisor.*

*\* Work used or cited in this dissertation has been appropriately acknowledged both in*  
*the text and reference list.*

Signature: J. H. Shepherd  
Date: 10-09-07

Supervisor: [Signature]  
Date: 10/09/07

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## **ABSTRACT**

Sex and sexuality issues are still sensitive and controversial subjects despite the growing numbers of sexual and reproductive health (SRH) programmes for adolescents in sub-Saharan African countries (WHO, 2002; Department of International Development (DFID), 2004). The purpose of this study was to examine and analyze the structure and procedural mechanisms adopted by adolescent sexual and reproductive health (SRH) programmes in two African countries. This study also explored the adolescents' perceived usefulness and relevance of these programmes in addressing their SRH needs. The study was conducted in Ghana (West Africa) and South Africa (Southern Africa) as a cross-national study in these two sub-Saharan African countries. A comparative case study design was adopted involving the use of both quantitative and qualitative approaches to data collection and analysis. Snowballing, critical case, and purposive sampling methods were used. A wide range of personnel from both countries including programme directors, managers, nurse/midwives, peer educators and youth counselors (n=48) were interviewed within the context of adolescent sexual and reproductive health (ASRH) programmes and adolescents (n=247) participated through client exit surveys and focus group discussions. Records review, document analysis and observation of the facilities were employed through a checklist. A Tri-dimensional conceptual framework adapted from Donabedian (1980) and WHO (2001) for: (1) Structure, (2) Process, and (3) Output of ASRH programmes, guided the study and served as the frame for analysis and comparison. Qualitative data were transcribed and analyzed using framework analysis and quantitative data through use of SPSS Version 13.0.

Findings of the study revealed that both Ghana and South Africa have established ASRH structures through development of programmes and policies for young people. They also shared common features related to programme focus and philosophy on ASRH matters. Both countries face several challenges associated with sexuality issues, inadequate human and material resources. Religious, socio-cultural, logistical and structural factors were identified as barriers, which hindered access and use of the facilities. These barriers were found to have a profound influence on programme implementation, achievement of objectives and future development.

Adolescents in the two countries are confronted with a range of issues affecting their sexual health and general well-being for which they seek services from ASRH programmes. These programmes in both countries were generally perceived as relevant and important by youth utilizing the facilities. The need for changes in the attitude of service providers, structural layout, logistical improvement and staffing composition was expressed. Despite efforts made, there are still programmatic issues needing attention, for which specific recommendations towards improvement were made on the basis of findings from both countries. Findings from this study have implications for nursing practice, management, education, research and relevant stakeholders involved with adolescent health, including policy makers. Recommendations are made that may contribute to the development of an effective model of “Adolescent-Friendly” programmes in the two countries.

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## LIST OF ABBREVIATIONS

<b>Abbreviation</b>	<b>Meaning</b>
<b>AGI</b>	Allan Guttmacher Institute
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARH</b>	Adolescent Reproductive Health
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>AYA</b>	African Youth Alliance
<b>CEDPA</b>	Centre for Population and Development Activities
<b>CHAG</b>	Christian Health Association of Ghana
<b>DFID</b>	Department of International Development
<b>FIDA</b>	Federation of Women Lawyers
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICDP</b>	International Conference of Development and Population
<b>ICM</b>	International Confederation of Midwives
<b>IEC</b>	Information Education and Communication
<b>MOH</b>	Ministry of Health
<b>NAFCI</b>	National Adolescent-Friendly Clinic Initiative
<b>NGOs</b>	Non Governmental Organizations
<b>PHC</b>	Primary Health Care

<b>RH</b>	Reproductive Health
<b>RHRU</b>	Reproductive Health Research Unit
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection
<b>UCSF</b>	University of California San Francisco
<b>UN</b>	United Nations
<b>UNAIDS</b>	United Nations Program on HIV/AIDS
<b>UNDP</b>	United Nations Development program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Emergency Fund.
<b>UKZN</b>	University of KwaZulu-Natal
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization
<b>YMCA</b>	Young Men Christian Association

## CHAPTER ONE

### INTRODUCTION

#### 1.1 BACKGROUND TO THE STUDY

Sexuality and reproduction are an integral part of almost every human life, but remain controversial subjects in African countries, especially when they concern young people (Senderowitz, 2000; Greene, Rasekh, Amen, Chaya & Dye, 2002). Within the legal framework, they are seen as a human rights issue (Department of International Development (DFID), 2004) and essential elements for good health and human development (WHO, 2003). These concepts encompass a wide range of issues concerning puberty, reproduction, sexual activity, health and lifestyle, and have profound physical, psychological, social and cultural significance for societies worldwide.

The phenomenon of sexual and reproductive health (SRH) of adolescents and young people has recently evoked considerable concern globally, due to the increasing disease burden among this age group (Network, 2000; Mc Intyre, 2003; Advocates for Youth, 2006). The threat of reproductive health-related conditions is a major cause for disease among adolescents worldwide (McIntyre, 2003). More importantly, high figures of mortality and morbidity associated with these problems were reported among this age group (UNFPA, 2005). Consequently, sexual vulnerability is emerging as a major issue that jeopardizes young people's health in different countries (Blum, 2005).

According to Oladepo and Brieger (2000), adolescent sexuality is instead viewed as a social problem, rather than a health problem to be coped with in terms of planning for development. This concern is further emphasized in a position paper by the Department of International Development (DFID, 2004), that clearly expressed dissatisfaction over



the lack of attention that SRH problems have received so far in African countries.

According to the World Health Organization (WHO, 2003), the SRH needs of young people, especially in African countries, remain largely unmet due to a number of reasons which negatively impact on their health.

Realizing the serious nature of this problem, the need for reproductive health of young people to be treated as a priority by governments was stressed at several conferences. The International Conference on Development and Population (ICDP), held in Cairo, Egypt in 1994, emphasized that more needs to be accomplished by countries through the establishment of adolescent-friendly services. As a show of commitment, international as well as national efforts were made through signing of treaties and youth policies to respond to the public and social health problems of adolescents and young people.

Despite these commitments, findings from several studies show that this is an area of importance that has been neglected, due to silence and a host of factors surrounding sexuality issues (Senderowitz, 2000; Reproductive Health Research Unit (RHRU), 2002; African Youth Alliance (AYA), 2004). Inequalities in reproductive health are reported, as a disproportionately large share of reproductive ill health was found in low-income countries, in particular, sub-Saharan Africa (Geelhoed, 2003; UNFPA, 2005). This is more so in the era of HIV/AIDS, when sexually transmitted infections, sexual abuse, teenage pregnancies, unsafe abortions, maternal deaths and other reproductive health problems are observed to be increasing among adolescents. These health problems ultimately undermine their future health and well-being and pose a challenge to existing structures in society.

Although adolescents are vulnerable to these SRH problems, few or no structures or youth policies are in place to cater for the specific needs of adolescents and young people (McIntyre, 2003) in some African countries. Consequently, the majority of adolescents are poorly informed about sexuality and reproduction, exposing them to further health risks which are inimical to their well-being and future development (UNFPA, 2005). In an attempt to resolve these concerns identified among adolescents, different countries have designed a number of programmes to address the SRH needs of young people (African Youth Alliance (AYA), 2005). These are currently offered to young people by a range of government and non-governmental organizations. They may be offered outside the health care services in some countries, in which case they are usually located within educational projects and a few health care clinics and hospitals on a short or long term basis as is revealed by analysis at country level (RHRU, 2000).

While specialized programmes which include screening centres are available for adolescents and young adults in countries such as Chile, France, Peru, Switzerland and the United States of America, the vast majority of adolescents in developing countries are included in services which are often designed to meet the health needs of adults (WHO, 2000). On observation, reproductive health services generally tend to focus on adults, with relatively little attention for adolescents as a specific age group with unique needs (Oladepo & Brieger, 2000). Where it is present, access to information is usually inadequate, and adolescents do not know of the existence of some of these programmes (Advocates for Youth, 2006). Lack of access to information by both females and males is a weakness evident in most of them (Oladepo & Brieger, 2000).

In a survey conducted in Ghana in 1998, there is evidence to support the claim that less than half of adolescent males and females have heard or seen anything about family planning either in the mass media or in the community (Alan Guttmacher Institute, 2004). Health information and services for young people are said to be uneven, and tend to concentrate more on information provision than on services (Alan Guttmacher Institute, 2004). They are reportedly scattered, poorly documented and not rigorously evaluated (Senderowitz, 2000). Access to prevention education regarding their SRH was limited as these services tend to be concentrated in the urban areas.

In South Africa, unequal geographical distribution of schools to Primary Health Care services, lack of financial resources, fragmented implementation of School Health Services and youth health were cited in a school policy document as concerns that posed a challenge to existing services targeting children and youth (Department of Health, KwaZulu-Natal, 2004). This situation negatively impacts the implementation and utilization of ASRH services in these countries further serving as barriers to youth services. Several barriers limiting use and access to SRH services were identified in the literature (Akinbami, Gandhi, & Cheng, 2003; Advocates for Youth, 2006).

According to findings, issues of access to information and services by young people are compromised under prevailing factors such as religious, socio-cultural values and beliefs, policies and structures (AYA, 2004; Senderowitz, 2000). Evidence suggest that cultural sensitivity and adults' objection to youth sexual activity either served as a deterrent or hindered use of such facilities by young people (Senderowitz, 2000). Adolescent chastity is still considered the ideal among a considerable proportion of service providers and the general public in some countries (Geelhoed, 2003). Basically, society provides a

dominant set of values and gender-based constructs to which adolescents are constantly exposed (Senderowitz, 2000), as gender stereotypes are constantly reinforced by social structures worldwide (Bertrand & Escudero, 2002; Kehily, 2002).

Apparently, these cultural barriers pose a threat to the SRH of adolescents and young people, thereby exposing them to numerous health risks. In the midst of these health risks, sexuality issues are still generally shrouded in secrecy, shame, fear, embarrassment, age restriction and limits within existing social structures in most African countries (Senderowitz, 2003; AYA, 2004). Problems confronting adolescents in relation to defining their sexuality and reproductive rights remain, even with the proliferation of programmes aiming at risk reduction among young people.

In view of the numerous problems and increasing disease burden among young people, a significant number of programmes and projects directed at adolescents' health in developing countries have been criticized as lacking the desired impact (WHO, 2002). New questions have therefore been raised about programme design and the effectiveness of interventions targeted at reducing the disease burden among adolescents. A call for innovative strategies to improve access to health for young people was made (Department of Health, KwaZulu-Natal, 2004; Advocates for Youth, 2006) to ensure they also benefit from health promotion activities.

## **1.2 STATEMENT OF THE PROBLEM**

Although there was increasing recognition of the scope and problems of ASRH in African countries in the late 90's, it is clear that the response made by programmes is insufficient (Okonofua, 1997). Until recently, the focus of health care services have been

directed at maternal and child health components, with little or no emphasis on adolescents as a unique group. An analysis of current statistics on the reproductive health status of adolescents especially in several sub-Saharan countries, paints a poor picture (DFID, 2004), and thus poses a challenge to health professionals and experts in related disciplines. Realistic programming appears problematic, as available evidence suggests that reproductive health problems of adolescents are mounting and there is absence of visible signs of their abating (Okonofua, 1997).

Youth programmes were initially designed in order to ameliorate the negative effects of the SRH problems of adolescents through use of a variety of adolescent educational campaign strategies by different countries. It was hoped that with the provision of SRH information and services, a positive formation of healthy sexual attitudes and practices will develop leading to reduction in health risks among young people (WHO, 2000; Thomas, 2000). Despite their growing numbers, little or no progress is noted in terms of reduction of the problems confronting this age group (Hock-Long, Herceg-Baron, Cassidy & Whittaker, 2003). Concern has been voiced as to the activities of these programmes in African countries (Advocates for Youths, 2006) as it was pointed out that there are some loop holes in the various SRH services (DFID, 2004).

From analysis of the literature, eight key factors were identified as crucial in bringing about innovation and reformation of programmes to achieve the intended outcomes (<http://www.pathfind.org/pf/pubs/focus>, Retrieved 22<sup>nd</sup> February 2005). These are: vision, national guidelines, leadership skills, data-driven planning and decision-making, supportive norms, administrative and management support, adaptation to local concerns, dedicated time and resources (<http://www.pathfind.org/pf/pubs/focus>, Retrieved 22<sup>nd</sup>

February 2005). It is doubtful whether these elements and the appropriate models are being used for the health care of adolescents and young people.

The structural and procedural input of programmes is a crucial factor for a successful outcome (Donabedian, 1980). The importance of links between the structure, process and output is discussed by system theorists. This is one issue that often goes unmentioned in most existing reviews of ASRH programmes. Equally, it remains largely unwritten about. Very colorful and explanatory descriptions are done through advertisement in the mass media; however, not much is done by way of research into their overall structure. An in-depth analysis of their operations is imperative to the understanding of the structure and mechanisms of programmes in African countries.

In an editorial report, Okonofua (1997) reiterated the need to evaluate different intervention measures for improving various aspects of adolescent reproductive health. This view has also been earlier observed in a comprehensive review of the literature (UNAIDS, 1997) assessing the effects of HIV/AIDS and sexual education on young people's sexual behaviour. In the review, the Department of Policy, Strategy, and Research of UNAIDS and the Joint United Nations Programme on HIV/AIDS (1997) reported that out of 53 studies that evaluated specific interventions, 27 reported that HIV/AIDS and sexual health education neither increased nor decreased sexual activity and attendant rates of pregnancy and STIs.

Despite various health messages and interventions by programmes, little or no impact on the behavior of young people was observed (Shucksmith & Hendry, 1998). Twenty-two reported delay in the onset of sexual activity, reduced number of sexual partners or

reduced unplanned pregnancy and STD rates. Only three studies showed a positive effect with regard to sexual behavior after exposure to sexual health education. As a result, the usefulness and relevance of approaches and methods used in teaching adolescents have been questioned.

Based on these research findings, the campaigns used by some programmes have come under critical analysis, as McIntyre (2003) maintains that many young people regard such services as irrelevant to their needs. The perceptions of adolescents using these services on the suitability of the methods can possibly throw some light on understanding what works for them. Another observation made by McIntyre (2003) is that evidence on the successes achieved in addressing adolescents' needs remains limited, as programmes operate at different levels and in different backgrounds, all targeting young people.

Doubt remains as to the effectiveness of the methods used in targeting their audience as they appear not to address the highest risk group within the particular age group (Myhre & Flora, 2000). A clearer understanding of the various services offered at different levels, strategies and interventions adopted is therefore of relevance in understanding the activities and the outcomes of the existing ASRH programmes. In support of this move, DFID (2004) emphasized the need for continued investment in research in order that there might be available a body of knowledge on what works to improve SRH.

Over and above this, DFID (2004) reiterated that SRH programmes often lack components that address issues such as gender discrimination and other forms of social exclusion. Studies indicate that most of the activities offered to youths are not well organized or coordinated and gender-sensitive elements are absent (Department of Social

Development, South Africa, 2002; Allan Guttmacher Institute, 2004). Such omissions are quite critical to the success of SRH programmes addressing young people, especially in African countries, as these issues have a key role to play in the utilization of these services by adolescents. Success stories from other countries as to what worked best in such instances can be shared.

More recently, the World Health Organization published a framework for country programming for adolescent health, as major health problems demand attention (WHO, 2000). It is not clear, if, and how many of, the existing ASRH programmes have applied an integrated theoretical framework, despite recommendations by WHO to use the model for directing their work. The role of theories and learning strategies suitable for use with adolescents was deemed appropriate at this point in time. Analysis of the structures, processes and approaches employed by the various countries towards fulfilling their goals and objectives cannot be over-emphasized.

Arguably, there is extensive information on problems confronting adolescents with special reference to their sexuality and reproduction. In the literature, research studies have generally focused on the SRH problems affecting beneficiaries (adolescents) using the services offered and a few case studies which are not inclusive of all components of the programmes, giving a narrow view of the situation. Key aspects of the services pertinent to adolescents' health as a whole are being overlooked. Evaluation studies have been conducted in a few countries such as South Africa and Kenya as a way of identifying programmes' strengths and weaknesses (Myhre & Flora, 2000). Most of these evaluation projects were based on individual projects and were carried out by managers



and staffs for their funders. This approach may have provided a biased view, which could be seen as a weakness in the reported findings.

There is a need for a cross national comparative analysis through a systematic enquiry of the phenomenon under study in its entirety, especially in African countries where the statistics of the global disease burden of adolescents remain high. A holistic view of the three elements of ASRH programmes is needed for a better understanding of the overall phenomenon under study. On the basis of the above problems outlined, there are questions regarding ASRH programmes that require answers to increase knowledge and thus contribute to development of new ideas through an empirical study:

- i) What is the philosophical basis for the establishment of these structures?
- ii) What basic structures do ASRH programmes have for addressing the needs of adolescents?
- iii) What are the various levels or types of health services offered by these programmes?
- iv) How do adolescents get to know about these services offered?
- v) What types of problems are reported by adolescents?
- vi) What processes and activities are adopted in the programmes to resolve these problems?
- vii) Who does what in the programme and for what purpose?
- viii) What are the challenges, weaknesses or barriers encountered by programme managers and service providers in implementation of programme activities?
- ix) How do these programmes cope with the challenges and barriers faced in their work?
- x) How do adolescents respond to these programmes?
- xi) What successes and achievements have been accomplished?
- xii) How accessible are these services to the target groups?
- xiii) What is the perception of adolescents regarding the structure and process elements?
- xiv) What are their views and suggestions towards future improvement and development

of ASRH programmes? xv) What are the common features, cross-cutting issues, similarities and differences in ASRH programmes in the studied countries?

### **1.3 PURPOSE OF THE RESEARCH**

This study seeks to provide insight into ASRH programmes in selected African countries.

The main purpose of this study therefore is to:

1. Comparatively analyze philosophical basis, demographical imperatives, and existing structures for ASRH programmes in selected African countries.
2. Analyze the processes, approaches, strategies, programme response, successes, challenges and barriers of ASRH programmes in selected African countries.
3. Analyze the conceptualization of adolescent-friendliness of the ASRH programmes from the perspectives of the adolescents in terms of knowledge of the existence of the programme, relevance, benefits and key principles underlying the concept.
4. Make recommendations towards essential ingredients to include in developing a model for ASRH programmes in Africa, based on the findings of the study.

### **1.4 RESEARCH OBJECTIVES**

The complex and diverse nature of assessing programmes required the establishment of general and specific objectives, targeting various programmatic elements in order to fulfill the purpose of this study. The objectives of the study are threefold, directed at three key dimensions of ASRH programmes as follows:

#### **1.4.1 The Structure of the Programme**

- To analyze the various structures, philosophical and demographic bases of programme conceptualization and design of ASRH programmes in selected African countries.
- To analyze the physical infrastructure, human and material resource composition of the programmes in terms of funding and sustainability.

#### **1.4.2 The Process of the Programme**

- To compare the framework, theories, method and approaches employed in service delivery and the teaching/learning in carrying out programmes' objectives.
- To evaluate the levels of service delivery, strategies, interventions and services offered in relation to the types of problems reported by adolescents to the programmes.
- To identify and discuss the different roles and functions, responses, programmatic challenges and barriers encountered in the implementation of ASRH services in the studied countries.
- To evaluate comparative services of the programmes from the selected countries in addressing cultural-gender issues and a comparative analysis of male–female ratio within the given context.

#### **1.4.3 The Output of the Programme**

- To determine the beneficiaries' (adolescents) knowledge of the services, perceived usefulness and relevance, and perceptions of an adolescent-friendly service in comparison to the WHO's guidelines.

- To identify gaps and weaknesses in the service delivery on the basis of the perceptions, attitudes and feelings expressed by the users to the services offered by ASRH programmes.
- To analyze and compare key findings from the three elements, gathered from the structure, process and output in the studied countries, towards identifying essential ingredients that can be used to develop explicit model(s) of ASRH programmes and services in future, and particularly within the sub-Saharan African countries.
- To highlight implications, make recommendations and suggestions in key areas to inform programmes and policies, in an attempt towards improving the quality of SRH of adolescents and young people.

### **1.5 SIGNIFICANCE OF THE STUDY**

The 2000 Census of Population and Housing in Ghana, reported that, young people aged 10-24 accounted for 30.4% of the total population in the country and formed about one-third of the population (Population Census, 2000). In South Africa for example, 40% of the population is reported to be under the age of 20 (RHRU, 2003). Adolescents who make up a greater part of the populations of the world (WHO, 2002), according to current figures, are said to be a vulnerable age-group. Persons within this age group are seen as vulnerable due to the developmental needs of this phase in their lives. The fact that a lot of young people out there are at risk, challenges the very systems that are designated to care for them. Thus, this study addresses a significant population group considered vulnerable.

In recent literature, the SRH needs of young people were identified as significantly contributing to increase vulnerability among adolescents (WHO, 2004), consequently

affecting their future well-being and development (DFID, 2004). Reproductive health was raised as a potential area of concern worldwide and is of particular relevance and interest, due to the increasing disease burden observed among young people (Network, 2000; McIntyre, 2003; Advocates for Youth, 2006). Adolescents are at risk of SRH problems, leading to a high mortality and morbidity among this age group, especially in sub-Saharan African countries (McIntyre, 2003). This study thus identified and addressed a significant international health issue on sexual and reproductive health programmes for adolescents in two sub-Saharan African countries, Ghana (West Africa) and South Africa (Southern Africa).

Reproductive health has been listed in group one (Global Forum for Health Research, 2004) as one of the areas of research in the 10/90 Report on Health Research (2003-2004). The specific health needs of adolescents are frequently overlooked when national health plans are reviewed and developed. In this context, adolescent SRH was listed as one of WHO's priority areas of research for the 2004-2009 Global Forum for Health Research (2004), as the needs of adolescents continue to remain poorly understood or underserved in many parts of the world (WHO, 2004). Agreeably, this topic is appropriate at this time when global efforts (WHO, 2004) from various sectors dealing with adolescents are aiming at making life safer and healthier for adolescents and young people.

Nursing research focuses on the investigation of phenomena relevant to the health and illness continuum of individuals, families and populations to provide a scientific rationale for our actions. Recognizing the need to have a better informed and empowered society, a study on the SRH of the future generation is imperative and is a valuable contribution to

nursing as a profession and health educators, based on the challenges to the health of young people. Both adolescent SRH needs and the programmes are of paramount importance in Africa where the incidence of HIV/AIDS and teenage pregnancies are of great concern, to both the individual countries and the continent as a whole. This study is therefore invaluable in the era of HIV/AIDS among adolescents, early sexual activity, sexual abuse and increased teenage pregnancy, among other health risks.

In view of the important role SRH programmes play in risk reduction and prevention in the lives of young people, a systematic research study on such programmes will contribute to improving knowledge about them in the studied countries, and add to the body of knowledge required for providing SRH services for adolescents. It is therefore anticipated that the responses of the adolescents on the relevance of the programme to their needs could be incorporated in the recommendations, reflecting opinions that can be used to deal with existing SRH problems. The ultimate aim is to provide young people with a healthier and safer lifestyle.

Overall, the findings have highlighted potential areas and ingredients for ASRH programme development. This may have implications for revision of the programmes' activities and reinforcement of the best practices which could assist in the conceptualization and future design of ASRH programmes. This study therefore has important implications for policy makers, programme managers, health educators, nurse-midwife educators, nurses and other relevant stakeholders involved in adolescent welfare.

There is a need to identify and compare differences, similarities, and commonalities across these programmes in different settings, with a view to discovering which activities

work, which do not, and why. Much could be learned from an analysis of the strengths and weaknesses of different countries' approaches, strategies and lessons learnt.

Perspectives from different approaches, culture, traditions, history, and the people tend to bring richness to the information, and the contrasts that can be used to explain differences in outcomes if any, while comparing programmes. Moreover, cross-national comparative studies provide diverse views and broaden the scope of information which may not be available in a single country setting. Such comparisons give a better insight into the contributions of each country towards young people's SRH than if the study were conducted in a single country.

In view of the above, the researcher wants to find out how these programmes compare in actual practice. The reality of what they look like from a holistic perspective makes the study worth undertaking, as their role in the development and health of adolescents is critical. New knowledge generated from the study could be used to develop new ideas in maintaining adolescent-friendly services by future studies in African countries.

## **1.6 OPERATIONAL DEFINITIONS**

For the purpose of this study, the following key concepts are defined and applied within the context in which they have been explained.

- **Adolescents/Young People**

The term "adolescent" refers to any individual between the ages 10-24 years (WHO, 2000). The broader term "young person" refers to any individual between 10-24 years (WHO, 2000: 4). Within the context of this study, the terms "adolescent" and "young people" will be used interchangeably to refer to persons within the age range specified. When the term "young person" is used, this includes both adolescents and young people.

The term “youth” is used predominantly in the current document in a more generalized sense. According to WHO (2000), a youth is any individual aged 15-24 years. In instances where the term “youth” is cited in the literature or used by the researcher, this is specifically applicable to, or interpreted as, defined by WHO.

- **Sexuality**

Sexuality is recognized as a key component of reproduction in the context used in the study and refers to awareness of issues pertaining to biological differences, gender issues, behaviors and characteristics of being male or female. It is a normal developmental period and an identity process all adolescents go through in their lives.

- **Sexual and Reproductive Health (SRH)**

These include the specific needs that are related to biological changes and physical maturation of adolescents and young people in terms of their sexuality and reproductive functions, which expose them to health risks such as sexual activity with increasing risk of contracting sexually transmitted infections, including HIV/AIDS, in both sexes, teenage pregnancies, abortions and their associated risks. Knowledge on the anatomy and physiology of the reproductive system, behavioral risks and their consequences are necessary in order for them to cope with these needs and also form part of the content on sexual and reproductive health needs of young people.

- **Adolescent Sexual and Reproductive Health (ASRH) Programmes**

ASRH programmes in this study include those facilities and services where adolescents are recognized as a specific group needing special attention, and as such, structures and processes have been put in place to address their SRH needs as described above. These



programmes can be within the health care delivery services or in adolescent centres managed by government or NGO's. Each individual facility visited is identified and described as a "programme" on its own, but jointly, reference is made by the researcher to all such facilities or services which adolescents utilize as "programmes" within the specific context referred to in this study. For avoidance of doubt, such programmes may or may not carry specific names.

- **Adolescent-Friendly Programmes**

An adolescent-friendly programme is one that incorporates the viewpoint of adolescents regarding their needs. These are facilities that offer services within clinics/youth centres to improve adolescents' health and well-being, specifically their SRH needs as defined within the context of this study, and have laid claim to being an "adolescent-friendly" service or programme.

- **Comparative Analysis**

A comparative analysis is the method of approach used in this study to describe, explain, explore, analyze, present, and compare similarities and differences observed in adolescent sexual and reproductive health programmes in various settings. The pointers for comparative analysis will be identified within the three constituent elements studied in the programmes (Donabedian, 1980), such as the structure, process and output on a comparative basis, to give a complete picture of the findings in the two countries chosen. These key elements of the programmes will form the determinants for setting up the comparison on a cross-national case basis for the countries studied.

## **1.7 CONCLUSION**

Sexual and reproductive health problems confronting adolescents and young people in Africa are of major and global concern and not limited to any country in particular. This phenomenon has generated much debate, globally as well as nationally, due to the increasing disease burden among this age group. Given the threat to adolescents' future development and well-being, it is imperative to focus attention on these key concerns as identified. Background information provided in this chapter highlighted the need for an empirical study in ASRH, more especially in African countries. This chapter therefore sets the stage for subsequent review and analysis of the literature in the next chapter, in an attempt to build on current knowledge, and to provide a focus and structure for the scope and direction of this research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

In this Chapter, relevant literature was reviewed around and within the focus of the study. The majority of the content is adolescent specific and relates to issues affecting adolescents' health generally, and more specifically their SRH needs. The WHO and ICDP definitions on sexual and reproductive health are addressed and a description of the structural basis for ASRH programmes provided. Various types of ASRH programmes, with examples of such programmes, their goals, objectives in terms of relevance to ASRH needs, are highlighted. An overview of global perspectives on "Adolescent-friendly" clinic initiatives, the role of UN Agencies and NGOs involved in ASRH activities are discussed. Key concepts and principles in adolescent health and development, including models and theoretical perspectives are also critically analyzed.

Several adolescent interventions, major strategies and educational approaches to teaching and learning were examined from a multidisciplinary perspective, informed by research studies relevant to the issues reviewed. Barriers confronting adolescents in accessing and utilizing ASRH programmes are discussed as well as narratives of case scenarios of such encounters examined within socio-cultural, religious and structural factors. The conceptual framework guiding this study is also presented in textual and diagrammatic form, illustrating the constituent elements, key concepts and principles within each programme dimension, subsequently used as a frame of reference and comparison. The chapter concludes with discussions on the key determinants considered as ingredients for a successful adolescent programme based on findings from the literature and a review of academic and clinical writings by experts in the field of study.

## **2.2 WHY ADOLESCENTS? THE GLOBAL PICTURE**

Adolescents make up 1.2 billion of the population worldwide, indicating that one in every five people in the world is an adolescent (WHO, 2000). The World Health Report of 2001 indicated that more than two-thirds of the world's population is composed of people below 25 years old. In 2003, the UNAIDS reported that young people aged under 25 account for nearly half of the global population. WHO estimates that 85% of adolescents live in developing countries, and 16% of them live in Africa. Sub-Saharan Africa has one of the world's youngest populations (WHO, 2003). This younger generation is said to be the largest in history (WHO, 2001) and is highly vulnerable, due to radical changes in social conditions which can have a profound effect on health and represents a major challenge to governments.

### **2.2.1 Magnitude of the Problem: Challenges for ASRH Programmes**

A major challenge confronting reproductive health programmes is that of being able to effectively and specifically address adolescent problems in order to secure a healthy future for young people, who represent the future generation of our societies. Current demographic patterns in review of the literature indicate that the disease burden among young people is alarming (UNFPA, 2002; RHRU, 2002; DFID, 2004). The scale of the problem of SRH may be discussed in terms of the number of young people affected as important elements in the challenge. Globally, the major health challenges which threaten the SRH of adolescents and young people today according to WHO (2002), RHRU (2002), UNFPA (2002) and DFID (2004) are:

- Early sex, unsafe sex, increased sexual activity and its consequences;
- HIV/AIDS and other sexually transmitted infections;
- Unwanted/unplanned pregnancies, teenage pregnancies;

- Unsafe abortion and its complications;
- High incidence of maternal mortality and morbidity;
- Rape, forced or coerced sex;
- Other sexual and reproductive health problems.

### **2.2.1.1 *Early Sexual Activity***

High-risk sexual behaviour is linked with several adolescent populations who are believed to be more vulnerable to teenage pregnancy and STIs including HIV/AIDS (Kaestle, Morisky, & Wiley, 2002). Most young people are said to become sexually active in their teens, and many before their fifteenth birthday (Dickson, 2003). In the United States, young people aged 15-24 represent 25% of the sexually experienced population. Findings from a National Survey of 15-24 year olds in South Africa revealed that 67% of this age group reported having had sexual intercourse; age 15-19 (48%) reported being sexually experienced compared to the other age groups. Differences in gender were however not observed on analysis of the findings (RHRU, 2004). Data from Ghana reported that by age 15, 47% of males and 38% of females had had sex. The figures indicate that four in 10 female adolescents in Ghana and two in 10 males aged 15-19 have had sex (Alan Guttmacher Institute, 2004). In a survey conducted among male secondary school students in Nigeria, mean age at first intercourse was reported at 13.5 years among 19.9% who had ever had sex (Oladepo & Brieger, 2000).

### **2.2.1.2 *Sexually Transmitted Infections***

The impact of HIV/AIDS on young people is alarming. Globally, nearly half of the new cases of HIV infections are among young people below 24 years. Around 7 000 young people between the ages of 10-24 are believed to be infected with HIV daily, and five

young people are infected with the virus every minute (WHO, 2000). About 88% of all new cases of STIs occurred in persons aged 15-24 (Weinstock, Berman, & Cates, 2004). It is estimated that about 2.6 million new HIV infections occur among young people every year, representing 50% of all new cases (WHO, 2001). In sub-Saharan Africa, 63% of those who were HIV positive in 2003 were between ages 15-24 (UNFPA, 2005). The above figures reflect changes in the demographic patterns of sexually transmitted infections reported in young people in the past decades. An increase is observed in the number of young people infected with HIV, as well as dying from the disease. Various sources revealed that there is a propensity to sexual risk-taking among adolescents (Morisky & Ebin, 2001; Weinstock, Berman, & Cates, 2004). Early sexual activities and lack of knowledge of preventative measures (WHO, 2001) further exposes young people to sexually transmitted infections (McIntyre, 2003).

#### ***2.2.1.3 Teenage Pregnancy***

Teenage pregnancy has emerged as a major problem confronting young people and consequently undermines their physical and social health. The age specific fertility rate among 15-18 year old females in sub-Saharan Africa is 143 births per 1000 women (Dickson, 2003). The number of births to adolescents in sub-Saharan Africa is expected to increase over the next few decades, exceeding a total of 4.8 million births to girls aged 15-19 over the period 1995 to 2020 (Dickson, 2003). An estimated 14 million adolescents aged 15-19 give birth each year (UNFPA, 2005). Global data shows that a total of 15 million babies were born to adolescents (Fransen, 2002). One quarter to one half of adolescent girls in developing countries are mothers before they reach 18 (UNFPA, 2000). Most of these pregnancies are unplanned, unwanted and expose them to further life-threatening risks such as obstructed deliveries, leading to vesico-vaginal fistula,

especially in developing countries where there is a lack of access to emergency obstetric care and services (WHO, 2000).

Each year, half a million women die in pregnancy or childbirth and 90% of maternal mortality occurs in women in developing countries (WHO, 2000). Pregnancy-related complications are documented as the main cause of death in females aged 15-19 and at least 60 000 adolescent girls die from pregnancy-related complications each year, the majority in developing countries (WHO, 2000). Maternal mortality figures for women aged 15-19 years show that they have a 20% higher risk of dying during pregnancy or delivery (WHO, 1994) than older women. Complications and deaths resulting from such conditions could be averted if proper structures were put in place to address reproductive health needs amongst adolescents. Maternal age is reported as an important risk factor for perinatal outcomes. Additionally, infants born to teenage mothers face a high incidence of infant mortality and morbidity, low birth weight and prematurity (WHO, 1994).

### ***2.2.1.3 Unsafe Abortion***

Unwanted pregnancy is another sexual and reproductive health issue that often leads adolescents to procure unsafe abortions. Abortion is not without its complications. It is estimated that globally, 4.4 million girls age 15-19 years undergo unsafe abortions each year. Young women aged 15 to 24 years account for 40% of these and the risks of unwanted pregnancy among teenagers and young women in Africa leading to unsafe abortion are increased (DFID, 2004; WHO, 2000). Deaths usually occur in cases where the social and environmental conditions are unfavorable. Some of these deaths are unaccounted for, due to fear of disclosure of the actual cause of death, consequently, accurate figures cannot be provided for these deaths.

#### **2.2.1.4 Other Reproductive Health Problems**

Issues of rape, early marriage, sexual abuse, including forced prostitution and trafficking in young girls, and cultural practices such as female genital mutilation can be damaging or fatal for the SRH of adolescents. These problems are also discussed in the literature as serious health risks which threaten the sexual and reproductive well-being of young people (WHO, 2002; DFID, 2004; RHRU, 2002; UNFPA, 2002). The above problems of adolescents are compounded by the view prevailing in their societies in relation to sexuality issues, their developmental stage and age restrictions on certain knowledge, all of which lead to their increased vulnerability. Survey reports of these problems of young people vary throughout Africa.

### **2.3 THE STRUCTURAL BASIS FOR ASRH PROGRAMMES**

The global need for SRH programmes for adolescents has become critical in the past decade for a number of reasons (WHO, 2000). In terms of statistical figures, the world is experiencing an unprecedented increase in the number of young people; 85% of this number lives in developing countries (UNFPA, 2005). The health of adolescents and young people is constantly being challenged by diseases and illnesses, making them vulnerable and at risk of developing a broad range of health problems especially those affecting their sexuality and reproduction. Countries in sub-Saharan Africa are confronted with enormous challenges in terms of their youthful population. Teenage pregnancies, HIV/AIDS/STIs, unsafe abortion are accounted for among adolescents in large numbers (WHO, 2003). These specific health problems of adolescents seem to be increasing and high mortality and morbidity figures are linked to them (WHO, 2001) despite interventional measures (Greene, Rasekh, Amen, Chaya & Dye, 2002). Poor reproductive health services for young women, poverty, gender inequality, and the lack



of political will in some countries were cited as some of the underlying reasons for high maternal mortality and poor maternal health affecting young women (Fransen, 2002).

Regrettably, recognition of these health issues is not necessarily influential over the actual public health practice within some of these countries, though they are accepted as a priority that needs attention.

While international bodies seek to find a global solution to the problem, the efforts of individual countries are also critical in contributing to solving or lessening the problem of ASRH needs. Both WHO (2000) and African Youth Alliance (AYA, 2004) have produced reports in which they identify countries which have initiated ASRH programmes as well as policies on adolescent health. Such countries have realized that they have undertaken a huge task that needs a multisectoral and multidisciplinary approach. While the focus of programmes for adolescents is on meeting those specific ASRH needs, attempts are also made to make services attractive by offering recreational, vocational and library facilities along with reproductive health services.

Although reproductive health programmes for young people exist in some countries, the way the activities are coordinated to realize the objectives is crucial. If the quality of life for young people is to be improved in these respects, programmes designed for this purpose can play an important role in promoting SRH through a wide range of services using a variety of scientifically tested interventions.

## **2.4 SEXUALITY AND REPRODUCTION**

Sexual and reproductive health need is discussed in the literature as one of the important areas of concern as it contributes significantly to the statistics of mortality among young

people. Health, as defined by the World Health Organization (1990:2), is “a complete state of physical, social and mental well-being and not merely the absence of diseases or infirmity”. According to WHO (2000) sexual health is the capacity to enjoy and manage sexual and reproductive behavior in accordance with social and personal ethics. It encompasses freedom from fear, shame, guilt and other psychological states that can impair sexual relationships. The ICPD (2000:1) defines reproductive health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the sexual and reproductive system and to its functions and processes”. On the other hand, reproductive health care is defined by ICDP (2000) as:

*“The constellation of methods, techniques and services that contribute to reproductive and sexual health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases” (ICDP, 2000:1).*

Enabling young people to achieve better health is a fundamental part of good nursing care practice. Based on the justification that health is described as an entirety comprising various dimensions (WHO, 1990), a key distinction was made between sexual and reproductive health and other health needs of adolescents as of critical importance.

## **2.5 CONTRIBUTING FACTORS TO ASRH PROBLEMS IN SUB-SAHARAN-AFRICAN COUNTRIES**

A host of reasons are offered by governmental and health officials as contributing factors for the present situation. A review of the literature (UNAIDS, 2004) suggests that reasons such as changes in governments, political instability, and social and religious concerns with legitimizing sexual and reproductive practices, contribute to this neglect. The shortage or lack of qualified advocates of sexual education, such as nurses, and the

prevailing public opinion concerning sex education are also contributing factors (UNAIDS, 2004). Inadequate prioritization by governments, inadequate funding and lack of youth and reproductive health policy featured in the review as critical factors responsible for slow progress.

### **2.5.1 Inadequate Prioritization by Governments**

Accessible, comprehensive sexual and reproductive health services are the cornerstone of efforts aimed at empowering young people to make informed, safe and healthy choices. WHO (2002), however, contends that the SRH of adolescents has been neglected by governments and needs to be further prioritized world-wide. Accordingly, Okonofua (1997) laments that despite the mounting reproductive health needs of adolescents in Africa; very few African governments have created realistic goals for addressing the problems. According to observations made by DFID (2004) and the RHRU (2004), there are no specific governmental structures to address this increasing problem in most of the developing countries, and there is also limited data on how the objectives of these programmes fit into the overall health plan of the government (AYA, 2004).

### **2.5.2 Inadequate Government Funding**

Adolescent health is of low priority in sector planning and budgeting (DFID, 2004). This neglect leads to failure to provide for the needs of this age group. Okonofua (1997), for example, indicated that absent or limited funding exists for governmental projects concerned with adolescents in Africa as youth programmes received very little substantive funding from African governments (Okonofua, 1997). Furthermore, the health services in most countries do not have the resources to meet their objectives, and as a result they are rarely attuned to the special needs of adolescents and young people

(AYA, 2004). International donor support has served as the main source of funding for many of these programmes and has played a major role in terms of sustainability. Subsequently, the structure, activities, contents and models of most programmes are imported from Western countries and may not be culturally appropriate to the specific needs of adolescents in an African culture which is dominated by other norms and values regarding reproduction and sexuality.

### **2.5.3 Lack of National ASRH Policies**

According to WHO (2004), governments must recognize the need to have declared health policies, which clearly spell out their responsibilities to young people and which offer a plan of action as to the manner in which they are to be implemented. In a review of programme approaches to adolescent reproductive health, lack of clearly defined reproductive health and youth health policy was reported by AYA (2004). A few African countries, such as South Africa, Ghana, Kenya, and Zimbabwe, have taken a stride forward, but the problem of high risk factors among adolescents still remains and needs more effort (WHO, 2004).

## **2.6 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH) IN AFRICA: AN OVERVIEW**

The present quality of life for young people's SRH emerged as an important issue in numerous international conferences and workshops. Several meetings and consultations have been held with relevant stakeholders, with a view of addressing the problems highlighted above, such as the 1994 International Conference on Population and Development (ICPD) in Cairo, the 4<sup>th</sup> International Conference on Women held in Beijing 1995, and the Study Group on Programming for Adolescent Health (2000), all of

which formed part of the global commitment towards adolescents' health. These preliminary discussions in Cairo, Beijing and Zimbabwe, however reflect a poor prospect for future generations and have social and health implications for relevant stakeholders, health providers and partners in adolescents' health. A summary report of regional and in-country update on ASRH held in Harare, Zimbabwe, in 2000, recognizes that South Africa, Botswana, Lesotho, Swaziland and Zimbabwe were among the Southern African countries worst hit by problems confronting the SRH of young people, especially teenage pregnancy and HIV/AIDS (WHO, 2000). One of the recommendations resulting from this regional consultation was that of strengthening the provision of adolescent-friendly health services (WHO, 2000).

Several agencies and UN bodies such as WHO, UNICEF, UNAIDS, UNFPA, PPA, USAID, UNICEF, UNESCO and DFID have unequivocally indicated their position and support for the realization of international targets in sexual and reproductive health of young people. These groups have evolved major initiatives and policies regarding programme directives in African countries and it is therefore necessary to review certain aspects of their roles in adolescents' welfare.

## **2.7 TYPES OF ADOLESCENT PROGRAMMES**

Schalock (2001:6) defined programmes generally as “a set of operations, actions, or activities designed to produce certain desired outcomes”. Youth reproductive health programmes are involved in different areas of sexuality and reproduction, which form the core of any country's programme. Programmes for adolescent and young people originate from different sectors other than government and vary extensively in the types of services provided. Clinics are usually intended to promote and maintain SRH of young people,

using an adolescent-friendly approach. Some are exclusively designed for SRH needs of young people, whilst others include youth services as part of the general services.

### **2.7.1 Single Educational Programmes**

Single-focus programmes: these focus on specific conditions and intervene mostly at the tertiary stage when solution is needed. Examples are those dealing with teenage mothers and school dropouts: these are found in countries such as the United States of America, Sweden and France. They are said to be costly to run on a per client basis. Concerns about the quality of these programmes have also been expressed (WHO, 2000; Thomas, 2000) as studies have shown that they have not demonstrated the capacity to change the lives of adolescents.

### **2.7.2 Multi-Faceted Comprehensive Programmes**

These consist of various components of adolescents' health generally, and cater for all groups of adolescents and young people: single, married, in school, out of school, unemployed, parents, and mothers. The SRH components are included among the wide range of services offered in the form of health education, health promotion, the provision of contraceptives and family planning services, all in one package offered within the same complex. Multi-disciplinary programmes provide medical care, psychological support, and a comprehensive life skills approach to adolescents.

### **2.7.3 Comprehensive School Health Programmes**

Disease prevention and health promotion programmes have targeted children in schools for quite a long time. The introduction of reproductive health into already existing school health programmes, with topics such as sex education at both primary and secondary

levels was seen as beneficial in the prevention of early pregnancy, HIV/AIDS and STIs, and the development of healthy sexual attitudes and practices (<http://www.pathfind.org/pf/pubs/focus>, Retrieved 10<sup>th</sup> March 2005). Use of the classroom as a means of providing formalized, controllable and durable access to sex education for adolescents over a critical period of learning and psychosocial development was promoted. Development in decision-making, negotiating skills, and self-esteem were pointed among some of the potentials of young people exposed to such programmes (<http://www.pathfind.org/pf/pubs/focus>, Retrieved 10<sup>th</sup> March 2005).

#### **2.7.4 Street-Based Groups Programme**

There are an increasing number of disadvantaged young people who are homeless and live on the streets (UNICEF, 2003). This situation makes them vulnerable to risks, including sexual abuse and other reproductive health risks (WHO, 2003). The World Health Organization supports the fact that not all adolescents can be reached through schools, as some may never have attended school or may have dropped out (WHO, 2003). Suggestions for the development of health education programmes on sexuality and improvement of reproductive health for out of school youths were made by a number of organizations (UNICEF, 2003; UNAIDS, 2004).

In countries where young people cannot gain access to schools, strategies to reach them need to be explored through street-based programmes or organizations looking after them. Special efforts to reach out-of-school and non-organized youth are presently made by some non-governmental organizations. The mass media were recognized as powerful in reaching young people; unfortunately access to information is a problem for street children.

### **2.7.5 Clinic-Based Reproductive Health Care Services**

A clinic-based service offers adolescents a wide range of services including reproductive health care such as promotive, preventive, curative and rehabilitative at various levels of service delivery. Coordination of the various services offered in a non-fragmented way is believed to achieve better reproductive health outcomes for young people. Collaboration between the different sectors of the government and agencies involved in adolescents' welfare, however, appears to be absent in most of the countries (WHO, 2001). Accessible and affordable clinics with non-judgmental staff and reduced waiting times are desired and considered acceptable by young people utilizing such services (Network, 2000). Issues of privacy, confidentiality, and a conducive atmosphere created by responsive and sensitive health-care providers were cited as criteria by young people, if such programmes are to be considered as adolescent-friendly (Lovelife, 2004).

### **2.8 ESSENTIAL COMPONENTS OF ASRH PROGRAMMES**

Sexual and reproductive health issues form part of the services offered to young people in some programmes, at primary, secondary and tertiary levels, and include discussions on sexual relationships before marriage, early marriage, teenage pregnancy, early child bearing, motherhood and its consequences, adolescent fertility, and STIs including HIV/AIDS (RCH Unit, 2003; RHRU, 2004). In order to address these specific problems affecting the well-being of adolescents in a comprehensive and holistic way, the following core components are deemed essential and relevant. These services could take the form of the different levels of care, within the broader health care delivery services as follows: preventive services; promotive services; curative services; and rehabilitation (RCH Unit, 2003; RHRU, 2004).



### **2.8.1 Goals and Objectives of ASRH Programmes**

Adolescents live in a dynamic society that is challenging in relation to health risks such as HIV/AIDS. Youth-targeted programmes aiming at behavioral changes which lead to a healthy lifestyle are of paramount importance. Efforts are directed at promoting adolescent-friendly services in prenatal, postpartum and post-abortion programmes in hospitals in countries such as Brazil, Chile, Ghana, Kenya, Mexico, Nigeria and South Africa (Network, 2000). The provision of health information and preventative programmes for young people is directed at encouraging changes in behaviour considered risky for both males and females. The encouragement of safer behavioral choices has led to a decrease in the prevalence of HIV in some countries (UNAIDS, 2003).

These claims have, however, been the subject of critical analysis, and concerns have been raised on the effectiveness of these interventions. Programmes aiming at such changes in young people's lives require participatory methods that are involving and stimulating (Reproductive Health, <http://www.fhi.org/en/RH/Training>, Retrieved 14 March 2005).

The goal of reproductive health programmes for youth focuses on:

- Delaying sexual debut,
- Providing access to education and information,
- Access to contraception,
- Emergency contraception,
- Preventing complications from abortion,
- Maternity care and safe delivery,
- Mitigating the effects of early sex,
- Rehabilitation.

(Reproductive Health, <http://www.fhi.org/en/RH/Training>, Retrieved 14 March 2005).

## **2.8.2 Case Studies of ASRH Programmes in Some Countries**

There are existing case studies of ASRH programmes in some countries in the literature (<http://www.tarsc.org/prog5>, Retrieved 10<sup>th</sup> March 2005). These have only looked at specific aspects pertinent to the needs of adolescents in their own setting at national levels, but failed to analyze and compare models, and case studies of programmes within countries, across countries and regions, in terms of appropriateness and suitability, as well as their impact on the lives of adolescents. The philosophical basis or theories informing their operations, and the effectiveness of such programmes, are not adequately described in the literature, and are limited within the information provided. Other programmes were short-lived as they operated as projects funded for specified periods making it difficult to follow up on their activities.

The proliferation of various ASRH programmes suggests the need for a unified approach based on the best practices and accreditation procedures. The appropriateness of SRH programming to particular national settings, the socio-cultural context and the level of formal education of the adolescent are deemed relevant in modern day society. Examples of some ASRH programmes are:

### ***2.8.2.1 The Adolescent Reproductive Health Project (ARHEP) – Zimbabwe***

Adolescent reproductive health programmes in Zimbabwe are designed to address the reproductive health of adolescents in the area of reproductive health rights. According to Kaim (2001), the Adolescent Reproductive Health Project (ARHEP) arose out of work that was undertaken by TARSC since 1993 (<http://www.tarsc.org/prog5>, Retrieved 10<sup>th</sup> March 2005). This was done in 1997 in consultation with a network of organizations involved in reproductive health issues after the publication of a book on reproductive

health rights in Zimbabwe by Loewenson and Edwards in 1996 (<http://www.tarsc.org/prog5>, Retrieved 10 March 2005). It was then that Training and Research Support Center (TARSC) in Zimbabwe identified adolescent reproductive health as a key area for follow up work (Kaim, 2001). TARSC, with the support of various Ministries such as Education, Sports and Culture and Health collected data on the information, perceptions and concerns of adolescents on reproductive health and also provided information to adolescents. Research was conducted in twelve secondary schools in Mashonaland.

#### ***2.8.2.2 The Sex Education Counseling Research and Therapy (SECRT) Programme - India***

The Sex Education, Counseling, Research, Training and Therapy (SECRT) programme was initiated as a way of preparing young people to become healthy and responsible adults and parents (<http://www.tarsc.org/prog5>, Retrieved 10<sup>th</sup> March 2005). This programme was formed by the Family Planning Association of India (FPAI). Currently, they have nine such programmes operating throughout India. One-fifth of India's one billion citizens are between the ages of 10-19 years and almost 40% of them being young women between 15-19 who are sexually active (Family Health International <http://www.fhi.org/en/RH/Traning/trainmat/hapiindiaprogram>, Retrieved on 2005/03/22

The SECRT programme claims to provide factual information on aspects of sexual health, reproductive health, human relations, marriage, parenthood, and contraception. Other areas are counselling for teenage girls, married and unmarried people, sex education, family planning and information concerning other problems. Referral services are also available. The sexual health-care component caters for young people, parents, teachers, and others, including the disabled and mentally handicapped. The SECRT

approach young people through competitions, such as poster preparation, essay writing, drama, plays and debates at schools. This service is limited to schools participating in the competition; other young people are reached by peer-group educators through interaction and questioning (<http://www.tarsc.org/prog5>, Retrieved 10<sup>th</sup> March 2005). Other competitions are held in conjunction with public events.

The programme uses strategies aimed at adults as well as adolescents, to eliminate resistance to exposing youth to sex education. The effectiveness of this approach has not yet been proved. It is doubtful, however, that young people, whose cultural background does not allow pre-marital sex, will be allowed to make full use of the services. Another programme is “Healthy Adolescent Project (HAPI)” launched in 2000 designed to improve the reproductive and overall health of young people in the West Bengal region of India by the Family Health International in partnership with the Family Planning Association of India, The World Association of Girl Guides and Girl Scouts, and the Barat Scouts and Guides Association. Peer educators are trained to disseminate reproductive health information to other youth.

### ***2.8.2.3 The Lusaka Urban Youth-Friendly Health Services Project***

A similar innovative project in Zambia is called the “Lusaka Urban Youth-Friendly Health Services Project”. This offers participatory needs assessments and learning exercises involving community leaders and parents in teenage solutions. Education on contraception and prenatal care is provided through use of peer educators in some of the clinics. The clinic serves both pregnant and non-pregnant teenagers seeking counselling and contraceptive services (Network, 2000). Egypt and Uganda also had pilot projects.

#### ***2.8.2.4 Life Skills Programme in South Africa***

In line with the responses to the HIV/AIDS crisis among young people in South Africa, the life skills programmes for youth were implemented within the school environment. The programme was initially managed by the Department of Health, and then later taken over by the Department of Education in 1997. The target was selected primary schools focusing on children and youth, and the programme is not yet implemented on a wide scale. The stepping stone is one of the life skills manuals designed for use with all age groups and both genders. This manual was originally developed for use in small rural communities in Uganda and is currently adapted for use in South Africa. It is said to be successfully and extensively used as one of the life skills product (UNICEF, 2002) designed to promote sexual and reproductive health through a series of workshops. Issues such as gender, sexual health, HIV/AIDS, gender violence, communication and relationship skills are addressed in the manual.

#### ***2.8.2.5 The West African Youth Initiative (WAYI)***

WAYI is a peer education programme for adolescents and youth. It caters for both in-and out-of-school young people in several Nigerian and Ghanaian cities. The WAYI project, in a study, found that males had a better response than females on factors such as self-efficacy and willingness to pay for condoms. One of the recommendations from the WAYI project on the basis of this finding, (Oladebo & Brieger, 2000) was that there should be more gender-specific adolescent health programming.

#### ***2.8.2.6 The “Young and Wise” Center (Ghana)***

The Planned Parenthood of Ghana (PPAG) in January 2001 implemented an innovative programme to increase the knowledge of young people in sexual health matters in

addition to providing access to SRH services (Moyo, 2002). The centre carries the brand name “The Young and Wise” and is located at its headquarters in Accra. The centre has a youth clinic, counselling unit, computer center, Hot-line services, recreation and entertainment hall and library facilities as a way of attracting young people attending school, while at the same time providing them with sexual health education and life skills. The clinic is managed by nurses who offer STI/HIV testing, treatment of STIs, pregnancy tests, family planning services including emergency contraception and post-abortion care. The centre is patronized by both males and females.

## **2.9 THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI)**

Emphasis on the adoption and implementation of adolescent-friendly programmes was initiated by the World Health Organization at international and national levels in a bid to address the needs of adolescents in a comprehensive and acceptable manner. The adolescent-friendly concept is promoted in countries worldwide. The values underlying an adolescent-friendly approach have been specifically designed to assist clinic managers and health providers in attaining their objectives. According to a report by RHRU (2005), twenty-six countries have established national programmes of adolescent health, but, in the vast majority of cases, these programmes are found within other government services such as maternal and child health, reproductive health, and mental health. Clinics are provided with a set of practical guidelines against which they will be systematically assessed, evaluated or appraised as contained in the ‘Adolescent-friendly’ standards and criteria (RHRU, 2005).

### ***Key Objectives of NAFCI***

- To make health care services more accessible and acceptable to adolescents;
- To establish national standards and criteria for adolescent health care in clinics throughout the country;
- To build the capacity of health care providers to improve service performance for the delivery of adolescent-friendly services.

### ***Fundamental Principles of NAFCI***

- Every adolescent is unique, and has different needs for health information and services based on a range of factors that include age, race, gender, culture, life experiences, social situation, and physical or mental disability.
- Adolescents have inherent sexual and reproductive rights, including the right to a full range of reproductive health services.
- Gender inequalities and differences that characterize the social, cultural and economic lives of adolescents influence their health and development.
- The health needs of adolescents are best addressed by a holistic approach that takes cognizance of their physical, mental, and social wellbeing.
- The management of adolescent health needs includes the promotion of healthy development, the prevention of health problems, and the response to specific health needs.
- Community and parental support and participation are crucial to sustainable adolescent health services and programmes.
- Youth participation in the planning, development, and evaluation of services and programmes ensures that their needs are addressed in an appropriate manner.

### **2.9.1 The National Adolescent-Friendly Clinic Initiative (NAFCI) – South Africa.**

The NAFCI Project was initiated in September 1999 in South Africa (RHRU, 2005) as a five-year quality improvement programme designed to encourage public health clinics to become adolescent-friendly. NAFCI is a comprehensive service performance and quality improvement accreditation programme at country levels. This initiative is an integral component of the LoveLife programme in South Africa (Pleaner, Dickson-Tetteh, Mongochi & Moleko, 2001) and was developed as a means of enabling health care managers and providers in countries at national level provide quality services to adolescents by responding appropriately to their needs. As part of the LoveLife campaign, NAFCI is geared towards making health services more accessible and acceptable to adolescents. Moreover, the project aims at building the capacity of health care providers in order to improve service performance for the delivery of adolescent-friendly services.

NAFCI was designed to improve the quality of adolescent health at primary health care level and to strengthen the response to the sexual and reproductive needs of adolescents in an appropriate manner. This initiative forms an integral component of the Lovelife multi-dimensional initiative which also focuses on improving the sexual and reproductive health of South African adolescents. Included in the project's initiatives are: expanding access to youth-friendly health services, including HIV/STI prevention, counseling and testing, and provision of services and support. The goal is to instill positive change in young South Africans in order to reduce teenage pregnancy, sexually transmitted infections and HIV/AIDS (RHRU, 2005). Another objective of the NAFCI project is to establish national standards and criteria for adolescent health care in clinics throughout South Africa. Clinics are inspected by NAFCI officials, and if they are up to standard,



given the status of ‘adolescent-friendly’. Awards of achievement stars of gold, silver and bronze are given to clinics according to the NAFCI rating:

Other initiatives targeted at young people include a “staying alive” campaign, a television programme and concert “MTV Networks International, 2003” in partnership with UNAIDS, the World Bank, Family Health International, and other UN bodies.

## **2.10 ROLES AND FUNCTIONS OF UN BODIES AND NGO’S IN ASRH**

Given the magnitude of the problems confronting adolescents at the present time, the organizations listed below are lobbying at international as well as national and local levels in an effort to address some of these concerns. One of the objectives of a workshop organized by the WHO’s Reproductive Health Programme in South Africa in 1995 was to discuss countries’ needs in the development of policies and programmes for the provision of integrated reproductive health services within the primary health care setting. A key area of concern was the individual and collective progress of countries in implementing policy reforms and building district capacity for effective acceleration of “Health for all” strategies, with specific reference to SRH (Hall, 1997).

The role of international bodies in finding a global solution to the problem confronting young people in terms of their sexuality and reproduction is seen as important. These agencies are continually focusing on problems of adolescents through provision of funds, technical support, research, monitoring, and programme evaluation. However, it is important to point out here that other institutions and international bodies have also played a key role in addressing the SRH of adolescents. WHO, UNFPA, PPA, USAID, UNICEF, UNESCO and DFID are among those listed in the literature (DFID, 2004).

It is therefore not uncommon to find a listing of UN agencies and NGOs in health sectors in the forefront of this as many of the initiatives for adolescents are largely donor-driven. These groups have evolved major initiatives and policies regarding program directives and it is therefore necessary to review certain aspects of their role in adolescent sexual and reproductive health. In this study, the researcher intends to highlight those that are regularly cited among the forerunners.

### ***The World Health Organization (WHO)***

One organization that has given support and provided technical advice for adolescents is WHO. In response to the HIV/AIDS epidemic, WHO, in collaboration with UNESCO, developed a guide on HIV/AIDS prevention for use in schools by senior educational authorities and those responsible for programme development (Department of Child and Adolescent Health (CAH), 2005) This action was based on the recommendations formulated by school health education experts from around the world. WHO has published a guide which is used as a source of reference by policy-makers in the spheres of public information and communication. This guide is useful for the achievement of consistency between health promotion messages for schools and those in the community at large. The Department of Child and Adolescent Health and Development is dedicated to young peoples' health and well-being (WHO, 2005).

### ***The Department of International Development (DFID)***

DFID has been one of the agencies which are most effectively advocating the provision of reproductive and sexual health for all (DIFD, 2004). One recommendation made by DFID is that of integrating HIV information and sexual and reproductive health services on the grounds that an integrated body will better respond to people's needs (DFID,

2004). Accepting the fact that more needs to be done in this area, DFID strongly maintains a commitment to the improvement of reproductive health of young people (DIFD, 2004).

### ***The United Nations Population Fund (UNFPA)***

UNFPA is said to be the largest international funding source for population and reproductive health programmes in the world (UNFPA, 2005; AYA, 2004). Countries such as Bangladesh, Columbia, Jamaica, Palestine, Philippines, Kenya, Malawi, Cameroon, and Ethiopia have benefited through funding and case studies have been carried out on adolescent reproductive health. UNFPA has provided funding to assist developing countries to devise programmes that help women, men and young people to:

- Plan their families and avoid unwanted pregnancies,
- Undergo pregnancy and childbirth safely,
- Avoid sexually transmitted infections (STIs), including HIV/AIDS,
- Combat violence against women. (UNFPA, 2005).

### ***The University of California San Francisco (UCSF): Centre for Reproductive Health Research and Policy (CRHRP)***

The mission of this centre is to promote reproductive health, family planning and the prevention of sexually transmitted infections, including HIV, worldwide, through research, training and policy analysis (<http://reprohealth.ucsf.edu/> Retrieved 2 October 2005). The centre is based in San Francisco, USA, and is involved in domestic and international research projects in a wide range of areas concerned with reproductive health in various countries such as Zimbabwe, South Africa and Mexico. The goals of the centre are as follows:

- To advance new reproductive health technologies which provide additional choices in contraception, abortion, maternal health, and STI/HIV prevention for diverse populations.
- To understand the antecedent and contextual factors contributing to adolescent pregnancy and STIs.
- To evaluate programmes to improve adolescent reproductive health.
- To develop and evaluate new technologies to decrease maternal mortality associated with pregnancy and childbirth in low-resource settings
- To conduct evaluation and policy analysis of innovative domestic and international programmes to improve access to reproductive health care for both women and men.
- To train practitioners, researchers and future leaders in the U.S. and internationally in the field of reproductive health.
- To provide information, technical assistance and consultation to professional audiences, policy makers and the public on reproductive health issues.

Source: <http://reprohealth.ucsf.edu/> Retrieved 2 October 2005).

## **2.11 PROGRAMMATIC PROCESSES: CONTEXT AND CONTENT**

### **2.11.1 Common Elements for Effective Programmes**

According to Jemmott, Brown, and Dodd (1998), the criteria for successful implementation of educational/preventive programmes include concepts such as:

- Theory-based,
- Culture-sensitive,
- Development of appropriate strategies and interventions.

These concepts form the basic principles or foundation on which programmes effective preventive interventions can be initiated or developed.

### *Theory-based Interventions and Models in Youth Programmes*

Theoretical approaches in individual-level behavior are seen as beneficial in the planning and implementation of interventions demanding behavioural change in HIV and other health problems. Current trends in ASRH issues dictate quality and outcomes aiming at behavioral changes. This has generated a movement towards development of various theories and models by scientists to be applied in health education in order to achieve the desired outcomes. Emphasis on understanding of behavior theory in interventions for the youth was made by Jemmott, et al. (1998) as it was suggested that an understanding of behavioural theories is useful in exploring components of prevention programmes as to their effectiveness and success. Another reason is the importance of incorporating theories into programmes in order to improve the overall quality of interventions (Jemmott, et al., 1998). Theory has played a major role in assisting people to understand the communication process in a comprehensive way. It helps in describing, predicting, explaining meanings and possible interventions (Goddard & Melville, 2005).

A number of models of intervention attempting to address adolescents' problems have emerged over the years, such as family-life education, abstinence programmes, interpersonal skills-building interventions, school-based clinics interventions and multidisciplinary programmes focused on young people. Successful interventions focus on specific risk reduction rather than on change of general patterns of behaviour. Thomas (2000) argues that an "abstinence-only" approach as the way to avoid sexually transmitted infections in already sexually active teenagers does not fully address their needs. This argument is based on the principle that primary prevention strategies need to be multidimensional and targeted at the developmental needs and issues facing adolescents.

Despite the availability of these models, the complex nature of human beings makes it difficult to recommend a single theory, as not one of them encompasses the complexity of human behavior, due to its uniqueness (Jemmott et al., 1998). These approaches cannot be described as successful, the few that have been fully evaluated, had only limited effect on teenage sexual behavior (Issue brief, 1996). Although use of models is not the sole determinant of a successful intervention programme (Jemmott et al., 1998) use of behavioral theories in HIV prevention which involves educational and skill building has proved to be effective for adolescents (Obregon, 2000). On analysis, models designed for young people in western countries and imported are likely to face problems or rejection in other countries where the political and cultural structures remain unchanged. What will possibly work in a culture of openness and understanding might encounter problems such as resentment as to its suitability and age appropriateness in a country deeply enshrined in cultural values regarding sexuality and young people. The evaluation of intervention programmes in terms of application of models and theories for teaching adolescents and young people in African countries is therefore critically important.

### ***Culture-Sensitive Interventions: Relevance in Programmes***

Culture has both positive and negative influences on health behavior. Beliefs and values regarding sexuality are believed to be enshrined in the cultural orientation of individuals (Airhihenbuwa & Webster, 2004), thus the concept of culture within the context of ASRH has implications for successful implementation of interventions aiming at behavioral change. A culturally-based strategy is recommended as useful in the development, implementation and evaluation of health promotional programmes targeted at empowering young people (Airhihenbuwa & Webster, 2004). This principle is

essential, as stated by O'Connor, "*Every culture has its own world view*" (O'Connor, 1996: 42), and as such culture plays a vital role in determining the level of health of the individual, the family and the community (Airhihenbuwa & Webster, 2004). The World Health Organization (2004) reports the difficulty encountered by programmes and policy directions in several countries, as culture was identified as a barrier in the context of health education and health promotion. Nonetheless, changing the norms and beliefs of adults in the community increased the effectiveness of youth-targeted, behavior-change interventions (WHO, 2004). Arguably, adolescents and young people operate in a culture of their own within the wider culture of society, creating a generation gap.

A crucial factor in health promotion and disease prevention is the relationship between culture and health practices. Kabanga (1999), in her study on the influence of socio-cultural beliefs on modern family planning education among adolescents in Kampala, found that socio-cultural beliefs have an influence on the use of contraception among adolescents. The views of parents and teachers on modern contraceptives were found to be unsupportive of adolescents' usage (Kabanga, 1999). Similar findings were observed in a study by Stanbuck and Twum-Baah (2001) in Ghana, where service providers felt they have a duty to protect their society through preservation of cultural values by restricting access to modern contraceptives to young unmarried females. This attitude discouraged young people from seeking contraceptives from these clinics.

While use of theories has proven to yield positive outcomes, without consideration of the culture of that society or target group, its effectiveness remains questionable. This view is supported by O'Connor (1996) as he suggests that prevention efforts are compromised when cultural appropriateness is lacking, thus the need for culturally sensitive,

appropriate, and competent health care is critical. In the context of adolescents, communication, lifestyle pattern, values, gender roles and expectations are the very products of the culture into which they were born. A culture-centered approach to prevention, care and support in health promotion intervention for young people is thus seen as appropriate and of relevance.

### ***Development of Appropriate Strategies and Interventions***

Baryomunsi (1998), in his study on the impact of socio-economic and demographic factors on female adolescent sexuality in Uganda found that most female adolescents in Western Uganda were likely to be sexually active, but with no regular partners, and that adolescent sexual behaviours are common and probably increasing. The emergence of HIV/AIDS infection and increasing teenage pregnancy among the adolescent population brought about the need for development of effective prevention strategies as two-thirds of young people in sub-Saharan Africa are reported to be infected with HIV (UNAIDS, 2003:93). Preventive health services directed towards specific health needs in a population could avert some of these health problems (UNAIDS, 2003).

#### **2.11.2 Preventive Interventions by Youth Programmes**

There are various levels of prevention – primary, secondary and tertiary levels: to address solutions to the SRH problems confronting teenagers. Primary prevention aims at preventing diseases or identified health risks to health, for example educating young people about the use of abstinence, or condoms, and the dangers of unsafe sex. Secondary prevention involves the detection of disease at a stage before it causes any symptoms where it can be effectively cured (Kemm & Close, 1995). While tertiary prevention aims



at preventing recurrence of a disease which has previously been cured, or limit complications of disease.

It is estimated that 4.4 million unsafe abortions are performed each year, most of them among young people (RHRU, 2003). Studies also show that school-based and school-linked clinics have a limited impact on teenagers' sexual behavior, with most producing a modest increase in contraceptive use, but having no impact on pregnancy rates (Issue brief, 1996). The provision of contraceptives alone could not address the problem, a more comprehensive approach to the problem was recommended (WHO, 2003). The inability of adolescents to cope with problems of a sexual nature is partly lack of knowledge, insufficient knowledge and understanding of their sexuality (Planned Parenthood Association, 1992). The need for preventive interventions cannot be over-emphasized at a time when young people are confronted with major risks to their sexual and reproductive health.

Given that the prevalence of HIV/AIDS among young people is quite alarming (WHO, 2003), HIV prevention forms an integral part of reproductive health services. Serious attention is now given to health education and preventive messages on sex and its associated dangers. The aim is to empower young people with the knowledge and skills to make reproductive health decisions which will contribute to their well-being and health in a positive way.

***i) Information, Education and Communication (IEC)***

It is stated that knowledge and information are the first line of defence for young people (UNAIDS, 2004). The decision-making power of adolescents is handicapped by virtue of

their inaccessibility to vital information. Lack of knowledge is not the sole determinant of risky behavior among adolescents. According to UNAIDS (2003), factors such as lack of information on HIV/AIDS, education and services as well the developmental stage of adolescents are believed to be responsible.

Kondo (1993) in his study towards a better understanding of adolescents' sexuality within the social context found that there was a lack of vital information and knowledge on sex, sexuality, sexual affairs and safe sexual practices. Lack of parental guidance was seen as a contributing factor to increased adolescent sexuality. This has major implications for their reproductive health as the majority of the girls in the study initiated sexual intercourse between the ages of 10 and 15 years, whereas boys started between 12 and 15 years. Only 31.8 % of the parents provided their adolescents with some form of information on sexual issues. On the other hand, 17.3% of the parents imposed strict regulations and controls over their children's movements.

In a study conducted by Ahedor (1999) on the knowledge, attitudes and practices of sexuality and sexually transmitted diseases, including HIV/AIDS among junior secondary school adolescents aged 10-19 years in Ghana, findings revealed that about 24% of these adolescents had initiated coitus. Furthermore, thirty-one percent (31%) of these adolescents had already indulged in multiple partnerships even though the awareness of AIDS among them was high (87%), however, they had some misconceptions about the cause and mode of transmission of AIDS. Lack of vital information and knowledge on sex, sexuality, sexual affairs and safe sexual practices among adolescents, contribute significantly to this problem (Ahedor, 1999). Recommendations from the study included the teaching of family life education and life skills in schools. Another recommendation

was that teachers and health-care workers should intensify health education on risky sexual behaviour.

William and Mavundla (1999) in their study in a general hospital in Umtata, South Africa, on teenage mothers' knowledge of sex education reported that little information was provided by parents to their teenage daughters, and that they receive almost no sex education from health personnel. Essah (2000) studied the reproductive health needs of junior secondary adolescents in Akropong, Ghana. According to the findings, adolescents are eager to know the basic facts related to the menstrual cycle. Fear of the parents reprimanding them was a barrier to their seeking information on sexuality (Essah, 2000). They relied on television and radio for information about sexuality and reproductive health. Adolescents in the study felt that sexual experiences should not be shared or discussed with friends because they are of a personal and sensitive nature. Conclusions based on this study were that pupils should have a uniform and detailed education on their reproductive health needs before they initiate sexual relationships (Essah, 2000).

The World Health Organization and UNAIDS (1997) support the fact that access to information on HIV/AIDS alone is not sufficient to motivate a change in behavior, as use of alcohol among young people was associated with practices such as unsafe sex, despite information on safe sex. The argument was that, provision of information on safe measures in preventing HIV transmission cannot be successful on its own (WHO, 2003; Airhihenbuwa, Makinwa & Obregon, 2000). The inclusion of relevant components on sexual and reproductive health education and youth development is therefore essential (UNAIDS, 1997).

A number of teaching methods can be used to help young adults acquire new knowledge, skills and behavior. Literature suggests that role play, drama, group discussions and songs are the most frequently used methods/materials in the teaching of adolescents. Information and education campaigns are also some of the strategies to reach out to vulnerable groups including adolescents. These have proved useful tools in behavioral change, empowering and equipping young people towards adopting safer lifestyles (WHO, 2003; Barrett & Schueller, 2000). It is documented that programmes that combine factual information about sex and reproduction with assertiveness training and activities that help to improve decision-making and communication skills, appear to be more successful than traditional sex education programmes (Issue brief, 1996). A combination of various sources of information dissemination for adolescents was promoted as most effective (UNAIDS, 2004). Use of peer education is a useful mechanism for providing information to teenagers, but by and large, the onus lies on parents, teachers, health professionals, and key persons in authority such as policy makers.

### ***Sex Education as a Component of IEC***

Sex education is often considered to be of a sensitive and complex nature and thus resented by many people (WHO, 2003). It was a rather controversial and highly debated issue until the advent of HIV/AIDS among adolescents, when desperate attempts were made by some communities and countries to save young people from SRH problems. Impediments such as cultural values, lack of adolescent policies and other ethical dilemmas still exist, despite societal changes, the reason being that sex education has a social and cultural root in the historical background of societies, and is taboo-ridden and plagued by moral controversy (Meredith, 1989). The introduction of sex education in

schools in some African countries continues to be a subject of controversy and has met a lot of opposition. The reason most frequently, given was that political leaders and other adults often parents, believe that young people should not be engaged in discussion about sexuality believing that knowledge is associated with sexual behaviour (RCH Unit, 2004).

Nonetheless, the majority of European governments recognize in principle the need to equip young people with information, in order for them to understand and protect their reproductive health (Meredith, 1989). The facts and values in sex education served as an effective learning component, with consideration given to the pupils' capacity for comprehension and motivation. Compared with other Western countries, Sweden has the longest history of officially introducing sex education into schools' curricula and in research (Meredith, 1989). Sweden has accepted the fact that young people do have a sexual life and has made the introduction of sexual education in schools compulsory. Access to services and information was provided mainly through special youth clinics. This approach, referred to as the "Swedish Model" led to positive outcomes, including a decline in sexual problems associated with adolescents. Despite these gains, concerns have been expressed about the extent to which policy development and sexual education were related to the social and sexual norms of Sweden.

In a comparative study of the perceptions of sexual risk and sexual practices among youth in Kenya and Sweden, findings revealed a striking difference between the two countries in terms of the level of knowledge and the ability to talk with ease about sexuality. In Kenya, it was feared that the sex education would lead to promiscuity. Swedish adolescents, though knowledgeable in some aspects of sexuality and reproduction also

expressed similar sentiments to those in Kenya. Similarities were noted in each group, though lack of information on sexuality was more striking in the Kenyan group. The study found that adolescents in Kenya had little knowledge of conception and contraception, their bodies and STI/HIV, had wrong information, and believed in myths. They also had little or no access to information on preventive services because of a prohibitive sexual moral regime, as the introduction of sexual education was interpreted as having a negative effect on adolescents, leading them to sexual experimentation.

According to Dickson-Tetteh (2001), findings from global studies disprove this. Evidence abounds that knowledge on sexual matters does not necessarily lead to promiscuity, increased sexual activity or experimentation, but rather the opposite: on the contrary, lack of knowledge makes curious adolescents want to explore further (Dickson-Tetteh, 2001).

### ***What to Teach and at What Level***

Sex education forms part of health educational topics targeted at young people, as their knowledge of sexual and reproductive functions remains generally poor (RHRU, 2000). Present emphasis on sexuality and reproduction content includes facts about reproduction, puberty, pregnancy and childbirth, contraception, abortion, sexually transmitted diseases, including HIV/AIDS, responsible sexual attitudes and behaviour and a range of life skills (UNICEF, 2004). The need for educators to realize that the content of sexuality education must be presented bearing in mind issues such as age appropriateness was stressed (Edwards & Louw, 1998). The authors also caution educators to handle the content with the greatest care and sensitivity, as it is considered to be a highly personal and sensitive issue.

## ***ii) Health Education as a Strategy for Adolescents***

Many countries are faced with the challenge of protecting their youth from preventable deaths and disabilities, causing unnecessary suffering and loss of lives. Efforts are focused on “diminishing large threats to adolescent health so as to have large gains” (WHO, 2002:92). It is often said “prevention is better than cure”. Thus a key strategy for making improvement in knowledge acquisition and skills is that of health education, which is recognized as important and is seen as one way of empowering young people to make informed decisions on their health. Health is viewed as a multidimensional phenomenon with multiple determinants leading to positive health outcomes. On the other hand, the term “health education” was used to describe working with people to give them the necessary knowledge to improve their own health through a change in individual attitude and behavioural change (Ewles & Simnett, 2003).

Health education programmes cut across all components of adolescents’ well-being at primary, secondary and tertiary levels. Studies have shown that many aspects of health habits, sexual, personal, and environmental during the period of adolescence have a direct effect on our future health and well-being as adults (Stone & Ingham, 2003). According to Peters (2000), a powerful tool which can be used in reducing maternal mortality is education. The education of girls and women is a critical intervention believed to have a positive impact of maternal mortality rates. It is therefore important that young people are given the necessary knowledge at an earlier period to empower them for the future.

### ***Approaches to Health Education***

According to Bracht (1990), key philosophical issues on the aims and values of health education are based on five approaches as follows:

- ***The Medical Approach*** - addresses diseases and disability and involves medical intervention to prevent or ameliorate ill health. This approach is usually referred to as a “disease-oriented approach” that addresses specific health problems on the relevant risk factors. This approach is criticized as not suitable for schools curricula, as each disease is approached separately and often inconsistently; overlapping advice from teachers and health professionals exists. The focus is, however, on the individual’s own health-related behavior, rather than the impact of societal factors on individual lifestyles.
- ***The Behavior Change Approach*** – is also preventative, and emphasis is on changing people’s attitudes and behaviour so that they can adopt healthier life styles. The focus is on risk factors such as the risk to health from unprotected sex. The aim of this approach is to eliminate the particular risk factors in order to prevent the spread of infections such as HIV/AIDS and other sexually transmitted disease. This approach is seen as expert-dominated and non-participatory.
- ***The Educational Approach*** – aims at giving information and ensuring knowledge and understanding of health issues to enable individuals to make decisions based on informed knowledge. A mix of the disease-oriented and the risk factors is recommended.
- ***The Client-centered Approach*** – empowerment of the client is central in this approach. Clients take the responsibility of identifying what they want to know and then take action and make decisions and choices according to their interests and values. Notably, adolescents are at a transition phase from childhood to



adulthood, faced with an identity crisis and developmental tasks where some form of adult or peer support will be required. Specific initiatives can be tailored to fit the needs of the group and setting. A youth clinic specially designed to meet these sexual needs considering all the critical aspects of adolescent sexuality is likely to achieve the programmes objectives.

- ***The Societal Change Approach*** – The changes are directed towards the physical, social, economic, and environmental aspects in a way conducive to good health. Emphasis is on societal changes and not individuals.

Source: (Bracht, 1990:20).

The above mentioned approaches have each been criticized due to individual limitations. Despite this, each is unique and is useful for its appropriateness to its setting, and objectives (Bracht, 1990). Use of approaches tailored to the specific characteristics of the target group has proved successful. Some of the approaches are described as best suited to equip adolescents with the necessary knowledge and skills needed for a positive change in behaviour, leading to a healthier life. According to Bracht (1990), varying factors might be responsible for a change of behaviour, thus the impact of such actions cannot be limited to a single factor or measured in isolation. A combination of specific approaches can be beneficial in situations such as youth clinics, school-based programmes and youth centres. According to the views of WHO (1993), an interactive approach is beneficial as it allows young people to ask questions.

### **iii) *Health Promotion as a Strategy***

Central to health education is health promotion. Dennill, King, and Swanepoel (2000: 122), define health promotion as “the process of enabling people to increase control over the determinants of health, and thereby improve it”. According to Ewles and Simnett (2003), health promotion, is defined by priorities in current issues affecting health, the types of health promotion approaches and activities, and the type of health problem/s. It has an integral function in contemporary teaching about health care needs. Naidoo and Wills (2002) see health promotion as having a new focus, as the emphasis is no longer on prevention of specific diseases and risk groups’ well-being, but towards health and well-being of all within the context of primary health care.

In a study on assessment of health promotion in schools, Waggie, Gordon, and Brijlal, (2004) concluded that schools provided a valuable site for community-based education. Despite this, it was found that health promotion initiatives in schools might be uncoordinated, erratic, and limited by the resources that the school had at a given time or the demands of the curriculum. Findings revealed a response rate of 68.75 % in favor of health promotion as part of the school’s curriculum (n =55) by teachers and 100% (n = 4) by principals. Public health nurses, university students and a pharmaceutical company were the group of people involved in the health promotion initiatives at the school. It was not clear which aspect of adolescent health they dealt with. Interestingly, though, the teachers felt that health promotion has a place in the curriculum, though 36% of them felt that the school environment in itself was conducive to learning (Waggie, et al., 2004).

Kemm and Close (1995) described various models of health promotion, one example was the ‘KAP Model’ which lays emphasis on knowledge, attitude and behavior. It is

believed that an increase in knowledge will lead to a change in attitude, which in turn will lead to a change in behavior. This model has however been criticized as inadequate in description, as much emphasis is placed on behavioral choices with emphasis on avoiding disease rather than promoting health. Another model described by the authors is the “Empowerment Model” which aims at equipping individuals with the skills and information that will give them power to take control of their own health and also help in value clarification (Kemmer & Close, 1995). This model is criticized as value-free and can be misinterpreted as unconcerned about how people choose to behave as long as their choice is informed. In combination with other models the objectives of adolescent programmes can be achieved (Kemmer & Close, 1995).

### ***Designing Health Messages for Young People***

An understanding of the mechanism and dynamics of effective public health communications is seen as crucial for message design activities (Maibach & Parrott, 1995). Often health messages are prepared for young people with the intention of educating them. Though the intention may be a good one, Maibach and Parrott (1995) discussed the importance of examining the way adolescents learn in this context, as “*The use of ambiguous language in designing health messages for young people is reported to be misunderstood by such audiences*” (Maibach & Parrott, 1995:16). While emphasis was placed on the use of audience-centered approaches, it is imperative to recognize and embrace the basic principles involved in designing messages for different audiences, in order to be effective (Maibach & Parrott, 1995). According to these authors, adolescents are interested in health information they perceive as relevant, comprehensive and realistic. The use of simple words makes understanding of the subject matter easier (Maibach & Parrott, 1995). Therefore, it is important that health messages for young

people are developed in such a way that the receivers of such messages are aware of what is expected of them.

In Jamaica, the emphasis of these messages is on abstinence in young people aged 10-12 years, and on protection from pregnancy, HIV and other sexually transmitted infections among 13-15 year-olds. In South Africa, programmes such as LoveLife and the National Young People's HIV Prevention programme have responded by providing information on sexuality through 900 government-run clinics as a way of promoting youth-friendly health services. Provision was also made for HIV education and sexual health services in a recreational environment through youth centres referred to as "Y-centres". While such initiatives are commendable, it is also important to compare their effectiveness in relation to programmes' objectives.

Use of the mass media is promoted as one of the most important channels of reaching young people with information regarding their sexuality, especially in HIV prevention (UNAIDS, 2004). According to LoveLife (2004), use of the media was seen as having its own limitations in terms of power to attract specific age groups with messages.

Shortcomings identified are failure to: target appropriately; invest sufficient resources to give campaign visibility and the penetration needed in terms of scale; scope, and intensity, to sustain for long periods; and failure to adapt or refresh the campaign. In acceptance of these facts, the LoveLife programme states that within the limited value of the media, they can tell people what to think but cannot tell people what to think about (LoveLife, 2004).

### **2.11.3 Parameters: Meeting the Needs of Young People**

The objective of most SRH programmes is to promote behaviour change towards a healthy lifestyle. Efficient and sustainable interventions to promote health are usually multifaceted. Jemmott, et al. (1998) outlined pertinent information for assessing whether programmes are meeting the needs of the target group. The parameters and their description are listed below:

(1) *Intervention* – is described as any organized activity defined to influence knowledge, attitudes, beliefs, or behavior. Interventions vary in scope from a single educational programme to a multifaceted comprehensive programme. The types of interventions according to the authors can be at a primary, secondary, or tertiary level.

(2) *Objective* – the behavioral determinants that the intervention proposes to affect. This could be cognitive change (information, skill, social norms) or structural change (service product).

(3) *Target* – the level at which the intervention is targeted. This ranges from individual to the public.

(4) *Frequency* – The number of times the intervention is provided: once, ongoing or periodic.

(5) *Setting* – The specific place in which the intervention is presented to the target population: institutional site, the workplace, school, the street, and others

(6) *Mode* – the method or manner in which the intervention is provided: one-on-one, group process, media, community mobilization and others

(7) *Outcome* – the documentation of whether the intervention was successful or unsuccessful in producing behavior change or risk reduction.

Reasons for failure of programme interventions to meet the above objectives were as follows: (1) non-use of conceptual framework to guide the interventions, (2) lack of systematic assessment of the target group members, (3) pre-intervention information base, (4) their HIV risk reduction motivation, as well as their (5) behavioral skills regarding HIV prevention.

Source: Jemmott, Brown and Dodd (1998: 31) adapted from the Academy for Educational Development (1995).

## **2.12 PROGRAMME OUTPUT**

Output in the context of this study applies to the perspectives of adolescents utilizing the services offered by the programmes. This is in relation to their knowledge and information on the services; appropriateness and relevance of the services to their SRH needs, in terms of knowledge and benefit gained from a visit to a facility. Other key aspects included in their views were in terms of location; convenient clinic hours; comfortable environment; welcome at the facility; information given; privacy respected; adequacy of services; the attitude of staff; satisfaction with the services provided and general comments and suggestions for future improvement of the services. These aspects of the programmes are critical components in a comparative evaluation of the service provided, in relation to user-friendliness or adolescent-friendliness of the services.

### **2.12.1 Access to SRH Information and Services**

According to Kar, Alcalay, and Alex (2001:96), “accessibility and affordability of health services are a major determinant in health care use”. The World Health Organization (1988:7) defines access to services as “the degree to which health care services are unrestricted by geographical, economic, social, organizational or linguistic barriers”.

### ***1) Barriers to Access and Utilization of SRH Services***

Access to SRH information by people within reach of such services, especially adolescents, is often difficult (Hock-Long, Herceg-Baron, Cassidy & Whittaker, 2003). Similar views were expressed by Dickson-Tetteh (2001) as she maintained that reproductive health services in South Africa were either physically inaccessible or have opening times that are not suitable for adolescents. Concerns about confidentiality, cumbersome bureaucratic procedures, long waiting time, lack of privacy, fears, embarrassment, and the location of the facilities, timing and cost are listed among the barriers that make it difficult for adolescents to reach or utilize SRH services (WHO, 2000; Hocklong et al, 2003). Additionally, lack of awareness of the existence of SRH services was also seen as hampering adolescents' access to adequate and relevant services from SRH facilities (Dickson-Tetteh, Pettifor & Moleko, 2001). Dissatisfaction is often expressed by users of such services (DFID, 2004).

### ***Stigma as a Barrier to Utilization***

Several studies show that stigma is one of the barriers preventing young people from utilizing services offered to them (RHRU, 2000; Hocklong et al, 2003). Stigma associated with sexually transmitted diseases is one of the reasons why young people prefer not to use services specially designated for the treatment of these infections. A visit to a SRH unit by an adolescent may be interpreted as initiation of sexual activity or seeking treatment for sexually transmitted diseases, causing further stigmatization by the community (Network, 2000).

In some countries such as India and Indonesia, issues such as abortion and premarital pregnancies are highly stigmatized and this could be one of the factors for non-utilization

of the services. Disclosure of sexual problems to parents is often faced with fear and is likely to deter young people from seeking help, especially where parental consent is required. Young people may encounter reproductive health problems such as an unplanned and unwanted pregnancy, which causes them to seek abortion services as a way out of the problem. The need for privacy in these clinics is highly recommended as one way of improving the situation (WHO, 2004).

### ***Poor Programme Design and Lack of ASRH Policies***

One major issue surrounding accessibility and utilization of reproductive health services for adolescents in many African countries is the lack of policies regarding adolescent sexuality and reproduction (Okonofua, 2000). Poor programme design, management and restrictive policies do not provide a supportive atmosphere for both the staff and the users of the service. As noted by the WHO (2000), very few policies have been translated into integrated and concerted action in countries where they exist. Reproductive health matters such as the provision of contraceptives and abortion are beset by difficulties of access and consent (WHO, 2001). Legal limitations prohibit access to certain reproductive health services to adolescents, especially if they are unmarried or below the age of consent to treatment. It is also considered illegal to offer contraceptive advice to unmarried people in many countries due to restrictive policies and beliefs of staff.

By contrast, use of contraception by adolescents to prevent unwanted pregnancy is considerably greater in developed countries than in developing countries (WHO, 1993). In a study by Bennett (2001) on single women's experiences of premarital pregnancy and induced abortion in Lombok, Eastern Indonesia, findings showed that in terms of access to reproductive health and sexual services, young single women were treated differently



from those who were married (Bennett, 2001:37). Although members of staff agreed that reproductive health is the key to the prevention of premarital pregnancy and abortion, many of them refused to provide information about contraception to unmarried women, including adolescents. The statement below by Bennett (2001) buttresses these findings:

*“While abortion for married women is tacitly accepted, especially with two or more children, premarital pregnancy and abortion remain a highly stigmatized and isolating experience for single women. Government family planning services are not legally permitted to provide contraception to single women and their access to reproductive health care is very limited” (Bennett, 2001:37).*

### ***Cultural beliefs and Values, Attitude of Staff***

Conflicting aspects of staff behavior and practice were identified as a barrier to offering quality services. Interplay between cultural beliefs, values and attitudes of staff and adolescents using the services are observed in the literature (Bennett, 2001). Findings from a study in Dakar, Senegal, indicated that sexuality is closely linked to marriage and childbearing (Nare, Katz, & Tolley, 1997). The attitude of the service providers in the study was described as moralistic, as the content of the counseling offered by them encouraged young girls to abstain from having sexual intercourse until marriage (Nare, Katz, & Tolley, 1997). Conflicting values, cultural beliefs and judgmental attitudes by staff were also evident in the study by Bennett (2001). The scenario below demonstrates the need for policies for service providers and programmes involved in the health care needs of young people:

*“Abortion providers were highly critical of unmarried women who sought abortions, despite their willingness to carry out the procedure. The quality of abortion services offered to single women was compromised by the stigma attached to premarital sex and pregnancy. Their contradictory behavior suggests a divergence between public and private moralities of many health professionals in Indonesia today” (Bennett, 2001:42).*

Adolescents are often discouraged from seeking advice and treatment if the attitude of staff and the environment are not sympathetic to their needs (Okonofua, 1997). Concerns

are also expressed by the World Health Organization (1993) as they contend that *“the ambivalent attitude of adults towards young peoples’ sexuality causes a major obstacle to programmes aiming at preventing HIV infection and other sexually transmitted diseases”* (1993:32). A critical review of policies, laws and legislation governing the reproductive rights of young people is imperative in countries where such barriers exist. According to the World Health Organization (1993), services for the detection and treatment of sexually transmitted diseases are rarely designed to make access easy for use by young people. Findings of studies on adolescent’s utilization of ASRH services showed that lack of user friendly procedures and linkages to other services caused discontent and dissatisfaction among the users (WHO, 2003).

A comparative analysis of a study in Cote D’Ivoire confirms this view, as it revealed that adolescents did not use services if they were censured by the health workers or blamed for their problems (WHO, 2000). The study concluded that the project should train staff to modify existing services so that they become adolescent-friendly and provide better information. Emphasis on “mutual respect, patience and non-judgmental attitudes among health workers or persons administering these services” was made by WHO, as these are considered by young people to be very important qualities (WHO, 2000:7).

### **2.12.2 The Concept – “Adolescent-Friendly” or “User-Friendly”**

The concept “adolescent-friendly” or “user-friendly” was created as a means of addressing some of the barriers preventing young people from utilizing the services designed to help them. “User-friendly” is the core concept in terms of health-related services provided to adolescents. This programme strategy’s aim is to increase adolescents’ access to SRH care services. These structures when put in place will not

only improve the quality of services offered (WHO, 2000) but will also help prepare staff that are responsive to and understand the needs of adolescent. The importance of the need for adolescent-friendly policies is outlined in most WHO documents for adolescents and has been discussed in the relevant sections of this study. Nurses and other key stakeholders play a critical role in advocating friendlier, culture-sensitive services and policies for young people.

There are ten factors that are likely to affect how users of these services view the service. According to Ewles and Simnett (2003), a rating scale on the degree of user-friendliness can range from 1-5 for each of these ten factors. On the scale, one is regarded as very poor and five, excellent (Ewles & Simnett, 2003). A total score of a maximum score of fifty is indicated on the scale, which is given below: (Ewles & Simnett, 2003:107).

1. **Availability of the service** – do the times suit the user; are opening times convenient?
2. **Accessibility** – easy access by public transport; it is easy to locate the service?
3. **Quality of service** – what are the standards, reliability, results.
4. **Speed of service** -- do appointments keep to schedule; waiting times
5. **Friendly service** – a warm, welcoming atmosphere, continuity of services.
6. **Good environment** – safe, warm, clean, comfortable?
7. **Information about the service** – knowledge of such a service, information widely available, inviting, accurate, easy to understand?
8. **Reputation of the service** – do the adolescents rate the service highly; quality of the services?

9. **Attitude of staff** – is there understanding and acknowledgement of the user’s circumstances and feelings; are the staff friendly?
10. **Responsiveness of the service** – is the service relevant to the needs of adolescents? Does it reach potential groups of users? Are suggestions encouraged and complaints handled sensitively?

## **2.13 CONCEPTUAL FRAMEWORK**

### **2.13.1 Framework for Analysis and Comparison**

The conceptual framework for this study was developed based on an exhaustive review of the literature. The success and functioning of programmes is dependent on several elements. The choice of model was therefore influenced by existing global models, concepts, theories, propositions, current trends and principles on adolescents’ health. These can be learnt, copied, adapted and reinforced (WHO, 2000) to meet the present needs of adolescents and young people in African countries, based on scientific evidence. Various components that make up a programme are often interdependent to facilitate a successful achievement of objectives.

The provision of health care services involves a combination of resource inputs to deliver the different service outputs: human resources, physical capital, and consumables (WHO, 2000). A multidisciplinary perspective was adopted through use of key elements in the Donabedian’s “Model for Quality Care” (1980) for evaluation of programmes from a system’s perspective, key concepts in the “WHO’s Framework for Country Programming for Adolescent Health”, the National Adolescent-Friendly Clinic Initiatives and evidence-based theories on adolescents’ welfare.

According to Donabedian (1980), programmes are explored or evaluated on three key elements. These include (1) the structure, (2) process, and (3) outcome. All elements are important to success and are used to judge the overall quality of a programme. They are interrelated and interdependent and formed the pillar on which ASRH programmes are conceptualized by the researcher. A common set of concepts and principles underpinned each of the three different elements and represent the parameters for data collection, analysis and discussion serving as a frame of reference for comparison. The concepts in the framework are linked in different ways and are not unique to nursing. Figure 2.1 provided a schematic representation of the framework for analysis used in this study. Brink (2001) described a model as “a symbolic depiction of reality”. The arrows depict the relationship and interrelatedness between the three elements of the programme. For a systematic flow, the conceptual framework will be discussed under three aspects relevant to the phenomenon under study as follows:

### **1) Structural Inputs**

- Philosophical basis
- Demographic imperatives
- The Physical Infrastructure
- Human resources
- Material resources: funding, sustainability and complementary inputs
- Evaluation

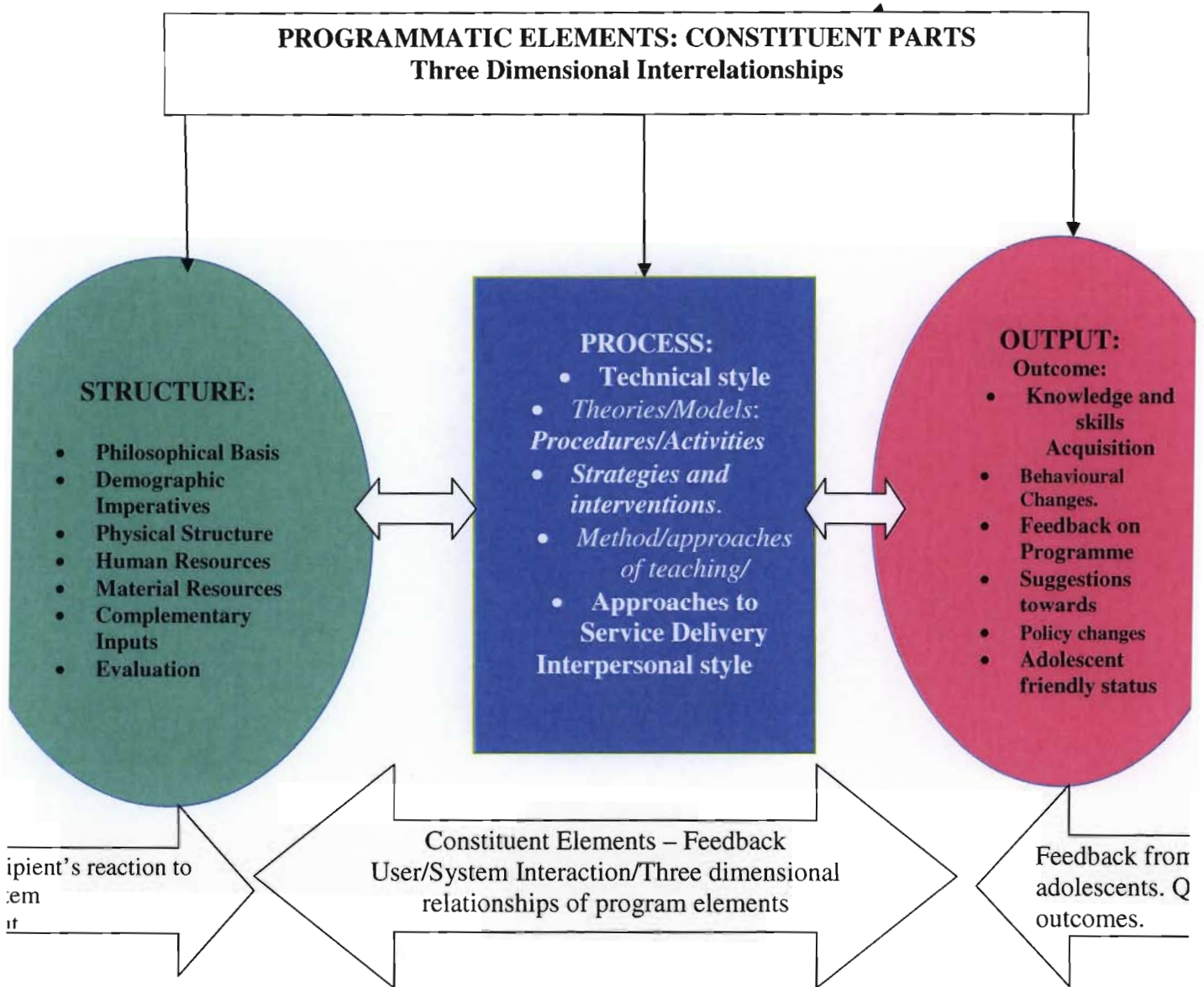
### **2) Process Inputs**

- Technical Style - Model/Theories
- Procedures and approaches to teaching/learning

- Approaches to service delivery
- Strategies and interventions
- Interpersonal style, challenges, successes, response.

### **3) Outputs of Programme**

- Knowledge and skills acquisition, behavioural change
- Perspectives of the users on the service
- User-friendliness and relevance of service
- Feedback on programmes' structures and processes.



**Figure 2.1: Framework for Comparison and Analysis: Adapted from Donabedian “Model for Quality Care” Systems Analysis (1980) and WHO (2001) Theories and concepts for Adolescents’ Health Programming.**

### **2.13.1.1) Structural Input of Programmes**

The structure is one of the most crucial elements and serves as the foundation on which programmes are built. It is made up of various inputs which collectively provide the required services needed to function effectively. These components, as shown in the conceptual framework are critical to the success of the programme.

- ***Philosophical Basis for Programme***

Programmes for adolescents are usually designed based on their philosophical underpinning for actions, their beliefs and value systems. The following concepts and principles represent the premise on which adolescent programmes are built:

#### ***Adolescence***

The period of adolescence is defined as “the period of life ranging from ages 10-24, during which individuals make the developmental transition from childhood to adulthood” (AMCHP, 2002:5). This period is a normal phase of human growth and development and is a complex and evolving process (AMCHP, 2002:1) and is also regarded as a vulnerable period in one’s life. A healthy adolescent has significant impact on national development and productivity.

#### ***Sexual and Reproductive Health***

A universal feature of human life which runs across cultures is the biological process. Developing into mature adults involves a process of dramatic biological and psychological changes (Kibel & Wagstaff, 1993) and is considered as a normal part of the process of growing up for adolescents. This stage of development is seen as crucial as it is characterized by marked physical, emotional, and intellectual changes, as well as



changes in social roles, relationships and expectation (AMCHP, 2002). Social, psychological, and cognitive development are part of the maturation process of adolescence, when abstract thoughts become conceptualized. Age group considered adolescents ranged from 10-19 years, youth 15-24 years and young people 10-24 years (WHO, 2002). Adolescents involve the whole population of young people who fit the above age description regardless of their gender, cultural background, circumstances, or country of origin. For these reasons, programmes need to recognize adolescence as a normal part of growing up, but unique to adolescents (WHO, 2002). The need to consider the developmental phase and age of the group before activities are planned is relevant in responding to their needs.

### ***Vision, Mission, and Objectives***

These are derived from philosophical beliefs that create the framework for programme conceptualization and development. These are also relevant components of the structure (WHO, 2002). A key challenge is having a clear vision or mission statement. The philosophy of programmes, the profession, and the individuals working in them needs to be clear in order not to compromise the vision (WHO, 2003). A common vision should be shared by all programmes for adolescents and young people globally (WHO, 2002). A vision statement that fully addresses all adolescents and the various subgroups considered as vulnerable will determine the behavior and direct the thinking, interventions and actions of stakeholders. If they are to respond effectively to a need or problem, a vision is necessary for efficiency, motivation and quality improvement. Relevance of the mission's goals to an identified need or problem is desirable in terms of programme directives, is critical to addressing the needs of the adolescents, whether in a clinic, a youth center or school. Accomplishment of the objectives requires a process that is based

on coordination, harmony, and evidence based on scientific findings. Objectives that best address the health problems of adolescents to meet their expectations and needs are acceptable (WHO, 2003). Recognizing that adolescents and young people have special health care needs that are common to all adolescents, identification of strategies and resources for implementing objectives is imperative in order to achieve the actualization of the vision (AMCHP, 2002).

### ***Adolescent-Friendly Policies***

Policy guides and directs actions in all spheres of social interaction including the provision of adolescent-friendly services and sexual and reproductive rights. The existence of supportive policies and legislation for adolescents as part of the philosophical structure is of relevance if they are to be recognized as a priority group, deserving access to quality reproductive health services. A supportive environment is a key ingredient for youth-targeted programmes, therefore the community and family should be involved with the support of appropriate policies, legislation and the media. Adolescents have basic rights as human beings and are entitled to a safe and supportive environment, information and skills, health services and counselling (The Convention on the Rights of the Child articles, 5, 12, 17, 19, 24 and 29). It is important for countries to consider International Conventions and national legislatures which support health services for adolescents.

### ***Adolescent-Friendly Services***

Young people, being sensitive, require an atmosphere of privacy and confidentiality. Adolescents need a safe and supportive environment that will provide supportive, close relationships with family and adults (within and outside the family), and peers. This

should foster healthy development and constructive behavioral choices. A supportive structure for adolescents is one that protects them from dangers and helps in their development. Similarly, the recommendations for Global Target 8 deal with improving access to comprehensive, essential, quality health care, supported by essential public health functions (WHO, 1993). The health status of adolescents is merged with the framework of the “health for all” concept. In this light, the Global Target 7 as recommended by the WHO is that by 2005, “*all member states will have operational mechanisms for developing, implementing and monitoring policies that are consistent with the “health for all policy” (WHO, 1993:9).*

A philosophical component for the foundation of adolescent health is the Primary Health Care concept which considers the health of adolescents as a priority:

*Primary Health Care is an “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1999:2).*

Key principles in the primary health care concept are: equity, accessibility, acceptability, availability, active participation, community participation and cultural sensitivity. These are important concepts enshrined in the Primary Health Care approach that can positively or negatively impact programmes (Wass, 2000). There is the need to target adolescents as a special age group with unique needs. Embracing these principles is of relevance in developing countries where poverty is rife. Programmes do not discriminate on these bases, but extend their services to all in this category of disadvantaged persons. The active participation of adolescents in decision making, implementation of the services, as

beneficiaries of such services is important. This, according to WHO (2000), will contribute to the acceptability of the programme.

### ***Demographic Imperatives***

Young people in sub-Saharan Africa account for 13% of the global burden of disease. One-third of new HIV infections occur in young people worldwide (WHO, 2001:5). Present risk behavior of adolescents and young people has future implications for their adult years and for ASRH programmes. According to WHO (2002), programme planners need to take into consideration the key demographic imperatives and the changing health needs of the population as the basis for development of such programmes.

### ***Characteristics of the Consumer***

**Vulnerability:** Due to the changing health needs of adolescents and poor ASRH statistics, reproductive health programmes need to consider these problems when designing the available structures and policies for adolescents. Reproductive-health problems affecting African adolescents include early marriage, early unwanted pregnancy, teenage, sexual abuse including forced sex/rape, unprotected sex resulting in unplanned pregnancy and high maternal and infant mortality; and sexually transmitted infections including HIV/AIDS (WHO, 2001). Preventing unwanted pregnancy and ensuring care for a healthy pregnancy are at the core of any country's programme (<http://www.youth-policy.com>, Retrieved 11<sup>th</sup> May 2005).

### ***Lack of Information***

Young people can be put at risk if they do not have the information, skills, support or access to health services to deal with problems associated with this period (WHO, 2003).

Armed with the necessary knowledge, young people are likely to make sound decisions regarding their health. Young people need to be armed, empowered, and equipped with the right information and skills to face these challenges to their health and well-being. The integration of educational contents on HIV/AIDS prevention and treatment, teenage pregnancy and abortion should form part of programme design (WHO, 2001).

- ***The Human Resource Component***

Conceptually, the human resource component is one of the principal health system inputs of all programmes (WHO, 2000; Donabedian, 1986) and the most important element in structure. The achievement of the overall programme objectives is dependent on the availability of skilled and knowledgeable workers (WHO, 2000). Different kinds of clinical and non-clinical staff provide services to adolescents. The composition, training and education of staff are of vital importance if programme activities are to be delivered in a comprehensive and insightful manner. Furthermore, in order for services to be more responsive to the health needs of the adolescents attending these programmes, trained and experienced health workers are critical in the delivery of services. Knowledge and technical competence of the staff, resources available to deliver services to adolescents and the characteristics and mix of the staff are included in the structure (Donabedian, 1980). Continuing education and on-the-job training are required to keep existing skills in line with new knowledge and changing consumers' needs.

The beliefs, values, and attitudes of health-care providers have an influence on the quality of the services provided (WHO, 2003). The interpersonal style of the service provider is therefore seen as important in service delivery. The clarification of values and beliefs of staff members as to the programme is necessary if young people are to enjoy the full

benefit of the services offered. The effectiveness of programmes also depends on leadership skills, administrative and management support, adaptation to local concerns, as well as dedicated time and resources.

Relevant stake holders in ASRH include a multi-disciplinary and multi-sectoral group.

The role of nurses, doctors, teachers, parents, health care workers, social workers, adolescent health advocates, researchers, service providers, policy makers, and personnel in related fields is important in the delivery and design of ARH programmes. This is crucial to achieving the vision, without which, the objectives will not only be misdirected but will fail (WHO, 2000). Collaboration between the Ministry of Education and the Ministry of Health in the introduction of these programmes in schools and clinics is recommended (WHO, 2000).

- ***The Physical Infrastructure or Environment***

The infrastructure or the environment, in which the services are offered, is part of the structural input of programmes (Booyen, 1997). According to the Association of Maternal and Child Health programmes (AMCHP, 2002), long-term experiences in countries such as the United States and internationally have shown that when services for specific population groups are provided through an individual unit or focal point, they are greatly enhanced. An environment with structures that are supportive, age-appropriate and friendly is seen as ideal (WHO, 2000). The infrastructure support within the context of adolescents' health is designed to address the special health needs of adolescents and young people through existing services, such as Maternal and Child Health and Family Planning programmes, within public agencies. Family planning services have acted as natural partners and leaders as they already have expertise in administering services in

the field of reproductive health. They also have a strong collaborative relationship with providers, families and others in the field (AMCHP, 2002). Service providers must use the physical environment in which services are provided to facilitate care.

- ***Material Resources/Complementary Inputs***

The availability of functioning facilities, diagnostic equipment, and medicines are critical to the quality of services rendered by service providers. The availability of drugs, medical supplies, contraceptives, condoms, safe abortion services, and other vital health and welfare services will greatly enhance the quality of services provided to adolescents. Workers are faced with problems such as inadequate materials, unavailability of educational materials, medicines and a lack of staff with expert skills. Complementary inputs are crucial to the effectiveness of the performance of the human resource component towards delivering quality care (WHO, 2000). Some of the obstacles to programme initiation and sustenance are identified as: lack of resources, lack of commitment by teaching staff and the community, insufficient staff training, insufficient time, heavy workload, and communication problems as a result of language barriers. Inadequate pay and working conditions also have a negative impact on the quality of services (WHO, 2000). A study of 18 low and middle-income countries indicated that there is an enormous shortage of qualified health personnel in sub-Saharan African countries and this has caused problems in service delivery at various levels of care (WHO, 2000).

### ***Funding and Sustainability***

The need for appropriate management of resources and in-built mechanisms for long term development was stressed by WHO (2000). The role of government and funding agencies

in sustaining a friendlier service under the primary health care approach cannot be underestimated in developing countries. Appropriate and effective management logistical support will go a long way to providing a basis for future growth and development. Inadequate funding of programmes and inadequate public sector services to cater for adolescent sexual and reproductive health are some of the constraints in the provision of a comprehensive service, especially in developing countries.

- ***Programme Evaluation***

Evaluation of a programme is a critical aspect that contributes to the overall structure of the programme (Carnwell, 1997; Waggie, Gordon, & Brijlal, 2004). Regular evaluation of activities and evaluation studies through research has been suggested by several authors (Carnwell, 1997; Waggie, et al., 2004). Periodic reviews and evaluation to assess their relevance and usefulness in catering for the changing health needs of young people was seen as crucial. This approach seeks to establish the value of a programme (or service) to the recipients (Carnwell, 1997), and is also crucial in providing evidence based information for continuing use of certain strategies. After scientific enquiry, findings can be used as the basis for further use, or to describe the best practices, which could include any health or social provision as well as health education campaigns.

#### ***2.13.1.2 The Process Element of Programmes***

The process represents the second element of the framework (Donabedian, 1980) and refers to all those activities such as approaches to service delivery, content, levels of service delivery, strategies, interventions and methods, teaching and learning strategies to meet the needs of adolescents.



- ***Technical Styles: Strategies for Responsive ASRH Programmes:***

The imperatives towards successful ASRH programmes in the context of ASRH, the methodology, theoretical framework, approaches and design used should be best suited for young people. Due to the SRH needs of adolescents and their developmental stage, programmes addressing adolescents need to take into account the necessary expertise, skills and knowledge for a successful implementation of their objectives. According to Donabedian (1980), actions taken by staff members working are considered as crucial, as they also play a role in the achievement of objectives.

- ***Approaches to Teaching/Learning: Methods and Interventions***

The key to successful teaching is the use of more than one method in information dissemination aiming at behavioral changes. Approaches in adolescents' health should be based on research findings, emerging issues affecting this age group, age appropriate, age specific, and flexible, bearing in mind uniqueness or individuality. This approach is scientifically proven to be effective in addressing adolescents' health issues, whereas single interventions are ineffective (Kibel & Wagstaff, 1993). A programme addressing long term change in the behaviour of the target group with the active involvement of health professionals is desirable.

Kibel and Wagstaff (1993) recommended preventive actions as a way to diminish risk-taking behavior in all adolescents. Innovative strategies to reach those with problems by staff specially trained in adolescent health were seen as a necessary requirement. Noe, Hollenbeck, Gerhart and Wright (2000) support this notion as they stressed that the choice of specific instructional methods used in training and education must be based on the training objectives. These should be sensitive and responsive to the needs of

adolescents. Flexible processes in the provision of knowledge and skills are encouraged, especially when dealing with young people from different backgrounds and circumstances (WHO, 1993). Focus on the differences in strategies and similarities in the process adopted in different countries as to which have been proven scientifically as successful, is imperative. Consideration of the age and development of adolescents in choice of the content and teaching methods adopted is valuable and appropriate in the learner-centered approach (Noe, et al., 2000). Activities undertaken by service providers of such services should be geared towards providing information that are needs-specific, age appropriate, culture-sensitive and that consider the important aspects of health problems affecting this age group.

In this context, a coordinated network of activities is desirable for the smooth running of the programme and needs of the users (Donabedian, 1980). Service delivery and learning activities focusing on skills for responsible behavior are crucial to the outcomes.

Activities put in place should be based on scientific information, to empower young people with knowledge and skills to equip them with the resources needed for healthy sexual and reproductive health (WHO, 2002). *Use of peers:* Adolescents need to talk to peers and/or adults to help them to deal more effectively with problems They are at a developmental stage of transition and a balance of views is needed to enable them to understand their situation better and to make sound decisions.

- ***Approaches to Service Delivery: Critical Attributes to Programme Implementation***

Regardless of the age, a variety of strategies is needed to acquire the necessary knowledge and skills based on the teaching and learning objectives. WHO (2003) identified concepts that need to be integrated into service delivery in order to achieve a

successful adolescent health programme: (1) Client-centeredness, (2) Comprehensive services, (3) Client- participation, (4) Multidisciplinary approach, (5) Scientific basis, (6) Comprehensive, integrated services, (7) Culturally Competent and Responsive programmes (8) Community-participation.

***Comprehensive services:*** The WHO, UNICEF and UNFPA advocated a comprehensive approach to enable adolescents to develop their full potential and be healthy. The World Health Organization (2003) contends that a blend or combination of such services is required at any one time if continuity of services is to be maintained. The underlying causes of adolescents' health and developmental problems are closely connected. Thus, programmes should focus on addressing multiple problems as they are interrelated and have common roots that can be addressed through combined interventions.

***Client-participation:*** The involvement of young people in the process is of paramount importance based on the PHC principles of active participation. One of the principles guiding adolescents' health is their involvement at all stages of programme design, implementation, and evaluation of information and services with parental guidance and responsibilities (WHO, 2003). This approach has been questioned in terms of its cost effectiveness and value. Consultation with adolescents is necessary whenever a decision is to be made affecting them, as the perception of the adolescents using these services is important.

***Multidisciplinary approach:*** Problems of young people are of a complex nature, thus the need for a multidisciplinary approach. The World Health Organization (2000) stresses the importance of the need for a multisectoral and multidimensional approach designed to

meet the specific needs of adolescents bearing in mind the geographical, institutional as well as socio-cultural settings.

***Culture-sensitive approach:*** Culture affects the health of adolescents and young people through five key processes: health-related belief, values, knowledge, attitudes and practices (Kar, Alcalay & Alex, 2001). A multicultural approach to health communication is justified based on several well documented realities, which is that behavioral risk factors are deeply rooted in culture. Access to care is strongly affected by the compatibility between the culture of the provider and the users of the health care (Kar, Alcalay & Alex, 2001). A model that incorporates cultural aspects and respects cultural diversity is likely to be socially acceptable, and supportive of interventions.

- ***Interpersonal Style***

The interpersonal relationship between service providers and adolescents is critical to the success of planned activities. Knowledge of life skills is needed for adaptive and positive behavior to enable young people to deal effectively with the demands and challenges of everyday life. The generic skills include: self-awareness, interpersonal relationships, communication, decision-making, critical thinking, negotiating skills and coping with stress. These would enable them to make healthy choices leading to healthy development. Topics and questions on sex and sexuality elicit strong personal reaction; health care professionals and other professionals working with adolescents must ensure that their personal values and beliefs, culture and religion do not interfere with the performance of their duties as adolescents feel uncomfortable discussing their problems in a judgmental atmosphere (RHRU, 2004). A private location in which the adolescent will feel at ease in discussing sexual problems is desirable for these reasons.

### **2.13.1.3 *The Outputs of Programmes***

Output as the third element of the framework in this study is conceptualized as the perspectives of the adolescent and young people utilizing the services provided by ASRH programmes. The output provides overall feedback on the services of the programmes in terms of accessibility, relevance, benefits and usefulness to their SRH needs to give an insight into the quality of the services offered.

- ***Adolescent-Friendly Environment/Services***

Adolescents must have access to services in an environment free of disapproval. Young people are known to often be embarrassed or ashamed to express themselves openly regarding sexual problems in the presence of strangers, sometimes even with their parents (WHO, 2000). The SRH of young people is ultimately threatened and can lead them to seek unsafe services elsewhere from backstreet abortionists thus leading to a higher rate of mortality and morbidity among young people. The well-being of young people using these facilities, types of services sought, barriers to such services are issues of top concern addressed in most WHO publications on adolescents and young people (WHO, 2000; 2003; 2004).

According to findings from an assessment study of youth centres in South Africa, the LoveLife centres served both boys and girls, whereas the YARHP and KwaZulu-Natal, Department of Health centres attracted more girls than boys (RHRU, 2004). One possible reason given was that their services in these centres are more focused on reproductive health services which are presumably used by female-adolescents. The study recommended that attention should be paid to the specific needs and circumstances of boys and girls in designing programmes that satisfy their distinct needs (RHRU, 2004). A

critical review of policies, laws, and legislation governing the reproductive rights of young people is imperative in countries where such barriers exist. Nurses and other key stakeholders play a critical role in advocating friendlier, culture-sensitive services

- *The Perspectives of User of the Services*

**(A) Quality**- as viewed by the user. WHO (2000:11) defines quality as “the measure by which satisfactory responses are provided to meet a person’s health concerns”. Recipients expect their concerns to be addressed with humanity, respect and personal attention through a comprehensive array of services; **(b) Equity**- The “health for all” concept addresses issues such as discrimination based on race, sex, religion, ethnic group, socio-economic status or age; access to appropriate services, and the power to protect and promote their own health by being adequately informed about health risks and a healthy lifestyle; **(c) Relevance** – WHO’s definition of relevance is “the measure by which priorities have been set in an action programme, accepting that the most important problems must be tackled first” (WHO, 2000:13) and; **(d) Cost-effectiveness** – The promotion of healthier lifestyle and preventive measures are emphasized as being more cost-effective than curative interventions.

### *Barriers to Effective Outputs*

Cultural practices have been an initial barrier to accessing information on reproductive health issues. Utilization of sexual and reproductive health services by young people is surrounded by various socio-cultural beliefs and attitudes to teenage sexuality. Sexuality is a taboo subject in most societies (WHO, 1993) making young adolescents ignorant on vital issues regarding their future sexual and reproductive health. The attitude of the staff involved in the programme may negatively affect their response to the needs of the

adolescents making use of such services (WHO, 2000). Even in countries where abortion is legalized, fear of a hostile reception from family planning staff whose beliefs are in conflict with those of the programme's policies prevent young people from making use of these services (WHO, 1993). This is seen as an obstacle and serves as a deterrent or barrier to young people consulting the appropriate health services, for fear of disapproval and judgment from staff members.

## **2.14 CONCLUSION**

In this chapter, major health issues relevant to ASRH have been discussed and analyzed. A tri-dimensional framework with constituent parts was selected as a suitable conceptual framework to guide this study, due to its inherent strength in addressing the phenomenon under study. Key concepts in the structure, process and output of ASRH programme were described and critically analyzed within the context of adolescents' health. Both the structure and process elements are regarded as vital to the achievement of programme's mission and can positively or negatively impact on the final products or outcomes. These two elements are seen as interactive and represent the key to success.

Finally, a user-system interaction and feedback response from the adolescents reflects on quality of the various inputs in the structure and process. The output provides feedback on the available services and their perspective on the systems input as a whole, towards making the pre-existing conditions adolescent-friendly.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The research methodology section forms an integral part of the research process and is one of the most fundamental aspects of any scientific study (Polit, Beck & Hungler, 2001; Mouton, 2002). A study of programmes or institutions addressing the SRH needs of adolescents and young people is a technically distinctive undertaking that needed a comprehensive research strategy. Underlying this statement, O’Leary (2004: 118) stressed that “the nature of the inquiry and the nature of your case will determine the most suitable methodology”.

Consequently, the methodology evolved around the conceptual framework, which was tri-dimensional and required a scientific process that embraced all three components of the study. Various methodological approaches were selected by the researcher in order to achieve the purpose and objectives of this study.

This chapter provides a detailed description of the research design, population and settings, sample and sampling strategy, data collection methods and data analysis procedures. Aspects pertaining to reliability and validity including academic rigour and trustworthiness as key principles in a research study using quantitative and qualitative methods are highlighted in the relevant sections. Key ethical considerations fundamental in nursing research involving participants as referred to in quantitative studies and informants in the case of qualitative research were given the necessary attention. Limitations of the study were identified and reported accordingly. An explanation of how the researcher overcame technical difficulties encountered in the research process is outlined in specific areas of the study.



### **3.2 RESEARCH DESIGN**

The main purpose of this study was to carry out a comparative analysis of ASRH programmes in selected African countries. A critical factor in this research is a carefully considered research strategy to accomplish the objectives of the study (Bless, Higson-Smith & Kagee, 2006). A research design according to Terre Blanche and Durrheim (1999) is a strategic framework for action that a researcher can use as a bridge between the research questions and the execution or implementation of the research. According to Yin (2003), the quality of a design is dependent on certain relevant logical tests.

Nonetheless, Brink (2006) indicated that the best design is always the one that is most appropriate to examine the research problem and purpose. Against this backdrop, a variety of issues were considered when selecting the design as a means of obtaining answers to the research problems raised earlier. Decision on the choice of design by the researcher was made along four dimensions: 1) the purpose of the research; 2) the theoretical paradigm informing the research; 3) the context or situation within which the research was carried out; and 4) the research techniques that would be employed to collect and analyze data (Terre Blanche & Durrheim, 1999).

Considering these four dimensions outlined, a comparative case study design was selected as suitable and appropriate by the researcher as a means of generating data from ASRH programmes in the selected African countries because of its distinctive properties related to gaining understanding of the complex social phenomena that this study sought to address. A case study is defined by Brink (2001:116) as “in-depth investigations or a

single entity of a small number of entities”. Polit and Beck (2004), on the other hand, indicated that a case study could mean an individual, family, group, institution, community or any other social unit. Case studies of programmes allow for in-depth exploration and examination of subtleties and intricacies; explore processes as well as outcomes and investigate the context and setting of a situation to build holistic understanding of the phenomenon studied (O’Leary, 2004). Intimacy in terms of knowledge of a person’s condition, thoughts, feelings, actions (past and present), intentions, and the environment was attainable through case studies (Polit & Hungler, 1999) as “its unique strength is in its ability to deal with a full variety of evidence” (Yin, 2003: 8).

The distinctive need for a case study design further arose out of the researcher’s desire to describe, explore and understand (1) the structure, (2) the process, and (3) the output of ASRH programmes. This is supported by the work of Yin (2003) who described case studies as descriptive, exploratory, or explanatory, or a combination of these. Each strategy is believed to have its distinct characteristics, but generally there are large overlaps among them (Yin, 2003). This approach was also advantageous for providing significant amounts of descriptive information and explains the ‘why’ and ‘how’ as well as ‘what’ in this study which also had exploratory and explanatory components (Brink, 2001).

Two African countries were selected as cases for comparison of ASRH programmes, in this case, Ghana and South Africa as a “two-case” or “multiple-case” design. Yin (2003)

gives a clear explanation as to preference for multiple cases to suit the purpose of a comparative study. This approach was recommended by Yin (2003), as useful when variables as well as differences between or among two or more programmes are present, to see if they differ on some variable. The “two case” approach also enabled an inclusive and pluralistic view of the phenomenon under study involving more than one country and provided the researcher with room for methodological guidance that generated data on a comparative basis using the two countries (Brink, 2006). Additionally, a multiple case study is seen as an enriching and worthy objective in a comparative study, as compared to choice of a single-case study of a programme.

According to Robson (1993), programmes and institutions are described as case studies with many possible foci. In essence, Burns and Grove (2001) identified the need for a detailed and thorough investigation of the cases, each having various units of analysis (Yin, 2003) to enable comparison and generalization across social settings in two countries. Several units of analysis in the study population were identified, each with different objectives and different data sources within the study. The researcher examined programmes that offered SRH services for adolescents and young people, the physical infrastructure, documents, as well as persons either working in or making use of the programmes to give a holistic view of the phenomenon in each country.

A blend of quantitative and qualitative approaches through use of mixed or combined methods is suggested in the literature (Gerrish & Lacey, 2006) as adding value, and complementary to offset the weakness of one by another (Polit & Beck, 2006).

Additionally, this orientation was also useful for application in this study on the basis of the different types of data that was collected (Bryman, 2004; Bertrand & Escudero, 2002), as some aspects of the data do not lend themselves to statistical calculations and were therefore subjected to mixed methods of analysis. Brink (2006) further believes that quantitative research focuses on a relatively small number of concepts, while qualitative studies attempt to understand the phenomenon in its entirety rather than focusing on specific concepts. According to O’Leary (2004), case studies are generally multi-method, as different approaches provided complementary answers. Given the emerging consensus that multiple paradigms are valuable approaches in understanding human complexities in research, Polit and Beck (2004:17) noted that:

*“Nursing knowledge would be thin, indeed, if there were not a rich array of methods available within the two paradigms-methods that are often complementary in their strengths and limitations. We believe that intellectual pluralism should be encouraged and fostered”*

Consequently, both qualitative and quantitative approaches were essential to this study, as the methodological and philosophical differences in each enabled the researcher to adopt a holistic focus through acquisition of objective and subjective data in a comparative study of ASRH programmes in two African countries in the same context, with diverse backgrounds and different cultures. For this reason, a mixed method approach to data collection and analysis were used in the study, as the strengths of one approach complemented the limitations of the other (Polit & Beck, 2004; Gerrish & Lacey, 2006).

The quantitative aspect of the study underpinned the traditional scientific approach to inquiry in a general set of orderly, disciplined procedures used to acquire information that can be quantified and generalized (Brink, 2006) and is often regarded as the dominant research paradigm in nursing. It incorporates logistic, deductive reasoning and has its philosophical basis in the positivist paradigm which seeks to be as objective as possible in the pursuit of knowledge through use of orderly disciplined procedures (Polit & Hungler, 1997, Gerrish & Lacey, 2006). Scientific measures are used by the researcher to make generalizations on the findings of the study. This approach is usually referred to as the 'scientific or empirical method' (Gerrish & Lacey, 2006).

In contrast, qualitative research is associated with an interpretivist tradition based on the assumptions that in order to make sense of the world, human behaviour should be interpreted in interactions with others (Gerrish & Lacey, 2006; Babbie & Mouton, 2001). Differences in human beings are noted in qualitative research; societies and cultures in which they live are recognized in qualitative research. The views of the informants were incorporated in the study to understand, interpret, explain, and support research findings showing similar concerns expressed, as well as differences in experiences shared, thus providing an insight of ASRH programmes as to the 'how' and 'why'. Rich in-depth information obtained in a qualitative study further has the potential to elucidate varied dimensions of a complicated phenomenon (Polit & Beck, 2004). Inductive and dialectic reasoning are predominant and emphasis was on people's interpretations of events and circumstances, rather than the researcher's interpretation (Brink, 2006). In effect, the

informants in the study were regarded as the primary gatekeepers and the researcher the secondary gatekeeper of the information.

### **3.2.1 Components of a Case Study**

Yin (2003) identifies a case study research strategy as one having five components that are of importance in a case study research design. These include:

*1) Study questions* – three key elements were identified in programmes generally, which the questions in the study were directed at: (a) the structure, (b) process and (c) the outputs (Donadedian, 1980), aimed at collecting respective data with the intention of findings answers to the what, why, and how in the study;

*2) Study propositions, if any* – theoretically, the conceptual framework used by the researcher examined various concepts, assumptions and principles proposed in the literature to be relevant and effective in accomplishing successful programmes outcomes for adolescents' sexual and reproductive health, thus directing the attention of the researcher to the scope and purpose of the study;

*3) Units of analysis* – these represents the people or objects from whom the data was collected from to answer the study questions. In this study, key persons such as programme managers, directors, service providers, adolescents, the physical infrastructure and existing documents within the programmes were defined as 'units of analysis' in this research, as they provided relevant information from different perspectives of the programme's components, making sense of the whole programme;

*4) Logic linking the data to the propositions* – prior development of propositions, as in the conceptual framework, guided the researcher in the data collection phase and laid the foundation for data analysis and the reporting phase, creating linkages in the study; and *5) Criteria for interpreting the findings* – prior establishment of the three distinct programme elements and variables of interests within them served as the basis for comparison of findings; similarly it served as a frame of reference and criteria for interpretation with data converging in a triangulation fashion.

These five components as outlined by Yin (2003) above have been incorporated into the relevant sections of this study as highlighted by the researcher.

### **3.3 POPULATION, SAMPLE AND SAMPLING SIZE**

#### **3.3.1 Study Population**

The interests of this study are programmes or institutions addressing the sexual and reproductive needs of adolescents and young people in selected African countries. The study population therefore refers to adolescent sexual and reproductive health programmes. Africa is made up of 54 countries, 48 of these are in sub-Saharan Africa. Several countries have already engaged themselves in the provision of SRH services as well as involved in the establishment of adolescent-friendly programmes. Examples of such countries are South Africa, Ghana, Zambia, India, and Kenya. Ghana and South Africa health sectors have engaged in the development of youth intervention programmes, integration of life skills and family life education in schools and youth-friendly clinics in recent years.

Ghana and South Africa were identified as countries that have representative programmes in sub-Saharan Africa. It is not feasible to access all countries in this region, therefore Ghana in West Africa, and South Africa in Southern Africa were specifically targeted for the study. It was also financially and technically impossible for the researcher to compile a feasible and accurate list of adolescent programmes of all the countries in Africa or sub-Saharan African, or even in the sub-regions as these are not forthcoming in the literature. Nevertheless, it was still felt that this study would be a starting point in gathering such data for future studies.

### ***3.3.2 Selection of the Cases***

The “case” in this context, refers to the individual countries studied. Contextual factors are generally considered in the “selection of cases” when studying a phenomenon that is intrinsic and of immediate significance, with a specific focus (Mouton, 1998) with the aim of investigating a limited number of cases in an in-depth manner. According to Yin (2003), the number of cases deemed sufficient for a multiple-case design is not based on sampling logic or typical criteria regarding sample size, as he further contends that these are irrelevant for this type of study. The important consideration is related to whether the cases selected represent the phenomenon under study, share common features that would provide an answer to the research questions. From the literature, valuable contextual data relevant to the study were used during the proposal phase to identify the two countries.

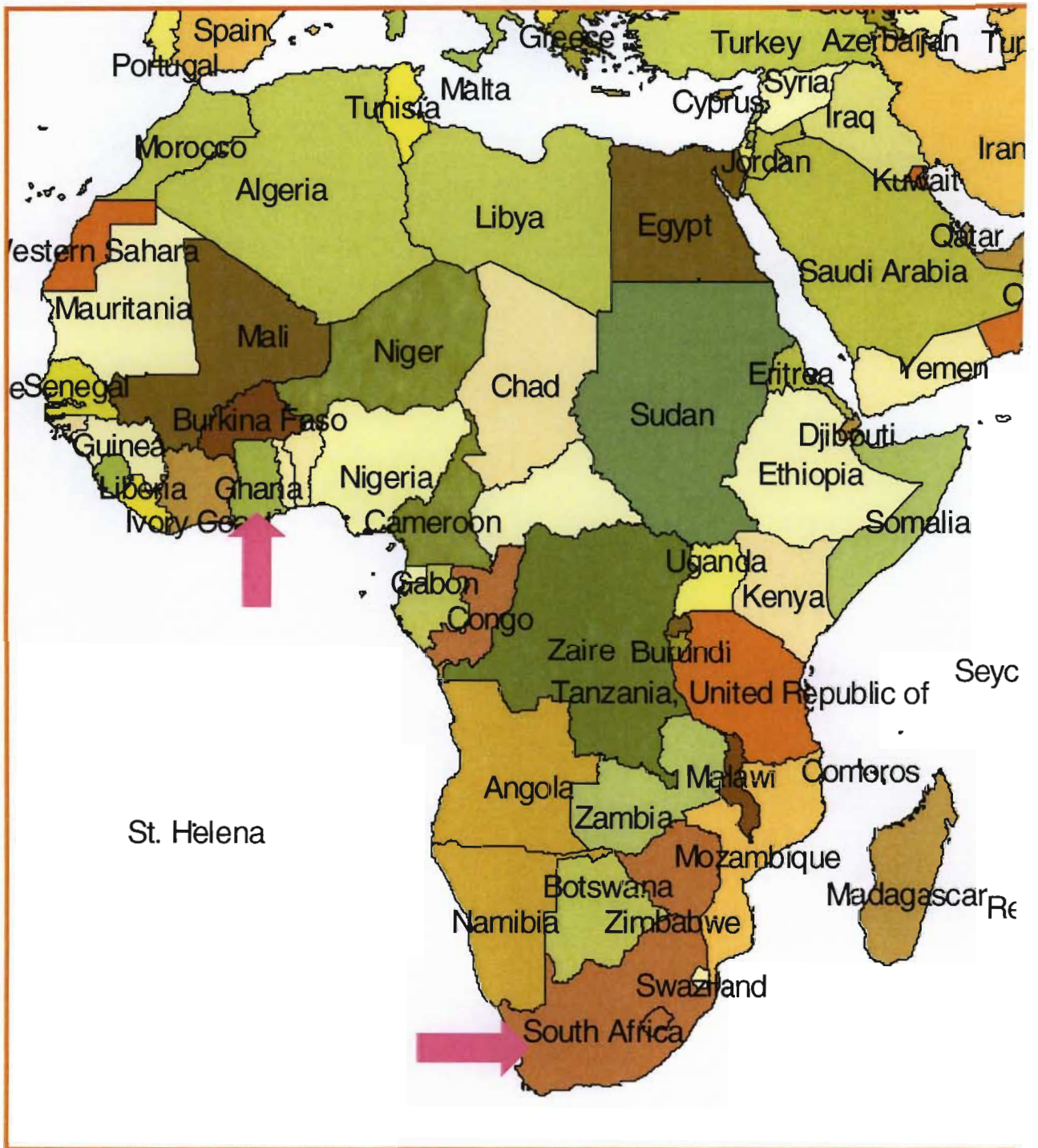
A description of the two countries chosen for the study and a motivation for the choice of countries and sites within the countries is also provided. The selection of Ghana and



South Africa was based on a purposive sampling technique, which Brink (2006) describes as a form of non-probability sampling based on the judgment of the researcher regarding the characteristics of a representative sample (Bless, Higson-Smith & Kagee, 2006) that is two African countries, Ghana and South Africa, that are typical of the problem under study (a high adolescent population with SRH problems). Gerrish and Lacey (2006), on the other hand, defined a purposive sample as one where people from a specified group are purposely sought out and sampled. These two countries were selected because of social and contextual factors (Mouton, 1998) as they share the same concerns on SRH problems of adolescents. The need for such a comparison was based on the needs identified among adolescents and priorities of the population group.

Demographic and country-specific data further provided compelling evidence to support the need to compare ASRH programmes in the two countries. In addition, geographical location and proximity to the country sites at the time of study and exposure of the researcher to the health care delivery systems in both countries was an additional factor. It is within this context that Ghana and South Africa have been selected for this comparative study in order to analyze the similarities, differences and specific responses of these countries in addressing the SRH needs of adolescents (see Figure 3.1). Each of the selected countries is referred to as a “case” with similar characteristics. These are:

- Existence of Adolescent structures such as youth policies & ASRH programmes,
- Demographic Imperatives: A high adolescent population in the country,
- Burden of Disease: A high percentage of ASRH problems among its adolescents,
- Geographical Proximity and Location of Researcher.



**FIGURE 3.1 MAP OF AFRICA**

**\*Arrows showing the two Sub-Saharan African Countries Selected for Comparison**

### ***3.3.1.2 Contextual Factors for ASRH in Ghana and South Africa***

Both countries were drawn from cultural and ecologically distinct regions of Africa for the sole purpose of comparison of ASRH programmes in these countries. Influential factors embedded in the socio-cultural diversity and political structures of each country serve as pointers to the differences needing further exploration. The Greater Accra Region, (capital city, Ghana), and KwaZulu-Natal Province (South Africa) served as the study sites representing the two countries. From current demographic figures, it is apparent that a large adolescent population exists in both countries. The two countries and selected cities are well established and had initiated sexual and reproductive health programmes for young people based on findings from the review of the literature. Both have representatives at international conferences held on behalf of adolescents and young people and have shown evidence of putting in place strategies to address the sexual and reproductive health needs of adolescents. The Primary Health Care concept forms an integral part of the health system of Ghana and South Africa's and has become the framework of their health policy.

The vulnerability of adolescents, especially in developing countries, has been highlighted in numerous SRH documents and research studies. Reproductive health indicators of adolescents in both countries provided a statistical insight into the contextual factors. On critical analysis of the literature, both Ghana and South Africa have a high prevalence of teenage pregnancy, HIV/AIDS and other SRH problems among teenagers in Africa (RHRU, 2000; AYA, 2004). The HIV/AIDS epidemic has affected adolescents in most countries in Africa. The age groups mostly affected are young people within the ages of

20-29 (The Joint United Nations Programme, 2002). This problem has contributed to bringing SRH programmes and the needs of adolescents into focus as one that demands urgent attention. Ghana and South Africa were therefore selected as case studies to find answers to some of the questions that have been raised in the past about the ability of the health facilities in African countries to provide adolescent-friendly reproductive health services, Ghana in the Western part of Africa, and South Africa located in Southern Africa. Although concerted efforts have been shown by both countries, there is not much in the literature about the operationality of their programmes from a holistic perspective.

### **3.3.3 The Study Settings**

#### ***(1) Ghana***

Ghana is a unitary state divided into ten political regions and 110 districts and is a multiethnic country located in West Africa. The capital city is Accra, where most adolescent programmes are focused; others can be found in rural settlements, but are of a short term nature. The country's population was 19, 894, 014 in 2001 and 20, 922, 000 in 2003 (United Nations Cyberbus, 2005). The population of adolescents in Ghana under the age of fifteen was quoted by the Reproductive and Child Unit (RCH Unit) (2004) as 50% of Ghana's population and young people aged 10-24 accounted for 30.4% (see Table 3.1). It is estimated that nearly one in three Ghanaians is between the ages of 10 and 24 (Allan Guttmacher, 2004). The adolescent population for Greater Accra Ghana 2000 was projected at 500, 641 in 2000. Concerns were expressed that boys and girls who fall within the age group 10-19 years were not singled out for special attention as a distinctive group with different physiological and psychological needs from adults and children

(RCH Unit, 2004). According to the Ministry of Health Ghana (2004), the majority of the marginalized youth cannot be reached.

**Table 3.1: Ghana - Population Breakdown 2000 Census Figures: Primary Target**

**Group**

Period/Phase	Age Range	Total % of the Population at 2000
Pre-adolescence	5-9 years	14.4 %
Younger adolescence	10-14 years	11.9 %
Older adolescence	15-19 years	10.0 %
Youth	15-24 years	18.5%
Young adults	20 -24 years	8.5%
Young people	10-24 years	30.4%

A review of the literature suggests that Ghana has several areas of concern related to the health of adolescents and young adults. The median age of first intercourse is 17 years, while median age at first marriage is 19 years. According to the Allan Guttmacher Institute (2004), more than half of the young women in Ghana marry in their teens and 12% of women aged 15-19 years have had a child. Data further revealed that more than 80% of adolescents and youth reported not using any contraception during their first intercourse. Three-quarters of young men and more than half of young women who have ever had an STI sought treatment most often from a drug store, hospital or clinic. This increasing trend among adolescents is notably high, especially in African countries with a high adolescent population. Young people aged 15-24 years accounted for one-third of all births as a result of early marriage, early onset of sexual activity, lack of knowledge and skills, lack of access to quality SRH services, poverty and low contraceptive use (5%) and baby abandonment (RCH Unit, 2004).

The majority of HIV infections occur among adolescents and young adults (Wolf, Tawfik, & Bond, 2000). The reason for this assumption is based on the fact that the length of time between infection and AIDS diagnosis may be up to ten years. The Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ghana reported that AIDS cases are predominantly seen in age groups 20-29 (34%) and 30-39 (38%) (Wolf et al, 2000). In 2002, more than 30% of 15-24-year-olds were estimated to be HIV positive, and the estimated HIV/AIDS prevalence rate among 15-24 year-olds in Ghana was 3.4%.

In response to the outbreak of HIV/AIDS epidemic, the Ghanaian government embarked on a set of educational programmes designed to increase awareness. Later, an increased awareness of the disease was reported in 97% of both males and females aged 15-19 year-olds, but, one in five young men and women still cannot name any specific way by which HIV is transmitted, and only about one in four believed themselves to be at risk of infection (Allan Guttmacher Institute, 2004).

Programmes and strategies are already developed in the country to tackle these problems. The 1999 National Youth Policy, the 2000 Adolescent Reproductive Health Policy, the National HIV/AIDS and STI Policy issued in 2001 provided a comprehensive strategy for addressing the needs of young people in Ghana. Special emphasis was placed on the youth and various ways to mobilize parents, policymakers, media and religious organizations to influence public opinion and policies in regard to young people and STIs, with particular reference to HIV/AIDS.

A wide range of governmental and nongovernmental organizations in Ghana are currently offering programmes and services to young people. In-school and out-of-school education programmes to ensure access to youth-friendly facilities and services were promoted. One of them is the “Young and Wise” campaign of the Planned Parenthood Association of Ghana, which provides SRH information, counselling and services at special youth-friendly services centres. The present challenge faced by the government is that of ensuring the policy objectives are translated into effective programmes and activities (Allan Guttmacher Institute, 2004).

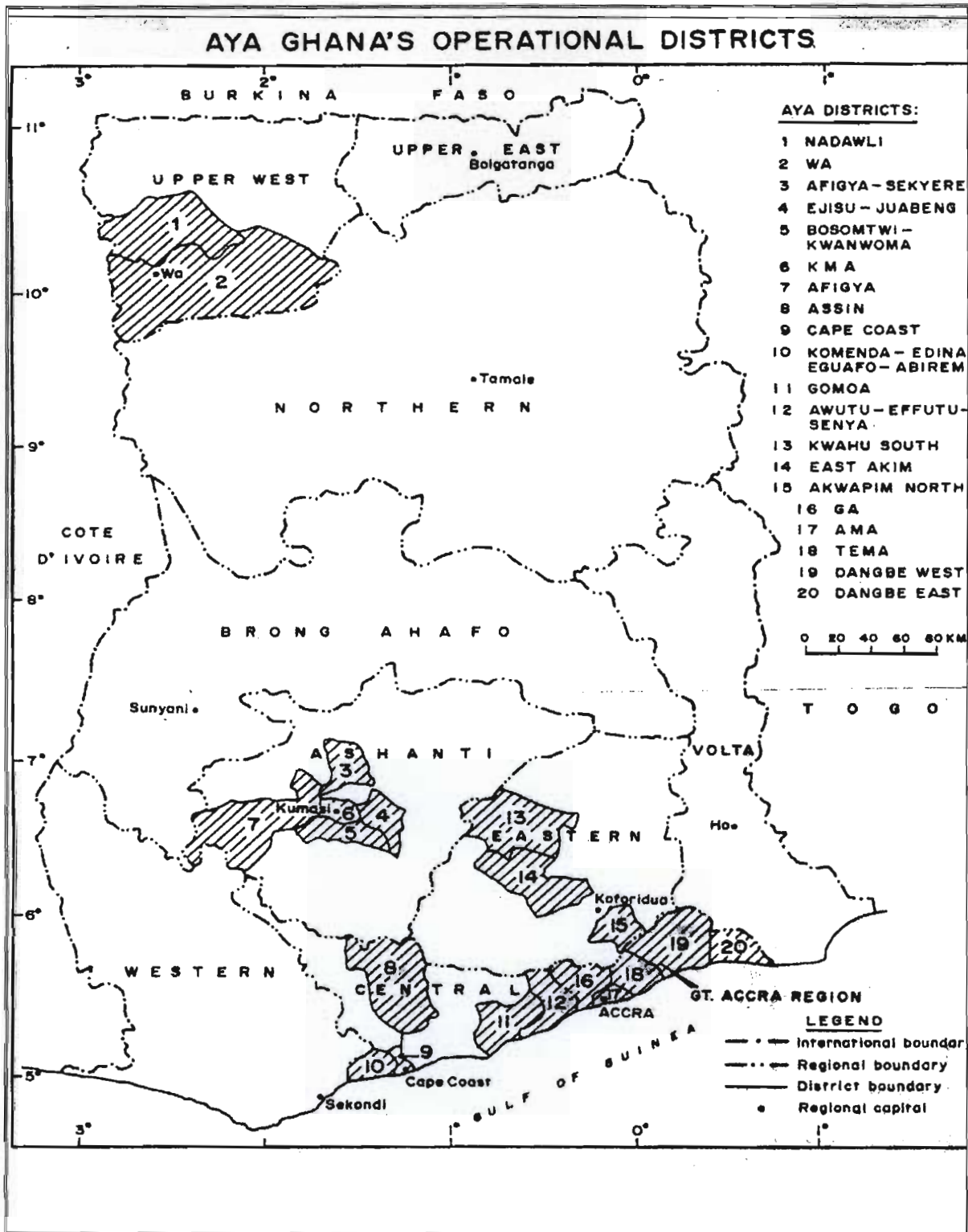


Figure 3.2: Map showing Areas of NGO ASRH Activities in Ghana



## *(2) South Africa*

South Africa is described as a country of great geographical diversity with considerable variation in climate and topography (van Rensburg, Fourie & Pretorius, 1993). South Africa is unique, in the sense that it has two attributes of being a developed country but still in part has attributes of a developing country. South Africa is made up of nine provinces. KwaZulu-Natal Province is geographically the 3<sup>rd</sup> smallest province (see Figure 3.4), but has the largest population at 9.16 million (South African Health Review, 1998), with 59.9% living in the rural areas. South Africa has undergone profound socio-political and economic transformation over the past ten years from an apartheid rule to a democratic rule in 1994 (van Rensburg, Fourie & Pretorius, 1993). The health sector similarly experienced reforms to a primary health-care driven approach to health (van Rensburg, 2004).

The South African population as of 2003 was estimated at 45, 026,000 (United Nations Cyberbus, 2005). Present statistics of the population age structure showed that persons younger than 15 years of age in South Africa exceeded that of world figures. The World Health Statistics (2005) indicated that more than half of South Africa's population is under the age of 25 (CEDPA, 2005). According to the Chief Directorate Population Development, in the Department of National Health and Population Development (1993), thirty seven percent of the population in South Africa consists of children below 15 years of age (Booyens, 1997). KwaZulu-Natal as compared to other provinces in South Africa has the largest number of adolescents. This province is described as having the largest school-going population with approximately 1 638 653 primary school learners in 3861

schools and 886 490 secondary school learners in 1478 schools (Department of Health, 2004). These figures are indicative of the large number of young people in the province. The need for health services to cater especially for the younger component of the South African population was described a priority area (Booyens, 1997).

In 2004, a Youth Risk Behaviour Survey found that 37.1% of learners in KwaZulu-Natal were sexually active with 15.6% having their sexual debut before age 14 years (Department of Health, KwaZulu-Natal, 2004). Of the group who were sexually active, 52% had used some form of contraception, while 54.6% reported having 2 or more sexual partners. In a National Survey of 15-24 year olds, 35% indicated they have had one lifetime sexual partner, while 27% stated that they had had more than one sexual partner (RHRU, 2004).

According to the Department of Social Development (2003), South Africa's teenage pregnancy rates remains amongst the highest in the world. The South Africa Demographic Health Survey of 1998 revealed that 35% of teenagers had either been pregnant or had a child by age 19 (Department of Health, 2002). More than 30% of 19-year old girls reported to have given birth at least once (Kaufman, de Wet, & Stadler, 2000). Teenage pregnancy was attributed to poverty and unemployment among young people (van Rensburg, 2004).

About 35% of HIV infections occur before the age of 20 in young people in South Africa (LoveLife, 2004). The current infections pose a threat to young people under 15, as

studies show that some adolescents within this age group are sexually active. KwaZulu-Natal, as compared to other provinces, has a large number of adolescents, with reportedly high numbers of HIV/AIDS as well as teenage pregnancy in this age group (National Youth Commission, 1997).

South Africa has a large number of well established projects for adolescents though these seem to be fragmented and unstructured (Dickson-Tetteh, 2002). The Reproductive Health Research Unit (RHRU) in South Africa focuses on young people and seeks to improve their SRH through strengthening the quality of, and access to, adolescent health care (RHRU, 2005). According to the RHRU, one way of controlling the crisis in the SRH of young people was through effective prevention intervention (RHRU, 2005). Preliminary evidence suggests that South Africa has responded to the problems of adolescents by putting in place adolescent policies and youth-friendly programmes and has made some strides in this direction (RHRU, 2002). These programmes are basically located in a youth-focused paradigm in partnership with government institutions and services (RHRU, 2005). South Africa has also developed a certification programme based on an essential service package of adolescent-friendly services, drawing upon WHO recommendations for primary health care services (<http://www.fhi.org/en/RH/Pubs/network> Retrieved 10/4/2005). Based on these facts, South Africa is selected as one of the African countries for a comparative analysis study.

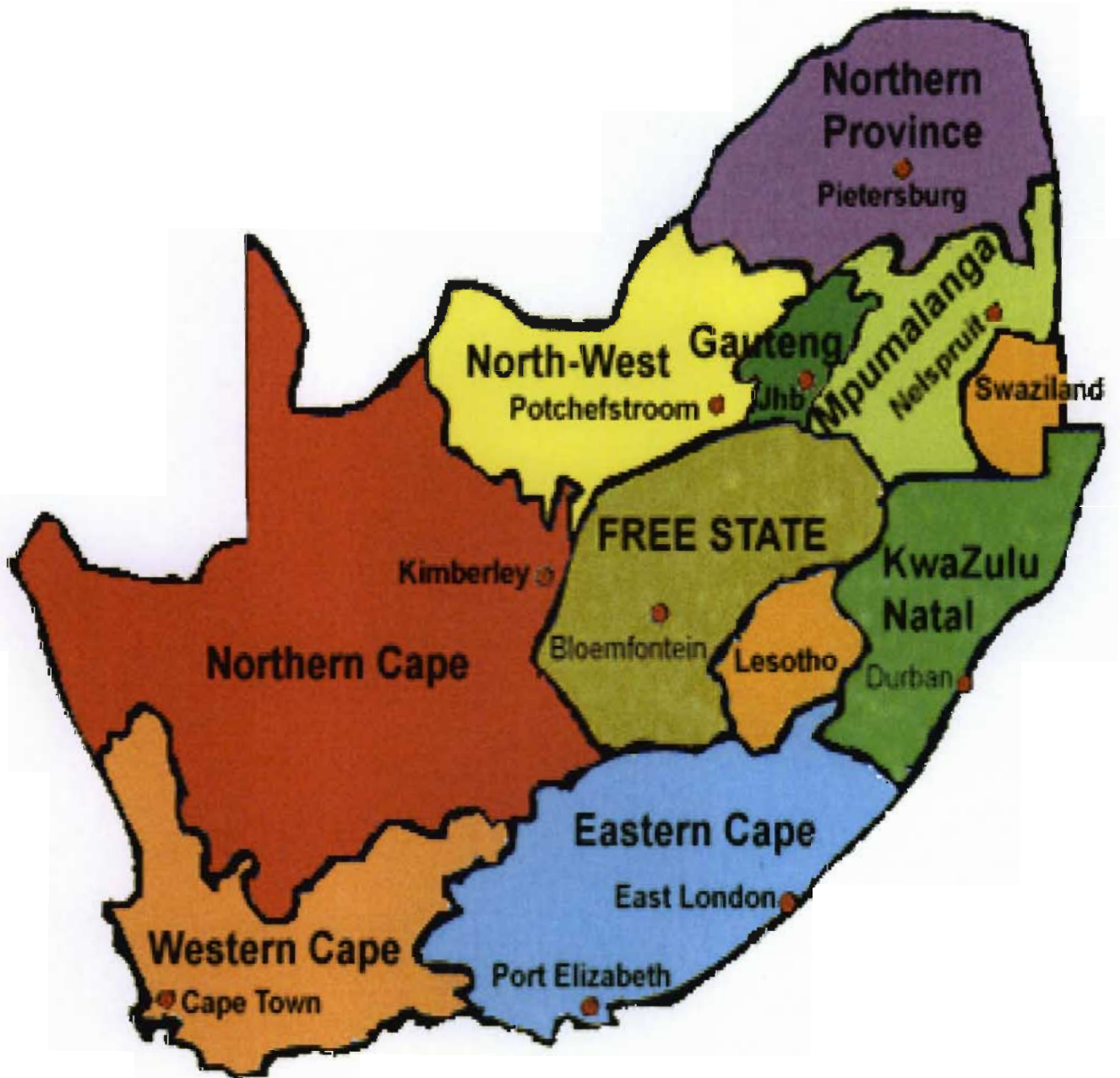
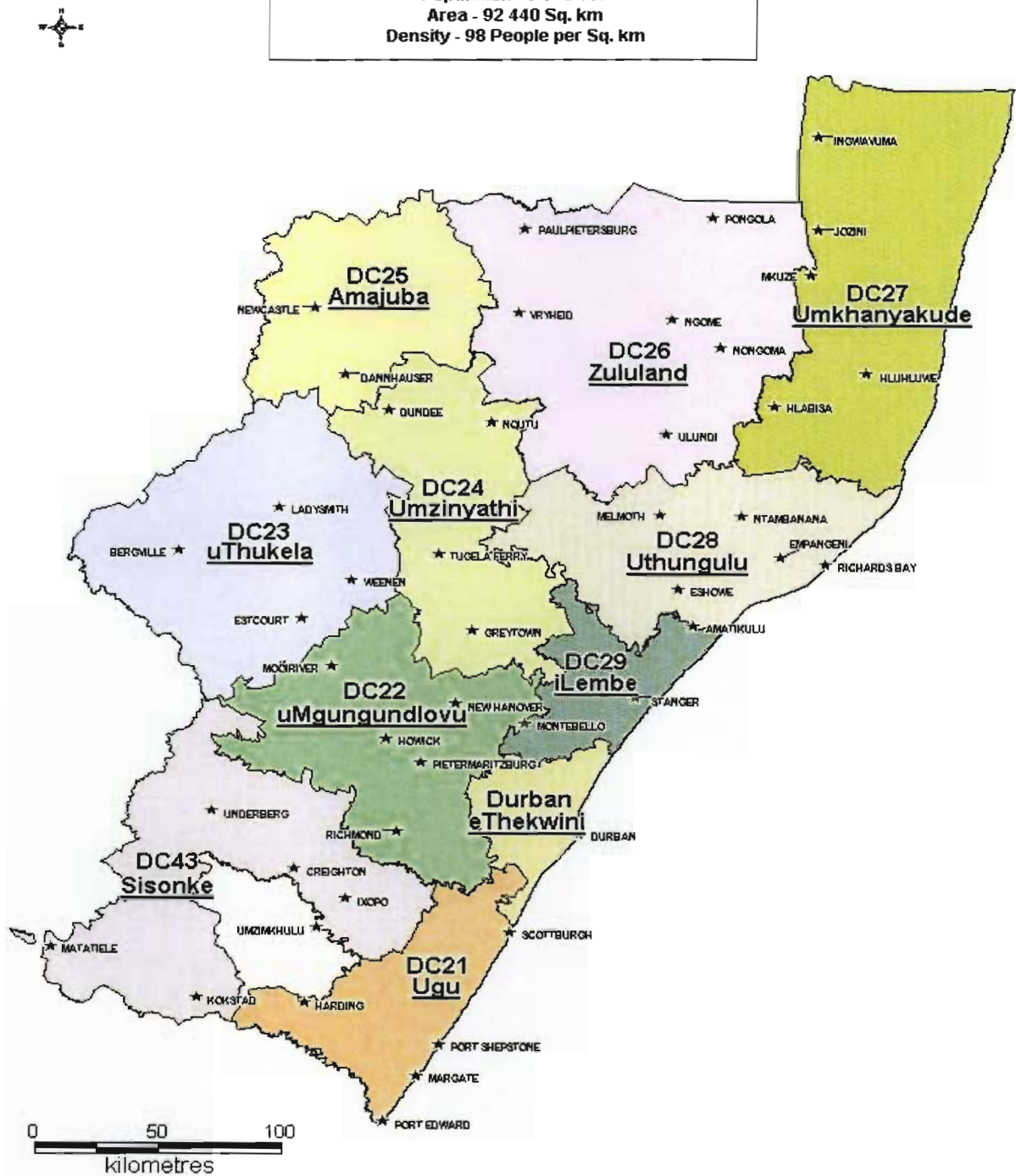


FIGURE 3.3: MAP OF SOUTH AFRICA

**KWAZULU-NATAL HEALTH DISTRICTS**

Population - 9 070 457  
Area - 92 440 Sq. km  
Density - 98 People per Sq. km



**FIGURE 3.4: MAP OF KWAZULU-NATAL**

### **3.4 SELECTION OF PROGRAMMES FOR STUDY**

A listing of institutions with adolescent sexual and reproductive health programmes that fit into the category of the selected group was targeted through the appropriate authorities and channels of administration in the two countries. The sample parameters included a list of recognized institutions, such as adolescent clinics and youth centres dealing with adolescents' health, specifically those whose main area of interest is sexual and reproductive health. Use of snowballing and networking as a sampling technique involved the assistance of ASRH providers in each country in identifying and directing the researcher to potential programmes with similar characteristics to those accessed (Polit & Hungler, 1999). The researcher selected those programmes that are recognized by the government and accredited by the Ministry of Health, as well as others renowned in the communities in each of these countries within the private and public health sector, and aged not less than 6 months in operation, and at the implementation phase. These programmes were selected according to the services they offered, which included sexual and reproductive health issues of young people, and the type of activities used to address the identified needs of young people. The inclusion criteria provided a boundary for the research study and in effect made classification and identification of the institutions studied easier.

#### **3.4.1 The Sample Units of Analysis**

The unit of analysis, according to Bless, Higson-Smith and Kagee (2006) is the person or object from whom the researcher collects the data. This included the human, the physical infrastructure and documents as part of the material resources, and users of such

programmes. These consisted of key persons such as (1) Programme managers/directors/coordinators (2) service providers in ASRH programmes, (3) the adolescents utilizing ASRH services and (4) social artifacts such as the physical structure and documents, which provided valuable information in giving the researcher a holistic representation of the three elements of the programmes (Mouton, 1998). Individual elements of a phenomenon can be fully understood and examined in terms of characteristics and significance when located within the larger context (Yin, 2003). Specific persons and objects within the programmes were identified to provide relevant data referred to as the “Units of Analysis”.

#### ***1) Programme Directors, Project Managers and Coordinators***

This group of key informants provided information on the “**Structure**” of the programmes which consists of the programme’s philosophical basis, mission statement, policies, human resource, consumer’s characteristics and needs, and evaluation of the programmes. Managers and directors provided information on how the programmes were conceptualized as well as the structures put in place for development, implementation and sustainability.

#### ***2) Service Providers or Staff Working in the Facilities***

This group of key informants provided data on the “**Process**” – which included the type of services offered, mechanisms for implementing programme activities, teaching/learning approaches, procedures, processes and methodology used to achieve the objectives of the programme, barriers, challenges and success stories.

### ***3) The Adolescents and Young People***

Adolescents are seen as beneficiaries of the programmes and consumers of the services offered and are also referred to as the outputs or products. They provided feedback on the programme's output in relation to the relevance of the programme and services offered and the deliverable outcomes of the programme.

### ***4) Relevant Records, Documents and the Physical Infrastructure***

ASRH documents found within the facilities provided secondary data pertaining to the structure and process of the programmes in accordance with the study objectives. This added extra benefit to the findings and gave credence to the information obtained through other techniques.

#### **3.4.2 Sample Size and Sampling Strategy**

Sampling, according to Polit & Hungler (1999), is the process of selecting a portion of the population to represent the entire population. The Programmes were viewed within three defined categories or programmatic elements forming the sample frame, which in this study are the structure, process and output (Donabedian, 1980). Within these three distinct categories, there were specific groups of data required to answer the study questions. Specific sampling strategies were selected for the relevant participants from the population of study according to the different variables to be studied, such as: the "Structure", "Process" and the "Output" within the framework. This required different methodological approaches and data collection techniques. A wide variety of respondents were selected from among each unit of analysis from the study population.



Both qualitative and quantitative sampling techniques were applied in order to arrive at the sample and sample size. The sample size for each of the above sample set was determined on the basis of data saturation for the qualitative data (Polit & Hungler, 1999) at a point where new information was no longer forthcoming. Data saturation was achieved for a wide representation of data from both the key informants and informants regarding various components of the study. The decision was then made by the researcher when no new information could be gleaned by further data collection on the study questions. Selected excerpts are provided namely from the informants in Ghana and South Africa as examples of data saturation in key aspects of the data pertinent to questions on the relevant SRH knowledge for adolescents in the extracts below:

- ***Informants, Ghana***

*“Adolescents need to know about family planning and contraceptives”  
(Informant, Ghana).*

*“Adolescents need to have knowledge on the use of contraceptives” (Informant,  
Ghana).*

*“It is important for young people to know about family planning and STIs”  
(Informant, Ghana).*

- ***Informants, South Africa.***

*“Even if you are on 2 months injections, still use condoms to prevent STD’s/STIs”  
(Informant, South Africa).*

*“Even though the pill etc. prevents unwanted pregnancy, people need to know  
that they are still at risk with STI/STDs (Informant, South Africa).*

*“The pill and condoms are not 100% so they must abstain if they can”  
(Informant, South Africa).*

The above extracts are examples of information derived on a specific theme. Similarly, other themes in the whole data were observed to be repetitive and redundant, on the basis of these findings, a sense of closure was attained by the researcher.

#### ***3.4.2.1 Sampling of Key Informants and Informants***

##### **1) Qualitative Data**

For clarity purpose, the **key informants** are programme managers and service providers and **informants** are adolescents who participated in the focus group discussions. These groups of individuals provided qualitative data for the study.

##### ***The Key Informants***

These were selected through consideration of contextual factors and a set of criteria to qualify for selection. As suggested by Polit & Hungler (1999:279) “The overriding consideration in a qualitative study is its representativeness”. These groups of persons were drawn from policy makers, programme directors/managers, service providers nurses/midwives, peer educators and counsellors, who work and care for adolescents using the facilities. They provided information on the types of activities used for teaching/learning as well as other strategies used and the procedural aspects in service provision in the accomplishment of objectives. A critical case sampling was used to select key informants in the programmes who provided the most information on the topic from within the study context or perspective (Grbich, 1999). The rationale behind this was that each of the key informants was chosen for the purpose of providing rich information on the units of analysis and relevant area of the study objectives. All key

informants were appropriately represented in the structure and the process. To take account of new situations that might arise during the research process, an opportunistic sampling was combined with that as described below (Grbich, 1999). “Maximum Variation” or “Heterogeneous Sampling” technique was used as a means of carefully selecting key informants who will provide the best representation of the research questions’ definable aspect (Grbich, 1999).

A total number of 46 key informants were interviewed from the two countries, 17 from Ghana and 29 from South Africa. All programme managers and service providers and persons trained in ASRH who were assigned to adolescent clinics or youth centres in the two countries studied were interviewed as they constituted a small number. They were accessed from their respective offices. In Ghana, seven key informants provided data on the structure of ASRH programmes in Ghana at top management level. One was a programme officer from the Reproductive Health and Child Unit from the Ministry of Health, Ghana Health Services at national level. Five of the other key informants were senior personnel involved in ASRH program conceptualization, development and planning, and as members of the Adolescent Sexual and Reproductive task force group, from government, private and NGO programmes visited, three of them were from NGOs, one was a representative from the Ghana Registered Midwives Association, and one was a programme manager at a University ASRH Centre. The rest, 11, were nurse/midwives, public health nurses or peer educators working as heads of unit in the clinics or youth centres.

In South Africa, one key informant provided information on ASRH conceptualization and development in South Africa, KwaZulu-Natal, at Ministry (Provincial Level), seven of the other key persons were programme managers/coordinators, senior nurses, nurse-midwives, or heads of unit in their respective programmes, either working for government ASRH clinics or within NGO-based youth centres. The rest of the key informants (21) were peer educators, ground breakers and youth counselors assigned to the LoveLife projects, located in the clinics and youth centres. These group of key informants provided information on the process of ASRH programmes in South Africa.

### ***The Informants***

Adolescents referred to as informants in this study were the group in the programme who provided qualitative data on the appropriateness, relevance and quality of the services offered. A total number of 47 adolescents were interviewed, 17 from Ghana and 30 from South Africa through focus group discussions. One of the advantages of the qualitative aspect of the research design was its flexibility (Polit & Hungler, 1999). The researcher was able to adjust to the present situation during data collection and interviewed adolescents from the youth centres only, as they were more suited for focus group discussions than the clinics and had time to take part in the discussions. They were selected using a convenience sampling strategy. This involved selection of the most conveniently available people in the study sites visited at a particular time (Gerrish & Lacey, 2006). A method of matching described by Polit and Hungler (1999) ensured that both male and female adolescents were included in the discussions. Representatives were selected from youth centres which have the overall affinities or similarities in terms of

programme elements, except where the centre is only visited by females or males, as the case maybe. These informants at one time or the other have utilized the services at the ASRH clinics. Issues such as bias in selection were minimized through observing the key principles in sampling and in empirical studies. The total number of key informants and informants was reached at a point when the data was saturated, and did not yield any additional findings to those collected previously from the other participants.

## **2) Quantitative Data**

A convenience sampling technique was used to distribute questionnaires to any adolescents who agreed to participate in the study. The initial plan of the researcher was to obtain a representative sample of the number of adolescents utilizing the services in each of the facilities visited; this proved impossible for a number of reasons. Adolescents from the clinics were mostly accessed in family planning or antenatal clinics. The total number of adolescents utilizing the services at the time of the study varied. In most of the clinics visited there were no usable registers as adolescents were placed in a general register for the populace making use of the services, so it was difficult to distinguish between adolescents and adults except when age was given close to the names. Use of the register as a basis for calculating the sample size required, accurately was not feasible in the adolescent-friendly clinics. In addition to this, adolescents were only available at specific times, usually in the afternoons, depending on the type of services required, and it was difficult to assess the numbers that would arrive at the clinics or centres at any given time for a particular service. Recognizing the need for a solution, the researcher devised a contingency plan under the prevailing circumstances. Adolescents, both males

and females, were selected from each study site, from both government owned clinics and NGO-based youth centers and clinics, where accessible and applicable at the time of study, age 14 years and above. A total number of 100 adolescents utilizing ASRH service for each country were sought.

In order to get a feasible number of participants based on a calculated sample from the population (n=200) from the two countries combined, Ghana (100) and South Africa (100) the following decisions were made: The sample size (SS) is obtained by applying the standard sample size calculating formula as illustrated in Katzenellenbogen, Joubert and Abdool Karim, (2001);

$$SS = \frac{Z^2 * P * (1 - P)}{C^2}$$

where:

Z = Z value (e.g. 1.96 for 95% confidence level)

P = percentage picking a choice, expressed as decimal

(.5 used for sample size needed)

C = confidence interval, expressed as decimal

Substituting in the above formula, one obtain the following sample size;

$$SS = \frac{1.96^2 * 0.5 * (1 - 0.5)}{0.9^2}$$
$$= 92.$$

However the sample size was raised to 100 for easy handling of the numbers and also to control for error due to inconsistent registration of the target group.

### ***3.4.2.2 Sampling of the Documents, Artifacts***

A purposive sampling technique was applied to retrieve specific documents that can provide answers to the research problem. All available material resources relevant to the study, such as registers, manuals, brochures, leaflets, pamphlets, magazines, posters, wall charts, pin ups, video cassettes, and souvenirs designed for adolescents or documents on the activities of the programme at each facility visited were accessed from the programme managers and service providers. The documents were subjected to content analysis and were selected in relation to: 1) policy documents, operations and manuals, 2) educational materials and; 3) clinical forms and clients records. The documents were systematically examined and analyzed for dates, contents and source or origin and analyzed using a pre-defined checklist which covered aspects that were of relevance to achieving the objectives of the study. Documentation included extracts from speeches, policy documents, facilitators' manuals, handbooks, clinic cards, case notes, newsletters, educational materials in the form of brochures, wall charts, pamphlets, events of the programme, proposal requesting funding, programme reports, plan of action and news paper report. A list of the documents retrieved was made and poster headings were highlighted under heading, purpose, contents, source, dates and types. Available relevant documents in each site were included in the analysis.

## **3.5 DATA COLLECTION TECHNIQUES AND INSTRUMENTS**

### **3.5.1 Triangulation of Data Sources**

Triangulation is defined as “the use of multiple sources or referents to draw conclusions about what constitutes the truth” (Polit & Beck, 2004:36). Multiple sources of data

collection techniques were used as follows: interview schedule, questionnaires, focus group discussions, record review and document analysis and observation. Gerrish & Lacey (2006) further explained data triangulation as one involving use of a number of different data sources that can shed light on a particular phenomenon. Employing the different methods of data collection will not only compensate for the specific limitations in the different methods chosen (Mouton, 2002) but will further add value to data required for a study of this nature.

Use of tightly structured methods is said to have certain disadvantages (Polit & Beck, 2004). One of these is that of leading to bias in capturing constructs under study (Polit & Beck, 2004:273). Therefore, in order to overcome these weaknesses, the researcher made the choice of triangulation as a method of data collection (Mouton, 2002). Both primary and secondary approaches to data collection and analysis were used for specific issues according to the study objectives. Primary approaches include collection of data from key informants through in-depth interviews, focus group discussions and administration of questionnaires. Secondary approaches - the study also made use of existing data sources to complement data. This included analysis of relevant records.

A variety of information was needed for data on comparative analysis of ASRH programmes. Polgar and Thomas (1996) define data as the term used to refer to the complete set of observations or measurements recorded in the course of a research process. The data for this study were therefore collected from key persons, informants and participants in the programmes through the application of diverse techniques.



Specific and appropriate background information was needed regarding the activities of the programmes to enhance the quality of the reporting framework. The relevant documents and observation of the facilities served as valid inferences for supporting information on the structure and process of the ASRH services

### **3.5.2 Instruments for Data Collection**

#### ***3.5.2.1 Semi-Structured Interview Guide***

A semi-structured interview schedule was used as a tool to collect information on the structure and process of the programmes in both countries. Two separate interview guides were developed by the researcher, one was directed at programme managers and the other was for the service providers. Each of the instruments contained three sections: section one dealt with background information on the programme for accurate recording and identification of data by the researcher; section two covered demographic data from the informants, and section three contained a 14 item interview guide aiming at questions on the structure and process of ASRH programmes. The contents of the questions were formulated around key issues, directed at the research questions and the study objectives (see Annexures 2A & 2B). There was overlap in some questions directed at both groups of ASRH informants as some concepts in the two are interrelated.

#### ***3.5.2.2 Questionnaire***

***Client Exit Survey:*** Two groups of adolescents were targeted: adolescents attending the youth centres, and another group who were attending the clinic-based services. The client-exit survey, in the form of a self-completing questionnaire, was designed for use in

settings where adolescents can find time to complete the form without affecting the purpose of their visit to the facilities. Administration of a 25 item questionnaire with three sections, containing both open-ended and closed questions was done (see Annexure 2C). These were directed at yielding data which gave feedback on the programmes from the perspectives of the beneficiaries. The questions were considered appropriate for their age groups, sensitive to their developmental needs, culturally appropriate and according to programme design. The first section covered relevant demographic information such as age, gender, marital status, educational status, type of facility. Section two of the instrument contained questions on sources of knowledge on the facility and relevance of the services – in relation to reasons for visit, ASRH needs, relevant services, information and/or treatment given during visit, knowledge gained during visit and sources of this information. Section three focused on their perspectives of the services provided by the programmes based on the adolescent-friendliness clinic initiatives by WHO. The questions covered issues on accessibility, clinic location, convenience, acceptability, and affordability, and adequacy of services. The attitude of service providers was rated and reasons for such ratings were required. Also included were questions on satisfaction with services, suggestions and recommendations towards the future development of ASRH programmes.

### ***3.5.2.3 Focus Group Discussions***

The parameters for focus group discussion were set by the researcher around three main themes; a) knowledge and information of the facilities; b) relevance and appropriateness to SRH needs; and c) views of the services and attitude of the staff. The structure

followed the same format as in the questionnaire. The questions addressed were of a similar nature, except that a different technique of data collection was used (see Annexure 2D).

#### ***3.5.2.4 Documents and Records Review Checklist***

A document review checklist was designed on the basis of the literature reviewed. The checklist contained four columns specifying the type of record, source and date of preparation and availability, whether for programme operation, educational or teaching purposes and the topics and contents covered where applicable. A specification of the types of documents was made in the rows and allowances made for writing of information gained on review of the documents (Annexure 2E). Provision was made for incidentals and relevant themes were extracted from data.

#### ***3.5.2.5 Observational Protocol and Checklist***

Direct Observation - A structured observational protocol was used to capture unique data in a pre-specified and objective manner as some phenomena are best studied in their natural settings (Polgar & Thomas, 1996). The physical structure and environment in which services were provided was observed by the researcher using the observational protocol which had columns on description of the items to be observed under specific sections as provided below. The following observations were guided by the protocol: 1) A description of the physical infrastructure, 2) type of facility, 3) focus of the programme; 4) components of the services provided in relation to information, education and training; 5) teaching methods used; 6) input-resources available in terms of human

and material; and 7) availability of records or documents of activities. A description of the items to be observed in the facilities was indicated in the observational matrix (see Annexure 2F). The ten steps to adolescent-friendly services (Annexure 2G) served as a checklist - standard for adolescent-friendly clinics based on the observations made on more than one element of the programme. Field notes were also recorded highlighting key areas pertinent to observations made on the facilities.

#### ***3.5.2.6 Pilot Testing of Instrument***

Pilot testing of the questionnaire with a small group of six adolescents was done in one of the programmes accessed at the initial stage of data collection in order to improve clarity of the instrument or identify any problems requirement restructuring of the tool. These adolescents did not form part of the actual study. During the pilot testing phase, no problems with the instruments were found, except that some of the questions posed to adolescents who were visiting the services for the first time did not yield the required answers prior to use of the facility, therefore the researcher waited until after they had gone through the services, then presented the questionnaire in the form of a client-exit interview. Adolescents paying subsequent visits were not affected since they had utilized the services offered by the programmes, as such were able to comment on the service.

### **3.6 DATA COLLECTION PROCESS**

#### **3.6.1 Data Collection Procedures**

The researcher was currently residing in South Africa and traveled to Ghana for data collection. After the necessary groundwork, data was collected systematically at differing

periods in the two countries at the time of the study. Ghana was the first country visited for data collection, followed by South Africa due to the time available to the researcher. For the purpose of description, Ghana will be labeled as **Case One** and South Africa referred to as **Case Two**.

- ***Case One: Ghana***

The months of December 2005 – January 2006 were spent in Ghana on data collection. A senior person responsible for SRH issues in one of the programmes in Ghana accompanied the researcher to some of the identified sites to initiate the communication process. The researcher contacted key informants to be interviewed after permission was granted by the Regional Director Ghana Health Services, Greater Accra Region. A timetable was mapped out after a visit to the ASRH programme manager for the Region. A briefing session with the programme managers and coordinators was arranged to discuss the layout of the plan and activities. The names of the relevant contact persons were identified and channels of communication opened. After the introduction, letters indicating the purpose and objectives of the study were sent in advance before the start of data collection. Contact details of the researcher were included in the letter such as telephone and email address for the purpose of easy access and communication. The contact details of the key informants of the programmes were also requested on an individual basis and consent to participate and date, time and duration of the interview agreed on. Dates and time of availability were arranged and confirmation of the interview dates and schedule was ongoing. The researcher personally conducted all the interviews of key informants, observation of the facilities and collected two-thirds of the data from

the adolescents. A paid, trained peer educator helped in collecting the remaining data (questionnaires) over another period of two months (February – March 2006) as the client turn out was low in some areas which warranted several visits to some of the facilities. This was necessary as the study settings were far apart. Another issue was that adolescents were not easily accessed during certain times and periods of the week due to school activities, and a whole day would go by without obtaining data. In some of the centres, the same adolescents would show up at the facilities repeatedly and could not be included in the study again.

### *Case Two: South Africa*

Data collection in South Africa followed a similar plan, but was extended over a period of seven months from February to October 2006 due to issues of access. After permission was granted by the Department of Health, KwaZulu-Natal Province, initial contacts were established with the senior person responsible for ASRH in the province for briefings on the study and the data collection plans. Relevant information was provided by the programme director on the available study sites and ASRH activities at provincial level. Visits were also paid to the individual offices of key informants responsible for the planning and implementation of ASRH services in South Africa. The researcher conducted all of the interviews, observations, focus group discussions and distribution of the questionnaires. Two trained peer educators from different youth centres in South Africa assisted the researcher in organizing the adolescents for the focus group discussions in the youth centres. Most of the facilities were visited more than once as the accrual of participants and informants at the facilities was slow in some instances. The

number of facilities accessed was dependent on several factors such as issues of unavailability of key informants to initiate the process of access to the facilities, time constraints, non-functioning and short life-term of some programmes, and heavy work load schedule of some key informants to make time for the research.

Data were collected from the two countries until saturation of the data occurred. The researcher found recurring themes in the data and additional data did not reveal new findings. Interviews, a client-exit survey, focus group discussions, document review, and observations provided both primary and secondary sources of data on each country. Data were collected from the project directors, coordinators, and staff members from the facility during site visits, and a review of the documents available and observation of the facilities occurred concurrently at specified intervals in weeks as indicated in the data collection plan (see Annexure 1F).

### ***The Interview Setting***

In-depth individual interviews with different categories of staff working on the projects were conducted using a tape recorder. An advantage of using the interview as a data collection technique was that information gained was directly from the primary source. Face-to-face communication greatly enhanced the flow of conversation. This gave opportunities for further probing and clarification, giving an insight into unclear statements in the presence of the researcher (Bless, Higson-Smith & Kagee, 2006). The interviews were conducted by the researcher, starting with an informal discussion clearly explaining the purpose of the study, the importance of the participants' contribution to the

study and explaining the rights of the participant to establish rapport and to facilitate a free flow of information in a conducive and relaxed atmosphere (Grbich, 1999). Each interview was expected to last from approximately 30 minutes to 1 hour, given the depth of information needed from individuals in the different groups. Not more than three interviews were conducted in one day due to the location of the study sites. This enhanced the quality of the interview with intervals in between, as it enabled the researcher to write up notes and important observations during interviews, and analysis of field notes for future reference without distortion in the original information received.

It was important that the interviews were carried out in a conducive atmosphere or in an environment suitable for the interviewee, where privacy and quietness were assured. Interviews were conducted with the key informants, when convenient in a private room or secluded corner, free from distractions or interruptions. The interview was taped recorded and a semi-structured interview schedule guided the interview process. The recorder and tape were carefully checked to ensure it was properly functioning prior to conducting any interviews. Each tape was labeled with an appropriate coding used only by the researcher for the purpose of accurate reporting in each country. The key informants and informants gave prior consent and the researcher proceeded with the tape recording whilst taking down notes. Probing or rephrasing questions was done where the researcher needed more information on the aspect under discussion, as well as to seek clarification on issues that were not clear. Key points were written down immediately after each interview, away from the interview scene while key data was fresh in the



researcher's mind. An appreciation and thanks were offered, followed up with a letter of thanks.

Appropriate background information was needed from the outputs (Informants) of the programme to facilitate assessment of the relevancy of the programmes and their objectives according to the viewpoint of users of the services, to capture complete data on the phenomenon under study in a holistic manner. Focus group discussions were held with small groups of 4-5 adolescents in a group depending on the type of facilities and services offered. Adolescents were able to express their feelings and their thoughts on the issues raised during the discussions and also on how the programme is perceived by them. The number depended on the total number of young people using these facilities within the given period. An hour -1 hour 30 minutes was allocated to discussions, and some of the adolescents even requested the researcher to continue as they found the discussion interesting, whilst others were in a hurry to go home as the exam period was getting close.

The administration of questionnaires to adolescents attending the youth centres and observation of the facilities where the various services were provided also informed the study. Data were collected from the adolescents in the clinics and youth centres according to the programme settings in a systematic way. The participant information sheet and informed consent document took cognizance of ethical issues involving parental consent. The researcher asked for permission to observe the environment and available physical structures at the study sites during data collection. This was done during visit to the

facilities for interviews and focus group discussions. The researcher observed events relevant to the study's objectives as they occurred and recorded them in a systematic manner. Situational and environmental factors relevant to adolescent-friendly initiatives were observed for this purpose according to WHO's terms of adolescent user-friendliness to ensure internal consistency.

### **3.6.2 Data Collection Sites: Study Settings**

Multiple settings and data collection sites were visited in each country (see Tables 3.2 and 3.3). ASRH services are offered in two types of facilities: government clinics and NGO youth centres. Data were collected separately from each country within different SRH programme settings such as clinics and youth projects. A total of nine ASRH sites in the Greater Accra Region (Ghana) were visited by the researcher. The majority of them, seven, were in the urban area, while two of the facilities were located in the rural area. Several visits were also paid to the offices of various key informants responsible for the planning and development of ASRH services in Ghana. In some cases, the offices were located away from the ASRH centres and clinics.

In KwaZulu-Natal (South Africa), a total of eight ASRH sites were visited. The majority of them, six (6) were in the rural area, while only two of the facilities were located in the urban area. Visits were also paid to the individual offices of key persons who also served as key informants, responsible for the planning and implementation of ASRH programmes at national and project level.

**Table 3.2: (Case One) ASRH Study Sites Visited in Ghana, Greater Accra Region**

<b>STUDY SITES VISITED</b>	<b>LOCATION</b>	<b>TYPE OF FACILITY</b>
Youth SRH Clinic	Urban	Youth-friendly Corner
NGO-Youth Centre	Urban	Youth-friendly Centre
ASR Health Clinic	Urban	Family Planning Clinic
NGO-ASRH Centre	Urban	Youth-friendly Centre
ASRH Clinic	Urban	Youth-friendly Corner
ASRH Clinic	Rural	Adolescent-friendly Clinic
NGO-ASRH Clinic	Urban	Adolescent-friendly Clinic
Youth Centre	Urban	Adolescent-friendly Clinic
Youth Centre	Rural	Adolescent-friendly Clinic

**Table 3.3: (Case Two) ASRH Study Sites Visited in South Africa, KwaZulu-Natal****Province**

<b>STUDY SITES VISITED</b>	<b>LOCATION</b>	<b>TYPE OF FACILITY</b>
Youth SRH Clinic	Urban	Youth-friendly Clinic
NGO-Youth SRH Centre	Urban	Youth-friendly Centre
ASR Health Clinic	Rural	Hospital Clinic
NGO-ASRH Centre	Rural	Adolescent-friendly Centre
ASRH Clinic	Rural	Youth-friendly Clinic
ASRH Clinic	Rural	Youth-friendly Clinic
NGO-Youth Centre	Rural	Youth-friendly Centre
Youth Centre	Rural	Youth-friendly Centre

**3.7 RELIABILITY AND VALIDITY****3.7.1 Quantitative Data**

This study employed both quantitative and qualitative measures, therefore the specific concepts used are discussed in the context in which they were applied in relation to the scientific measures used to address them. Research studies adopting a quantitative approach are guided by two scientific principles, “reliability” and “validity” of the instruments to be used in the collection of data. These criteria are used to evaluate the

quantitative aspect of this study, as these two concepts are very important in a research study. The researcher therefore ensured that the quantitative instruments used to collect data were constructed on the basis of these two principles.

### *Scientific measures to address issues of reliability*

Bless and Higson-Smith (1995:129) defines reliability as: “The extent to which the observable (or empirical) measures that represent a theoretical concept are accurate and stable when used for the concept in several studies”. Polit and Beck (2004:35) simply define reliability as “the accuracy and consistency of information obtained in a study”. Reliability was ensured through the use of a structured questionnaire and structured observational protocol (Annexure 2C & 2F). Draft instruments were prepared and pre-tested among the different respondents, with consistent responses, and a final version was developed based on the outcomes of the pilot study. A checklist was developed for direct observation of the facilities and the activities specifying exactly what the researcher was observing in relation to the objectives and focus of the study. This mechanism ensured that the instrument produced an equivalent result in all the settings which leads to high reliability (Polit & Beck, 2004; Goddard & Melville, 2005). The conceptual framework formed the foundation on which the study lends itself to subsequent analysis, and also formed the comparison matrix used as the reporting framework of the study. The conceptual framework equally served as a useful protocol or format to ensure relevant concepts are addressed in each of the cases, thus contributing to the reliability of the study as a whole. This helped minimize errors or biases that are likely to occur in any study (Polit & Hungler, 1997). It would be pertinent to mention however that there were

no further statistical tests of reliability conducted for the various instruments because of the nature of the data sources involved in the study.

### *Scientific measures to address issues of validity*

“Validity is concerned with just how accurately the observable measures actually represent the concept in question or whether, in fact, they represent something else” (Bless; Higson-Smith, & Kagee, 2006:149). Furthermore, “Validity is seen as a more complex concept that is generally concerned with the soundness of the study’s evidence—that is, whether the findings are cogent, convincing, and well grounded” (Polit & Beck, 2004:36). This criterion in research is important for assessing the methods of measuring variables to ensure that they measure the concepts they purport to measure (Yin, 2003). Content validity and criterion-related validity are proposed in the literature as empirical procedures for establishing validity in a study (Polit & Hungler, 1997). From Yin’s point of view, three aspects of the quality of the design to be maximized in this study in terms of validity are: (1) construct validity, (2) internal validity, and (3) external validity (Yin, 2003), issues which were addressed through the following measures undertaken by the researcher:

“**Construct validity** is the most important and most often used of the various forms of validity” (Bless; Higson-Smith, & Kagee, 2006:159). The authors also defined it as “the extent to which scores on an instrument reflect the desired construct rather than some other construct” (2006:159). This was enhanced through the establishment of clear operational measures and specifications for the concepts or variables being studied in the

conceptualization phase of this study based on the review of the literature. Use of multiple sources of evidence, multiple and complementary types of data collection tools, to collect specific data on all concepts within the three components of the programmes, by application of the different concepts consistently across the countries studied, construct validity was ensured. These measures taken were suggested by Yin (2003) as tactics to increase construct validity.

In order to ensure **content validity**, Bless, Higson-Smith, and Kagee (2006) pointed out that a researcher must link information and items to the theoretical components of the research topic with a view to providing some information on all its different components. Documents were used as secondary sources to supplement data sources and to increase the comprehensiveness and validity of aspects of the study pertaining to the documents in place for ASRH as provided by the key persons. A review of the relevant areas of the research problem and areas pertinent to the study assisted the researcher in including key contents in the instruments, covering all components of the study explored. The findings in each case were checked and interpreted in relation to the concepts in the framework as in Chapter Two. Triangulation of data collection tools, multiple sources and complementary types of data allowed for comparison and promoted validity. Three different instruments were prepared to cover all variables in the study appropriately; they addressed key concepts in the framework that the researcher established. The research proposal, including the instruments, was submitted to, reviewed and approved by a panel of experts at the School of Nursing, where the researcher was studying and expert opinion was given prior to finalization of the instruments for data collection. Pattern

matching was used and inferences made during cross-case analysis. Discussions were based on findings from interviews and documentary evidences, collected on a particular component of the study that is related to the present findings.

**External validity** is explained as the establishment of the study domain to which the study findings can be generalized. Yin (2003) recognizes this as a major problem in case studies, as the basis for generalizing, but reiterated that case studies rely on analytic generalization and as a result the researcher is generalizing to a particular set of results to some broader theory. The theoretical framework served as the basis for comparison among findings in the two countries about existing theories on the topic. The adolescent-friendly standard used by the researcher in observing certain aspects of the services was based on the “Ten Steps to Adolescent-Friendly clinics” by WHO and the NAFCI standards, which is internationally recognized and also used by the two countries studied. Inferences are only made in comparison to the documents in relation to what was actually seen in practice at the sites visited by the researcher as a standard guide.

### **3.7.2 Qualitative Data**

#### ***Academic Rigour***

As pointed out earlier, studies of a qualitative nature are judged on the presence of a key element which is described differently in a quantitative study, and this is usually referred to as “**academic rigour**” or “**trustworthiness**” to fit with the philosophical assumptions, purposes and goals of the qualitative paradigm (Polit & Hungler, 1997; Bless & Higson-Smith, 1995). One of the disadvantages cited in the literature on choice of a case study

was of lack of rigour (Yin, 2003). Therefore to overcome this problem, research techniques best suited to ensure trustworthiness of the qualitative aspect of the data collected in this study, were put in place. The concepts and mechanisms discussed below address the above concern.

***Key research elements to address academic rigour***

Credibility, Transferability, Dependability, and Conformability are used as criteria for supporting and substantiating qualitative studies (Yin, 2003; Polit & Beck, 2004). Issues such as credibility, authenticity, and accuracy of the instrument are crucial in the qualitative aspect of the study and addressed by the researcher through adopting various research measures.

***Credibility*** refers to the truth, value of the findings, and authentic quality of the data (Polit & Hungler, 1999). Credibility was enhanced through triangulation, researcher's credibility, peer debriefing and use of purposive sampling methods. Yin (2003) emphasized that many variables of interests are involved in a study of programmes and stressed the need for researchers to rely on multiple sources of evidence, with data needing to converge in a triangulating fashion. "Triangulation" of methods strengthened the research design chosen, as use of a case study design is said to be lacking in rigour (Yin, 2003). Triangulation was used as a technique to provide credible findings as more than one source of informants was used and multiple references can be made to the same topic studied. Methodological and data triangulation were applied by the researcher to provide a more complete picture of the phenomena through use of both quantitative and



qualitative approaches to data collection and analysis (Burns & Grooves, 2001), because such a mix had the potential of addressing the complex nature of this study. Data were derived from multiple sources such as key persons who were knowledgeable on the topic and provided relevant information in real-life settings through individual interviews and focus group discussions. These informants and participants were selected on the basis of purposive and convenience sampling, using multiple perspectives to get a comprehensive view of the phenomenon under study, as well as through use of observation and documents to confirm data collected. These findings were interpreted from two philosophical perspectives obtaining subjectivity and objectivity, as one complements the weakness in the other method used. The researcher personally visited the study sites in order to see the real settings in which services were provided to young people through observing the facilities and reviewing available documents pertinent to the study to draw objective conclusions on the truth.

“Researcher credibility”: Polit and Hungler (1999) made mention of the ‘researcher’s credibility’ as one important aspect regarding credibility in qualitative studies. A similar reference to issue of case study designs was made by (Yin, 2003). The researcher who has background experience in youth training, and ASRH issues during 26 years of exposure in the field of nursing and midwifery and is currently involved in Nursing/Midwifery education as Head of the Midwifery School, served as a board member and resource person on SRH issues, and has made several presentations on the topic in national and international conferences. The topic has therefore been an area of interest due to prior exposure to knowledge in the field of study. Extensive review of the

literature from multidisciplinary perspectives provided further insight and focus. “Peer debriefing” was done as confirmation of the information provided to reflect and confirm accurate findings. Meanings from verbal and written forms were validated, to reflect statements as a true and accurate analysis.

***Transferability*** – refers to the extent to which the findings can be transferred to other settings (Polit & Hungler, 1999). The research settings and contexts were appropriately described and motivation for choice of the two countries and sites within the countries provided within the relevant sections in this Chapter. Descriptive data were provided by programme managers and service providers on ASRH issues within the context of ASRH programmes which provided a comprehensive description of the same issue, and similar concerns: thus judgment and discussions were made along these trends observed for knowledge transfer and application. The same comparable methods of data collection and analysis were used for each country, and further enhanced transferability and comparison of the data collected.

***Dependability*** – of qualitative data “*refers to the stability of data over time and over conditions. It might be said credibility (in qualitative studies) is to validity (in quantitative studies) what dependability is to reliability*” (Polit & Hungler, 1999:306). Dependability in effect is crucial to the credibility of qualitative data. The pre-structured interviews, questionnaires, focus group discussions, and the observational checklist were designed according to WHO standards of assessing adolescent-friendly programmes, and around relevant themes in the conceptual framework. These instruments were subjected

to internal scrutiny during submission of the proposal for presentation to the faculty. As mentioned earlier, the team reviewed the documents and inputs on these were given and the necessary restructuring of the instruments done. Induction plays a central role in a comparative analysis (Valenzuela, 1998) therefore the definitions of key concepts used in the study were opened to revision and clarification in the early phases of the study.

Triangulation of methodology, data collection techniques and data analysis was undertaken in a holistic manner giving a comprehensive account of the phenomena. Pilot testing of the instruments before the main study was carried out, assisted in identifying any anticipated difficulties that were likely to be encountered during administration of the instruments and modifications were made accordingly.

***Conformability*** – refers to the objectivity or neutrality of the data, so as to have an agreement between two or more independent people about the data’s relevance or meaning (Polit & Hungler, 1999). Documented evidences were obtained from the programme managers and service providers to confirm aspects of the phenomena under study. The conceptual framework was used as a blue print for the study, and recurrent patterning was used to identify instances where views, thoughts and feelings expressed by the key informants on the same event or activities, within similar contexts, were reflective of identifiable patterns of the responses emitted from the other informants. “Saturation” – exhaustive exploration of the study was determined by the researcher when the same information, similar ideas, meanings and experiences were provided in different study sites visited in the same country and new information was no longer forthcoming. Content analysis was used to analyze text data such as wall charts, leaflets,

brochures, posters, magazines found in the facilities. Debriefing with project managers was arranged before the researcher left the study sites.

### **3.8 DATA ANALYSIS**

The researcher incorporated an integrated approach to data analysis to communicate the findings of the study. Yin (2003) justified the possibility of having several levels of analysis and interpretation in a case study research. Gerrish and Lacey (2006) further pointed out that case study approaches to research may integrate sampling with data collection and data analysis, each informing the other. Data were firstly organized into manageable forms and transcribed manually according to country as data were collected from Ghana and South Africa. The researcher did a collation of all the responses to specific categories in the study and presented them in three parts. Overlapping views and findings from documents analysis and observations are presented and discussed within the same context. Therefore, the data analysis method ranged from simple to complex and from descriptive to explorative to interpretive data using the conceptual framework developed by the researcher for displaying data across the different categories.

#### **3.8.1 Qualitative Analysis of Data**

Gerrish and Lacey (2006) pointed out that despite the relative lack of prescription on qualitative data analysis there are some helpful principles to consider. Qualitative analysis is described as complex, creative, ongoing, interactive, inductive and reflective (Gerrish & Lacey, 2006). The qualitative aspect of key components of the study involved ongoing analysis of the data from key informants and informants simultaneously, to

embody the conception of life experiences through periodic review of field notes and key findings from interviews, reflecting the perceptions, feelings, attitudes, and opinions of the respondents. The discussions from the focus groups were of a qualitative nature and thus the narratives are provided. The record reviews and accessible documents were subjected to document analysis, based on the literature and protocol provided for this.

Data were analyzed qualitatively through the use of '*Framework Analysis*' in order to arrive at a holistic and humanistic view of the study findings (Gillis & Jackson, 2002). Manual analysis was done by the researcher using the Framework Analysis developed by Ritchie and Spencer (1994). This involves a number of distinct though interconnected stages. Transcripts from the interviews were analyzed under the three programme elements, in separate themes and emerging issues as identified within the themes, in answer to the questions the study set out to answer. A thematic analysis of issues recurring in each study site/sites was done and themes emerging from the various categories of data were conceptualized into meaningful themes on the basis of regularities and convergence in the data. Data were analyzed according to the five stages of data analysis described in the Framework approach by (Ritchie and Spencer, 1994) as outlined by Gerrish and Lacey (2006: 424).

### ***The "Framework Approach"***

- 1. Familiarization** – immersion in the data (example, listening to tapes, reading transcripts, studying notes, etc.) to get an initial feel for the key ideas and recurrent themes.

2. **Identifying a thematic framework** – the process of identifying key issues, concepts and themes and the setting up of an index or framework. This can be used for sifting and sorting data including *a priori* issues (used to inform the focus of the research and the data collection guides), emergent themes raised by respondents and analytical themes that are evident in recurring patterns in the data.
3. **Indexing** – the process of systematically applying the index or framework to the text form of the data, by annotating the text with codes in the margin.
4. **Charting** – data are ‘lifted’ from their original context and rearranged according to themes in chart form. There may be separate charts for each major subject or theme and they will contain data from several different correspondents. This process involves considerable synthesis and abstraction.
5. **Mapping and interpretation** – the charts are used to define concepts, map the range and nature of the phenomena, create typologies, and find associations between themes in order to provide explanations for the findings. This process is guided by the original research questions as well as the themes and relationships emerging from the data.

### **3.8.2 Quantitative Analysis of Data**

Descriptive statistics were used to summarize the data obtained from adolescents through a client exit survey. Data from the questionnaires completed by adolescents were analyzed and presented in a quantifiable form, processed through SPSS 13.0 (Polit & Hungler, 1997). Close-ended questions were statistically analyzed with the use of SPSS. Variables such as age, professional background of key informants, marital status of

adolescents and youths are presented in frequencies, percentages, and averages. Content analysis was used for open-ended questions before analysis. Responses were organized in groupings of similarity in views expressed by the participants. Charts, tables, matrices and figures are created for data display to communicate specific findings of a quantitative nature where appropriate.

### **3.8.3 Final Analysis of Cases: Country Results**

#### ***Case Presentation and Analysis of Country Reports***

Findings of each country are analyzed and presented as individual case reports. A cross-case comparison of the similarities and differences in the data set obtained on the three defined categories of the structures, processes and products of each country setting formed the basis of discussion in the relevant sections.

## **3.9 ETHICAL CONSIDERATIONS**

Research studies with human beings are guided by ethical principles, regardless of the researcher's goal or paradigmatic orientation (Polit & Beck, 2004). Throughout all phases of this study, various structures and processes were put in place to ensure that the rights of the informants and participants were respected and protected. Ethical issues based on the principles outlined by Nursing bodies, the University of KwaZulu-Natal, Research Ethics Committee, the Departments of Health in Ghana and South Africa underlying the principle of beneficence, respect for human dignity and justice were duly recognized and embraced throughout the research process. Furthermore, the standards in the prescribed format of the Ethics Committee were recognized and adhered to in the relevant areas

applicable to the study. The researcher initially submitted a proposal indicating the purpose, aims and objectives of the study as well as the process in which the study would be carried out for scrutiny and subsequent approval by the Ethics Committee.

### **3.9.1 Ethical Clearance and Permission**

Permission and approval to conduct the study were obtained from key persons as indicated below:

#### ***i) The Ethics Committee of the University of KwaZulu-Natal***

Copies of the research proposal were forwarded through the Faculty to the Ethics Committee, including pertinent documents regarding the study, the key informants, informants and the participants. Following approval, permission was then sought from the respective authorities in the studied countries as indicated below before data collection (Annexure 1A).

#### ***ii) The Departments of Health in Ghana and South Africa***

The research proposal for this study was first approved at faculty level before embarking on the data collection phase. Prior contacts were made with persons working in the reproductive health area serving as a link between the researcher and the study areas. The researcher identified these persons in the Ministries of Health in the two countries, and the programmes, through personal contacts already established via Emails and telephone calls during the proposal phase of the project. The approval of the respective National Health authorities was sought in each country through a contact person and meetings with



the Reproductive Health Task Force for adolescents and young people. Copies of the proposal were made available and relevant documents such as participants' information sheets, ethics approval letter and individual letters to authorities formed part of the research package. Permission to gain access to facilities and relevant documents belonging to the programme was requested in a formal letter to the respective persons in charge of such documents (Annexure 1B). Approval to conduct the study with staff members, and clients/adolescents utilizing the services was granted at the Ministry level, by the Director-General of Medical Services in the two countries. Further contacts to the various clinics or centres out of the ministry's domain were made through contact persons using the permission letters from the Ethics Committee and Ministry as references.

***iii) The Programme Managers and Unit Heads***

Permission was sought through the project managers of specific sections through their respective heads to participate in the study. The Heads of clinics, projects, and staffs of the youth centres involved in ASRH services, at the various levels and sites where the study was conducted and other authority figures who forms part of the list of persons were also included as directed by the person in-charge in each country and study site (Annexure 1C).

***iv) The Adolescents and Young People***

Those attending the programmes or utilizing these services, through a participant information sheet informing them of what was involved in the study, their rights as

participants, followed by a written consent form agreeing to voluntarily participate in the study (Annexure 1D).

### **3.9.2 Ethical Issues Addressed in the Study**

Basic ethical principles underlying protection of human beings, as well as the rights of the participants, were recognized and protected in this study. The following ethical issues were noted and observed throughout all the phases of the research, and form part of the information included in the information sheet and consent form provided to the key persons, informants and participants:

#### ***i) The Rights of the Participants***

***Informed Consent:*** The essential elements of the informed consent form provided by the University of KwaZulu-Natal Research Office were complied with according to the prescribed format (Annexure 1D). Informed consent was sought from all the informants and participants included in the study in writing as well as verbally. General information about the nature and purpose of the study was provided including the objectives and contact details of the researcher. This information formed part of the participant information sheet. Adolescents below the age of consent are regarded as a vulnerable age group in research studies (Gerrish & Lacey, 2006). In the case of an adolescent below this, an additional section was included, requesting the permission of the parent or guardian to allow his/her child to participate in the study (see Annexure 1E). The peer educators and youth coordinators served as gatekeepers when the parents could not be

reached. All the other information regarding the right to participate or refuse applies in each case.

### ***The Right to Choose and the Right to Withdraw***

Participation in the study was voluntary and based on informed consent, both written and verbal. Assurance of no harm or ill-effect as a result of participating in the study was given to the informants and participants. Refusal to participate, freedom to choose whether to take part was accepted, and there was no undue pressure on the participants. Selection of the key informants, informants and participants was on a fair basis directed by scientific process. Almost all of them consented except one participant in a family planning clinic who was in a hurry and could not consider the invitation. All persons in the study were not obliged to answer any question they felt uncomfortable with.

### ***Anonymity and Confidentiality***

Steps were taken to safeguard the anonymity and confidentiality of all the informants and participants. All information collected for this study was treated as confidential, codes were used and no names appeared on any of the documents. At the onset of the study those willing to participate were informed accordingly. Effort was made not to interview key informants and informants in the presence of their colleagues, heads of unit, youth or adults attending the center or clinic. All tapes and instruments used during the study were used for the purpose of the study only and will be destroyed after retrieval of the information through transcription and a final report.

### ***Right to Service, Privacy and Benefits***

Participants visiting clinics were allowed to proceed for treatment, services or care without interference. Interviews and focus group discussions were conducted within the normal working days of the facilities. Information was collected at a time convenient for the informants and participants, avoiding disruption of service flow and to conserve resources. A convenient place and time was decided ahead of the interviews, especially those involving programme managers, directors and service providers. The rights to privacy and respect, emphasized in the literature (Goddard & Melville, 2005) as areas of ethical concern were observed throughout the study by selecting an ideal area in the facility for interviews and focus group discussions. The principle of beneficence was adhered to in order to prevent the participants from harm and exploitation. The purpose of the study was outlined, indicating reasons why the key informants, informants and participants had been selected for the study. The information gathered from the study, it is hoped, when disseminated will contribute to programme development and improvement of services for young people.

### ***Protection against Disclosure***

**Key Informants, Informants and Participants:** The ethical implications of the research report were given the necessary attention. The identity of those interviewed was protected in every possible way. An agreement on the basis on which the study would be conducted at the initial phase was made. Permission for subsequent use of the data and approval for reporting of the research findings was obtained. Where mention of a specific content would reveal the identity of the interviewee, the researcher discussed the implications of

this with the person concerned and was told whether to go ahead. In situations where an unintentional reference to a specific project or acknowledgement of source would reveal an identity of the key informant, the researcher ensured that the discussion was done in such a way as to avoid disclosure, whilst providing the findings relevant to the question asked.

### ***Researcher Bias and Power Relations***

“Researcher’s bias”: The development of a theoretical framework, formation of semi-structured questions, and use of an interview guide, set parameters on the topic and were empirical means of avoiding bias or subjectivity. Another technique employed was the use of “bracketing”. This refers to “the process of identifying and holding in abeyance any preconceived beliefs and opinions one might have about the phenomenon under investigation” (Polit & Hungler, 1997:204). Knowledge, theories, assumptions and beliefs on the topic were based on the literature and not the researcher’s personal beliefs, desires, convictions or opinion. This approach was advantageous in reducing the researcher’s bias. The observational aspect of the study was context-specific and a key aspect of the facilities. Attempts were made to observe key research elements in a less obtrusive way during the data collection phase, through a combination of research techniques and professional experience in order to minimize the environmental factors or confounding variables in an objective way (Brink, 2001). Cross checking of observations and interpretation was also done as and when the need arose during the data collection process.

“Power relations”: Human interaction is an intrinsic and extremely important component during all phases of this study. The problem of power relations is common to studies with adolescents, especially where an adult is the interviewer (Grbich, 1999:98). With this in mind, during interviews and discussions, use of good communication skills and rapport when dealing with the informants and participants were developed to minimize differences in status, knowledge or power (Grbich, 1999:98). The role of the researcher was that of a facilitator, guiding and stimulating the discussions in the focus groups through a peer leader, ensuring free flow of communication and an atmosphere of adolescent friendliness prevailed. Ground rules for the groups were established by a trained peer leader in a supportive and non-judgmental way. The researcher recorded the information in some of the focus group discussions and left leadership in the hands of the peer educator or youth representative and only clarified issues when necessary.

### **3.10 LIMITATIONS IN THE STUDY**

The study was conducted in only two sub-Saharan African countries both of which are “Anglo-phone countries”, which means that issues may be unique in Franco-phone or Luxo-phone countries, therefore findings cannot be applied to all ASRH programmes in Africa. In addition, each country and within country differences occur in Africa due to the unique cultural aspects in these countries. The complex nature of programmes required in-depth exploration and time, distance between the study sites required a series of movement and visits to and between facilities in order to collect data; the client turn out was also unpredictable in some clinics and centers; this situation demanded a flexible plan in the event that the data collection schedule became overwhelming. As a

contingency plan, the researcher recruited trained experts in the field (peer educators) to collect some of the data from the adolescents; this may have interfered with the reliability of the data.

A comparative study of a descriptive and exploratory nature is usually seen as a threat to the people providing such a service (Carnwell, 1997). It is evident from the research design that a high degree of collaboration was needed for eliciting responses. A fundamental task of the researcher was to establish a good rapport with key persons to foster cooperation and facilitate data collection, as reluctance to reveal certain information, or unwillingness to participate in the study is described by Yin (2003) as a disadvantage in a study of an evaluative nature. Funders of the programmes visited in NGO settings might dictate particular patterns of operation, so the findings might reflect control by the funders rather than the expected realities.

An accurate and reliable list of ASRH facilities was not available. Snowball sampling was used to access the programmes and required knowledge of their existence. This approach might possibly limit the total number of programmes that were included in the final study. Findings only reflected the perspectives of those studied and does not include the whole population. Another limitation is that bureaucratic procedures, policies and programme design tend to interfere with data collection plans, as schedules of activities already set up by the researcher and school activities such as exams limit the number of adolescents visiting the centres. Convenience sampling was used to access those available for family planning services, antenatal care and recreational centres and the views

expressed about a particular facility might not necessarily mean the overall facility, but would reflect the views of adolescents in a particular facility on certain aspects or components of the services offered. This may vary from one country to the other; hence a comparative view was provided by way of analysis.

### **3.11 Strength of the Dissertation**

A comprehensive review of the literature, relevant to ASRH programmes, adolescents and the health problems encountered by them provided the theoretical foundation for discussion of the Donabedian framework (1980) and WHO's guidelines for SRH for adolescents in country programming (2001) and guided the evaluation of the programmes. A comparative case study design was adopted as it was the most appropriate design to fulfill the purpose of the study. Justification for the research design chosen and each decision made, ensured scientific rigor was maintained throughout in meeting the set objectives and purpose of the study, while at the same time addressing key ethical issues relevant to the population in the study. Use of mixed methods and multiple sources of data, combining both quantitative and qualitative approaches for data collection and analysis, and discussion of the findings were adopted. A thick description of relevant findings, representing themes and emerging issues provided clear details related to the perceptions of key stakeholders and health providers in adolescent SRH care. Additionally, perceptions of the adolescents in relation to the services received and their satisfaction with the SRH services in the two countries studied provided a cross-comparative national representation. A comprehensive discussion of the findings was done at a cross-national comparative level, bringing out the common features,



similarities, differences and uniqueness of ASRH programmes in Ghana and South Africa. Implications of the finding and its applicability to practice including clear and comprehensive recommendations to the various stakeholders and ingredients of a model of SRH specific to adolescents were incorporated on the basis of findings from the study.

### **3.12 CONCLUSION**

A detailed description of the methods of research needed to achieve the purpose and objectives of the study has been discussed. Multiple triangulations were achieved through data triangulation, theory and methodological triangulation (Bless & Higson-Smith, 1995). The research design chosen was neither exclusively qualitative nor quantitative as the study was grounded in both methodological approaches and paradigms. Controversy exists in the literature on the integration of qualitative and quantitative methods within single studies. Polit and Beck (2006), on the other hand justify use of this approach, as a new trend, with enriching advantages in nursing research when striving to understand complex and multidimensional issues. It was therefore incumbent on the researcher to explain her choice of mixed methods and approaches and its appropriateness in a comparative case study. Description and rationale for a specific method chosen and its potential for addressing the research questions in providing answers to the phenomenon under study were justified in the relevant sections of this work. Various scientific measures were put in place to ensure that the methods chosen conform to basic scientific principles for each of the approaches adopted. The most appropriate research design was eventually selected to further examine the complex issues related to Adolescent Sexual and Reproductive Health programmes.

## **CHAPTER FOUR**

### **ANALYSIS AND PRESENTATION OF FINDINGS**

#### **4.1 INTRODUCTION**

This chapter highlights key findings from ASRH programmes in a cross-national case study of two African countries, Ghana and South Africa. The Greater Accra Region and KwaZulu-Natal Province were selected as study sites. Findings presented in this chapter are derived from use of multiple data sources and data collection techniques. Interviews, client exit surveys, focus group discussions, records and document analyses and observation of the facilities studied were conducted. Multiple methods of analysis were used as the findings draw on data generated from both qualitative and quantitative paradigms in research.

The key elements of the conceptual framework served as the frame of reference for analyzing and reporting of each case result within the given parameters (1) the Structure, (2) the Process and (3) the Output (Donabedian, 1980). The WHO guidelines for adolescent SRH (2001) were also integrated into the conceptual background for the study and guided the analysis. Data generated from the interviews, documents and focus group discussions are of a qualitative nature. The framework approach developed by Ritchie and Spencer (1994) was used for qualitative analysis of the data as suggested by Gillis and Jackson (2002). Findings within this paradigm are firstly presented in the form of textual illustrations and narratives emerging from the main themes.

Background information into the initiation of ASRH concept in each country is presented as part of the philosophical components of the structure. This information is of relevance in a case study to illuminate the context in which the phenomenon was originally conceived in each country, for better understanding of the succeeding findings. The quantitative aspects of the study focus on descriptive statistics to compare programmes in Ghana and South Africa. Quantitative aspects of the results are accounted from data generated from the participants through the client-exit survey. These are reported and presented as tables, bar charts expressed in figures such as frequencies and percentages.

Findings from each country are firstly presented as an individual case study to give a distinctive and holistic view of the results as obtained at country level. Presentation of the results from each country is structured around the three predefined categories or programme elements (see Figure 2.1). Each element is analyzed around specific themes and emerging issues within the data throughout the layout of this chapter of the thesis. Key issues, concepts and patterns derived in each theme are presented within the context in which they apply and interpretations for such findings given. The sources of information and associations between themes and emerging issues observed in the data are illustrated in a summary box.

Where indicated, excerpts from document analysis and observations are used in conjunction with the other sources of information as supporting evidence to illuminate key issues of a similar concern, relevant to the themes presented. Those from the focus groups are considered as a component of the overall results obtained from the

“programmes’ output”. Results emanating from the informants in the focus groups therefore formed the basis of cross referencing on key findings from the participants in the client exit survey, to support views accounted for as part of the ‘output’. These are presented within the specific themes emerging from the data.

In summary, a cross comparison is made at country level showing the relationship between the three core elements to give a holistic view of the overall findings. A summarized format of the findings, on the three programme elements for each country is presented in a template form (see Tables 4.1, 4.2, 4.9, 4.10 & 4.11), acting as a guide within which the narratives are applied and interpreted. In this form, each constituent element of the conceptual framework represents the template or comparison matrix for comparative analysis of findings in the two countries in the next Chapter.

## CASE ONE: KEY FINDINGS FROM GHANA

### 4.2 THE STRUCTURE: GHANA

Six themes were analyzed under the structural inputs of the programmes, these are: 1) philosophical basis; 2) demographic imperatives; 3) physical infrastructure; 4) human resources; 5) material resources which include funding, sustainability, complementary inputs and; 6) and evaluation.

**TABLE 4.1: The Structure of ASRH Programmes Ghana: Summary Box:**

Sources	Themes	Emerging Issues
<ul style="list-style-type: none"> <li>• Excepts from key informants</li> <li>• Programme policies</li> <li>• Mission statement</li> <li>• Vision statements</li> <li>• Goals and objectives</li> <li>• Relevant ASRH Documents</li> <li>• Training manuals and protocols</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Philosophical Basis</b></li> </ul>	<ul style="list-style-type: none"> <li>○ <b>International Events:</b> Paradigm shift</li> <li>○ Adolescent-friendly services</li> <li>○ Primary Health Care principles</li> <li>○ Principles of Holism, Totalism, Integration</li> <li>○ ASRH as a human rights issue.</li> <li>○ Economic value and asset</li> <li>○ National influences.</li> <li>○ Cultural values and societal norms</li> </ul>
<ul style="list-style-type: none"> <li>• Excepts from key informants</li> <li>• Documents</li> <li>• Clinic registers</li> <li>• Records</li> <li>• Observation</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Demographic Imperatives</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Target group</li> <li>○ Large adolescent population</li> <li>○ Increasing SRH problems in target group</li> <li>○ Vulnerability</li> <li>○ Exposure to risky behaviours</li> <li>○ HIV/AIDS, teenage pregnancy, abortion, unsafe sexual practices</li> <li>○ Lack of knowledge</li> </ul>

<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Observation of facilities</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Physical Infrastructure</b></li> </ul>	<ul style="list-style-type: none"> <li>○ RCH Unit set up</li> <li>○ Use of existing structures</li> <li>○ Creation of adolescent-friendly corners</li> <li>○ Different levels of development</li> <li>○ Stand-alone structures</li> <li>○ Inadequate structures</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Observation of facilities</li> <li>• Document analysis</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Human Resources</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Staffing component</li> <li>○ Needs assessment</li> <li>○ Capacity building</li> <li>○ Training and orientation</li> <li>○ Partnership - stakeholders</li> <li>○ Multi-sectoral and multi-disciplinary</li> <li>○ Inadequate human resource</li> <li>○ Staff shortage/Attrition rate</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Observation of facilities</li> <li>• Documents</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Material Resources and Complementary Inputs</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Logistical Inputs</li> <li>○ Funding and Sustainability</li> <li>○ NGO financing-Donor-driven funding.</li> <li>○ Inadequate funding</li> <li>○ Lack of incentives, motivation, fund raising activities.</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Documents</li> <li>• Project Reports</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Evaluation of Programme</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Donor request,</li> <li>○ Client exit survey</li> <li>○ Mystery client survey</li> <li>○ Base-line and end-line.</li> <li>○ Not rigorously done</li> </ul>

#### 4.2.1 Philosophical Basis of ASRH Structures

An insight into the theoretical background of the programmes provided answers for the philosophical basis of ASRH structures in Ghana. Various philosophical influences stemming from unfolding events at international and national levels led to a chain of ideas on adolescent health. These form the basis for the adoption of several principles, concepts, values and shared beliefs, evident in programme policies. These are also reflected in statements from key informants and contained in the goals, vision and mission statements of the programmes visited. Key issues emerging from the findings

were: a) paradigm shift leading to change of programme focus; b) creation of adolescent-friendly structures; c) adoption of the “adolescent sexual and reproductive health” concept leading to d) conceptualization of “adolescent-friendly” services at national level; e) Primary Health Care principle; and e) Reproductive health rights and youth-friendly policies.

### ***Paradigm Shift and Change of Programme Focus***

The principal basis for setting up “*adolescent-friendly*” structures in Ghana emanated from directives at the International Conference on Development Population (ICDP, 1994) in Cairo, Egypt leading to a paradigm shift at international level. This spurred an important change in the future focus and direction of sexual and reproductive health service delivery in Ghana. The Planned Parenthood Association of Ghana (PPAG), an NGO-based organization, made the first move to establish ASRH structures in the country. This initiative was revealed in the excerpt below by a key informant in ASRH activities at policy and management level:

*There is a paradigm shift from purely family planning programme. It started in 1986, it first started with PPAG. The Family Planning then started ASRH around 1990. After the Cairo conference, in 1996-1997, it was established and we trained people within PPAG. PPAG initiated the move to Adolescent Sexual and Reproductive Health. We were initially offering family planning services but the youths were not able to access Reproductive Health services as they report on headache and other minor ailments and refuse to talk about the real problem.*

Pre-existing health structures did not include relevant components of reproductive health in the health care delivery system in Ghana as the primary focus of reproductive health services was more generally focused towards the provision of family planning services. Due to previous programme designs and structural layout, issues of accessibility and

openness to report reproductive health problems were encountered by adolescents as explained by a key informant at Ministry level:

*The problem is that most of the hospitals the youths do not have a place in the hospital and the adults look down on them and when you mention sex, they feel the youth do not need to know about these issues. There is lack of freedom, confidence when mixing with adults.*

In effect, problems were encountered by adolescents in relation to their sexuality and reproductive health as they were frowned upon by adults. The excerpt below by a unit manager in a single statement summarizes this phenomenon:

*It looks as if the youth has been sidelined.*

A redefinition of the concept “Adolescent Sexual and Reproductive Health” was acknowledged to suit cultural expectations and values of the Ghanaian society based on several evidences at country level. Reproductive health in broader terms includes sexual health; however, some resistance to use “sexual health” was noted. During the course of the study, it was observed that the programme managers and service providers limited their discussions to reproductive health and the word “sexual” was not mentioned or referred to in definitions and was noticeably omitted in several discussions. The researcher decided to probe further and got the following responses from a programme officer in-charge as below:

*Yes, the use of the term “sexual” is not used in the centers for the youths. The word ‘adolescent health’ is used and there is no emphasis on sexual because adolescent health is part of it. Adolescent reproductive health and development is used instead as some of the members thought we should leave out the word sexual but some NGOs such as UNFPA, PPAG used the word sexual and reproductive health. We (MOH) look at the total health which involves their total health; sexual health is part of health. There is equal emphasis on all aspect of health not necessarily sexual and reproductive health. Adolescent sexual and reproductive health however, forms a large component of Reproductive Health.*



Notwithstanding, sexual health is accounted for as part of the reproductive health of adolescents by relevant stakeholders, respecting cultural values, they thought it fit to avoid use of the term to identify structures for adolescents. This conclusion is supported by statements made by key informants as contained in the following excerpt:

*In Ghana, you can't freely talk about sex. We are trying to break this, any young person can come and we talk to them in the age appropriate language and necessary skills to educate them. In the North of the country, traditionally it was not permitted for young people to speak in public with adults. This created problems with project implementation.*

According to a unit manager, the identification of body parts especially those relating to the sexual organs are done in a manner considered acceptable by society:

*In terms of calling certain body parts, we identify the acceptable words.*

On subsequent analysis of available information, this observation could be possibly attributed to the cultural values and societal norms in the Ghanaian society as discussions of a sexual nature are still not freely and openly discussed. This is supported by a statement from a key informant:

*The area of reproductive health has been a taboo especially talking to young people. They are afraid to tell the doctor the real problem instead they complain of headaches and fever. If they have rashes in the private part or genitals, they refuse to talk about it immediately they see a doctor or nurse, they are afraid to disclose*

It is apparent from the ensuing discussions that cultural values and beliefs had an influence on the philosophical basis guiding the development of ASRH structures in Ghana. Conflicting values and beliefs that are incongruent with programmes' mission seemed to prevail despite the new thinking on ASRH issues as evident in the statement by a nurse-midwife:

*The young people when they see an elderly face, they want to draw back. They can feel uncomfortable in the presence of an adult. Adolescents have a separate entrance to the clinic. Some of the midwives allow the adolescents to use the back door as entrance and exit to avoid them being seen by adults in the community.*

### ***Adolescents as Valued Economic Assets***

The above analysis indicates that cultural restrictions and societal norms do exist on SRH issues regarding young people, based on the demonstration of shared beliefs and values from multiple sources. Nonetheless, there is evidence to support the recognition of adolescents' reproductive health as a valued asset in the Ghanaian society. These excerpts from programme managers illustrate a shared philosophy in ASRH issues among key informants interviewed:

*In every country, the youths are the asset and these are the people who are going to be the future leaders and if they get enough knowledge, they are able to practice the right thing, they will also adopt healthy life style.*

*I think reproductive health has both economic and developmental importance for every nation if it is properly implemented.*

References from these excerpts showed a recurring theme that recognizes the reproductive health of adolescents, deemed to be of economic and developmental importance in Ghana. Adolescents are also recognized as an asset to the country and are perceived as future leaders in the Ghanaian society.

*Adolescents are our future leaders and we need to take care of them*  
(Programme Manager NGO-base centre).

Premium is placed on adolescents' reproductive health through the provision of information in Ghana as highlighted through various concepts and principles identified in the data from SRH documents analyzed during the study:

*To have a well-informed adolescent adopting healthy lifestyle physically and psychologically and supported by a responsive health system.*

(Source: RCH Annual report, 2002:57).

These value statements can be interpreted as part of the philosophy describing the way adolescents are perceived by programme managers, in the context of their reproductive health.

### *Adolescent-Friendly Services*

As a demonstration of these values and beliefs, efforts were needed at country level to specifically resolve issues of marginalization and neglect previously observed in the service delivery area, in an attempt to address SRH problems of adolescents in Ghana in an adolescent-friendly manner. The expertise of trained staff in an adolescent-friendly approach at various levels was required in ensuring appropriate services were provided in an efficient manner as represented in the statement extracted from a SRH document on

Adolescent Health in Ghana:

*These services will be delivered in a humane efficient and human manner by trained, friendly, highly motivated and client-oriented personnel (RCH, Unit, 2004).*

At national level, the programme officer further supported this policy statement as reflected in the excerpt below:

*All our staff members are orientated to be youth-friendly.*

Philosophically thinking, this new concept “*adolescent-friendliness*” formed the basis for conceptualization of new structures at national level in Ghana as to those already initiated by PPAG. A change of focus and approach to service delivery to embrace the concept (ASRH) was acknowledged as relatively new in adolescent health and well-being. This

idea was supported in the excerpt from a senior programme officer at the Ministry of Health:

*Conceptualization started in 1996 by the Ghana Health Services then called the Ministry of Health. The 1st component was in 1999 but the programme was actually launched in May 2001. PPAG the lead NGO started ASRH before the public sector and they have a center for sexual and reproductive health which offers comprehensive services. The programme is called 'Adolescent Health and Development'.*

The above views, as expressed, gave an indication as to the period when official commitment was made to embrace ASRH structures at national level. A comprehensive package was planned so that services can be extended to include a wide range of young persons considered within the definition adolescents. The principles of a 'holism', 'totalism' and 'integration' were identified in the statement made by a key informant as representing the philosophical viewpoint needed to direct services in an adolescent-friendly manner in Ghana:

*We look at preadolescents, adolescents, and young adults. We are looking at the total health of young people. The purpose was to integrate adolescent health into existing services and public health sector.*

### ***Reproductive Rights of Adolescents in Ghana***

The reproductive rights of adolescents in Ghana are recognized as 'human rights' issues in several policy documents in Ghana. It is also included as a major component of the Adolescent Health and Development Policy in Ghana. The following policies, convention and treaties are declared as evidence supporting the reproductive rights of adolescents in Ghana:

- The Universal Declaration of Human Rights, 1948
- The Children's Act 1998

- The National Reproductive Health Service Policy
- National Adolescent Reproductive Health Policy
- The HIV/AIDS Policy 2001
- Second Ministry of Health Five Year Programme of Work (2002-2007)
- Vision 2020 and the Patient/s Charter for the Ghana Health Service

These documents contained sections pertinent to ASRH issues, within which adolescent reproductive health needs are recognized and promoted by all programmes designed for them and were listed among the policy framework. Excerpts contained in the 1994 National Population Policy document in Ghana, recognized young people as having reproductive rights. Moreover, paragraph 7 of the document specifically focuses on adolescents' reproductive rights as follows:

*The promotion of the responsible exercise of the right should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries (A/54/38/Rev.1, Chapter).*

In addition, objective 4.3.7 of the policy reads:

*To educate the youth on population matters which directly affect them such as sexual relationships, fertility regulation, adolescent health, marriage and child-bearing, in order to guide them towards responsible parenthood and small family sizes (section 4.3.7).*

Excerpts from policy statements and guidelines highlighted in key documents and policies provide further supporting evidence at international and national levels adopted

as legal framework which contained values and principles directing adolescent reproductive health in Ghana. The availability of the Government's "Policy on Adolescent" also serves as a framework of reference for addressing adolescents' rights within the domain ASRH programmes as well as other youth sectors. According to key informants, these policies affirm the government's commitment to ensuring adolescents have a right to access reproductive and sexual health services. At national level, available copies of programme policies and standards relevant to ASRH were revised at top management level as indicated by the ADH programme officer below:

*We have the Health Sector programme of work, National RH Policy and Standards, Adolescent Reproductive Health Policy for Ghana, National Reproductive Health Service Protocols, National Training Manual for Healthcare Providers in Adolescent Health and Development (ADH), Brief on Adolescent Health Development Programming, Draft Technical Guidelines on Programming in ADHD. The policy of the Ministry of Health is to have centers in all the districts.*

The national goal of ASRH programme extracted from the SRH Facilitator Guide reads as follow:

*To improve adolescent health through the provision of adequate health information and knowledge which will ensure behavioral change and increased utilization of health services including reproductive health in both public and private health delivery systems in Ghana*  
(Source: Ministry of Health, GHS, Facilitators' Guide, 2003).

Structural support in terms of technical expertise and project initiation are also provided through joint efforts by other bodies as evidenced in the statement by a key informant from a UN based organization below:

*We have operations manuals and handbooks distributed in Government and NGOs. We work with 12 implementing partners, it's quite a big project. We helped Ministry of Health with their manual on ASRH.*

Despite having various policies which favor adolescents and young people at national level, it was however noted that the mission, vision, goals and objectives of ASRH in most government ASRH services visited remains unclear. There was absence of mission or policy statements on site in government centers. The excerpts below from a service provider support this observation:

*There is no specific mission statement for adolescents. We have the client's rights which cover the adolescents as well. The training manuals and guidelines are used by the staff and facilitators.*

On observation of the facilities, NGO-based centers offering services to adolescents and young people had written policies on SRH rights on adolescents put up on visible areas on the walls, whereas this was not the case in most of the government services visited. Given that, the policy environment varied from government programme to NGO-based programmes:

*There is no Mission statement, but our vision is to go out there to train peer educator that can go into the community to educate adolescents and bring them here. Our objectives are the same as that of the Ministry of Health  
(Unit Head, ASRH Centre).*

In addition to these policies, common standards and curricula for ASRH training, guidelines and protocols were developed by the Ghana Registered Midwives Association (GRMA) for use by various service providers in public and private settings.

### ***The Primary Health Care Principle***

A key principle emerging from the data was that of primary health care. Extracts from key informants and the document review support this view. The provision of accessible services on reproductive health was identified as a relevant concept in the primary health

care principle towards improving adolescents' health in Ghana. A commitment on making available comprehensive reproductive health information and services was shared in the mission statement of the ADH Unit which reads:

*To make available appropriate information on young people's health and provide comprehensive adolescent health services including reproductive health*

(Source: RCH Annual report, 2002:57).

The above extracts are derivatives from policy documents, mission statements and excerpts from key informants, identified as theoretical and philosophical bases of ASRH programme' structure reflecting values and beliefs as interpreted within the Ghanaian context.

#### **4.2.2 Demographic Imperatives**

Current demographic data on adolescents served as a catalyst for the development of ASRH centres or clinics in Ghana that would better meet the needs of a specific age group, referred to as adolescents. This need was realized by relevant stakeholders and programme planners in both government and NGO-based facilities. Excerpts from various study sites gave an indication of programmes' focus and the age groups targeted, according to key informants:

*The adolescent friendly-clinic was founded by the "Young and Wise" along with the youths and it started in 2002, targeting the age group 10-24 years. The age range is from 10-24 years; they can freely walk in and make use of any of the services available (Peer Educator, Youth centre).*

A uniform definition of "adolescent" cuts across all the facilities visited in Ghana.

Persons age 10-24 are referred to as adolescents. Some of the programmes tend to drift from their protocols in an attempt to increase coverage by accepting young people within



and below the age group in an attempt to cater for vulnerable children seen as being “at risk” as explained by a unit manager:

*We receive calls from both males and females. The age target is 10-24 years but we also receive calls from above or below the age group.*

Multiple reasons emerged from the data indicating demographic patterns identified by individual programme planners and unit heads as the basis for developing ASRH structures. This initiative was taken in order to reduce high risk factors among adolescents. These were attributed to: a) high vulnerability adolescent population, large numbers of school-going adolescents with SRH problems, b) a high incidence of SRH problems such as: teenage pregnancies, early sexual activities, unsafe abortions, pregnancy related complications including maternal mortality; c) practice of unsafe sex and realization of the risks confronting young people in the era of the HIV/AIDS pandemic and other health risks and; d) lack of SRH information.

### ***Large Adolescent Population/ SRH Problems***

Large populations of adolescents of school-going age were accounted for by programme managers. The associated SRH risks among this age group were a cause for concern according to statements extracted from key informants. A nurse-midwife gave a general overview of the problems observed among adolescents in her community:

*This area is a highly congested and highly populated with adolescents. The programme was established in 2003, two years ago when we saw that there are adolescent problems such as teenage pregnancy, unsafe abortion and its complications, school drop out and drug abuse. This initiative was undertaken in order to reduce the high incidence of adolescent pregnancy and school drop outs in the society. Our target group is Junior secondary schools within the midwife catchment area are targeted at.*

Another service provider working in an ASRH unit located close to a school had this to say:

*The programme was established 3 years ago, because this area had a lot of adolescents attending schools in the catchment areas that we need to solve their problems for.*

Similar concerns were expressed by a programme director giving an insight into the current situation in a university setting:

*The need for the center became stronger for various reasons including the increasing number of student population, overstretched university accommodation, leading to overcrowding.*

### ***High Statistics of RH Problems***

According to a key informant in one of the NGO youth clinics, adolescents accounted for large numbers of those utilizing the antenatal services. Complications of pregnancies were also reflected in the clinic statistics among this age group:

*On analyzing our reports for April-June 2003, we found out that the total number of people who were seen at the OPD was 2637; out of which 619 were young people age 10-24 (23.5%). At the antenatal clinic, 28.2%, 21%, and 20% were figures for youth (teenage pregnancies) seen in April, May and June respectively. Deliveries for adolescent in the above months accounted for 33.3%, 28% and 24% respectively. Most of these clients had caesarian sections for various reasons such as Pre-eclamptic toxemia, fetal distress e.t.c out of this number, 61.5% of them were seen at the antenatal clinic.*

The HIV/AIDS pandemic, high teenage pregnancy and abortion statistics among young people in Ghana further exposed the urgency and need to redirect the service focus as evident in the excerpts from key informants working in SRH clinics:

*The effect of HIV/AIDS on the youth is also quite alarming and we need to do something to save the lives of our young people now and in the future.*

Sexuality is associated with problems among young people according to another key informant:

*The young people are faced with a lot of problems. Their sexual life is creating a lot of problem for them such as unsafe sex, HIV, and teenage pregnancy.*

The justification for the development of a new ASRH programme was based on the account of observation and needs assessment through evidence-based results in a university setting. Use of unsafe methods of contraception as a preferred choice was identified by reproductive health personnel as a concern among the group, as illustrated in the excerpt presented:

*Before the programme was established, a study was done on campus to find out what they know and what their needs as members of the panel are .... Counseling and Placement Centre organized a panel discussion on love, sex and the youth. It was found out the natural method is the most commonly practiced when asked, even this was not properly done.*

Given the HIV/AIDS risk among young people, the findings from the study further demonstrate the use of natural methods of family planning which does not offer protection from HIV/AIDS/STIs. Based on these findings, access to information on SRH was seen as relevant to young people in making informed decisions.

### ***Lack of information on ASRH Issues/Forgotten Group***

According to a key informant, the ASRH needs of adolescents are usually forgotten. This was especially the case in a setting where adolescents are exposed to new ideas that are considered to increase their vulnerability to high risk behaviours. The programme director in the ASRH center interviewed is quoted as saying:

*People don't even think about the University students but they have a high incidence of reproductive health problems because of the freedom for the first*

*time, they are on their own. The exposure of students to foreign cultures, the feeling of freedom from parental control and the insurgence of HIV/AIDS are all concerns. It is now fashionable for students to travel abroad on their own, so there is the need to be knowledgeable on sexual and reproductive health issues in order to make informed decisions.*

Another key informant gave this information with regards to a particular community she is assigned to work with, stressing the need for information on SRH:

*10% of the total population of Ayawaso lack information on reproductive health and lack access as well.*

In view of the above problems reported among adolescents, there was sufficient reason for urgent concerns to address the SRH problems observed among adolescents. This concern was also addressed in a document source from the study site as it reads:

*Recognizing the need to increase its focus on providing services for adolescents, the Ministry of Health (1996) set up a desk on Adolescent Development and Health in the Reproductive and Child Health (RCH) Unit of the Public Health Division (Source: RCH Unit, 2003).*

#### **4.2.3 Physical Infrastructures**

##### ***The National RCH Unit: Setting up of Adolescent-friendly Corners***

The Reproductive and Child Unit (RCU) was then set up as part of the structures of the Ministry of Health, tasked with the responsibility of looking at adolescents' health.

Physical structures were needed to fulfil these objectives. Use of existing structures such as family planning sections to provide adolescent-friendly services were put in place as established in the excerpt from the national manager:

*Ministry of Health is working toward youth-friendly facilities in every region; they will be called "Adolescent Corner" located at the family planning section.*

Currently, use of existing infrastructure such as the family planning section in polyclinics and hospitals as ASRH corners were observed during visits to the facilities. A key informant further explained the purpose of setting up an adolescent-friendly corner:

*This place will give the access to counseling ARH services, it will minimize these problems.*

These structures are observed to be at various levels of development and management.

Adolescent SRH services in Ghana are offered by various organizations in an attempt to complement government's effort in providing healthcare and development to young people.

A multi-sectoral effort from NGO, private and the public sector and religious bodies and communication links was reported by one of the key informants responsible for planning and development in the extract below:

*All structures in the Ghana Health Services are at different levels including human and physical structures. The integration of ADHD programme is ongoing at all levels within the Ghana Health Service, Christian Health Association of Ghana (CHAG), and Society of Private Medical and Dental Practitioners. However, there is now integration of youth services in all the hospital and clinics. We have 51 facilities offering services in ADH and NGOs are involved. There is a link between the Ministry and the region, link between region and district, link between district and sub-district. Facilities are within the sub-district and facilities within the sub districts are managed by community-based organization. There is a hierarchical line of management.*

Academic nursing institutions as well as the private sector are also involved in the provision of ASRH services. The University of Ghana, Legon, recently made a unique contribution towards the actualization of ASRH center within the premises of the University's School of Nursing facility. A document retrieved from a programme planner's office, from a local newspaper (Daily Graphic, 2006) highlighted the following quotes which recognize the opening of the ASRH center:

*A well equipped center to provide sexual and reproductive health and other services for students and staff of the University of Ghana has been inaugurated at the School of Nursing of the College of Health Sciences on the campus of the university. The center would also provide for the needs of young people in tertiary and 2<sup>nd</sup> cycle institutions within the environs of the university. The School of Nursing, the initiator of the project, has named it "Community Based Center for Partners in Health (Daily Graphic, 2006).*

The programme director in the ASRH center was interviewed and also quoted in a document as saying:

*The programme was inaugurated in 2004, opened on the 9<sup>th</sup> of October, 2004. Initially the programme was founded by the School of Nursing, University of Ghana, Legon and sponsored by Engendered Health. It had been a crushed dream of the founders of the School of Nursing to promote positive sexual behaviour of the student and staff.*

However, regarding the setting up of ASRH facilities, a wide range of responses was derived, yielding variations when individual ASRH programmes were initiated in Ghana both in the private and public sectors.

### ***Lack of Adequate Structures***

One recurring theme emerging from analysis of the data was that of adequate structures to deliver ASRH services. Despite the effort made at national level to integrate adolescent health into existing services, proper structures needed in an adolescent-friendly environment seem to be unavailable in most of the clinics visited. On observation, some of the government clinics had specially designated areas for adolescents and young people but no defined or separate unit except for a few. This observation is supported in similar concerns expressed by unit managers:

*We do not have a special unit called Adolescent Health Unit. I am using this room which was part of the family planning section as a counseling room for*

*them at the moment but at the same we refer to this room as the “Adolescent Corner” where we offer ASRH information, education, counseling and advice.*

The approach to service delivery was used as a key determinant for maintaining adolescent-friendliness where such physical structures do not exist as derived from narratives from a unit head:

*We did not have a separate structure but make it in an adolescent-friendly manner to meet their needs. Private midwives who have added ASRH within their maternity homes allocate time for adolescents specifically.*

Inputs such as decorating the environment was considered by a unit head as a way of attracting young people to the facility:

*We are hoping that the center is refurbished and necessary inputs take place for the environment to be friendlier to attract more youth to come for services.*

Moreover, accessing sexual and reproductive health services in Ghana was seen as cumbersome for adolescents and young people due to inadequate structures causing lack of privacy. The excerpts below by a senior programme manager demonstrate this concern:

*I think if the centre was to have its own place out of the centre or out of the office so that they can be comfortable. Sometimes when they see cars, they feel when they are going out somebody can see them and if they pass through the back door they might not know where they are coming from.*

According to a key informant at national level, a joint effort is directed at the provision of ASRH services by government, as they are in the process of establishing more youth-friendly centres nationwide, but, in the interim, service providers were asked to provide adolescent-friendly services where such physical structures are not available:

*A new structure is to be set up for adolescents but it is incomplete. There is no specific structure.*

Reasons for lack of proper structures were attributed to procedural and bureaucratic difficulties, and slow decision making processes at Government level. Slow policy implementation was cited as responsible for the slow development by a key informant:

*There is slow pace of implementation at levels and reporting on ADHD programme activities is not adequate. The bureaucratic processes at the Ministry might take time to initiate this process.*

On observation of the facilities, the establishments of ASRH programmes and centers are actually in the pipeline in some areas. The distribution of adolescent centers is reportedly uneven as some areas do not have adolescent-friendly centres as yet.

#### **4.2.4 The Human Resource Component of the Structure**

##### ***Staffing Components for ASRH Implementation in Ghana***

By virtue of their practice area, public health nurses and midwives were identified as the first group of service providers that adolescents encounter when suffering from SRH problems. The human resources were in some cases provided by the Government through the use of existing structures such as hospital clinics. Nurse/midwives, public health nurses in the private and public sectors are the frontline service providers of ASRH in the hospital and clinics where such services exist as explained by a senior manager:

*Nurse-midwives are involved in ASRH service delivery; other nurses in government establishments are involved in adolescents, midwives, nurse-midwives.*

Psychologists and doctors are used in cases of referral for adolescents needing expert attention as evident during the interview with key informants:

*We have all types, a full complement of staff, psychologists, medical doctors, peer educators, and counselors.*



Major issues identified in terms of the human resource components were: a) training needs of ASRH personnel due to lack of knowledge and skills on ASRH; b) capacity building; c) orientation on contemporary ASRH issues such as “adolescent-friendly” service; d) review of existing curricula, integration of new concepts on ASRH; and e) development of protocols, manual and guidelines for use by forefront ASRH personnel and other stakeholders.

### ***Training Needs of ASRH Personnel***

Lack of knowledge and skills on managing ASRH issues presented to service providers was identified during the needs assessment. Self-directed models were developed for the training and orientation of midwives and frontline staff to better equip them on ASRH issues as evident in the statement from the training coordinator of midwives:

*Before adolescent reproductive health started there was a study, a needs assessment. It was realized that adolescents used to visit the maternity homes asking for services but the midwives did not have knowledge and skills in ASRH but Maternal and Child Health (MCH). After that a training was self-directed in ASRH issues, it was not formal, it done by self-directed to learn seven models after which they come together (midwives) for peer groups to share experiences and problems on the models, they had facilitators visiting them. Midwives were trained as facilitator.*

The results from the above needs assessment provided a background for the identification of knowledge deficits observed when dealing with adolescents. The need to upgrade knowledge and skills of personnel in ASRH was apparent in the findings as endorsed in the views expressed by a key informant:

*You need to have some kind of training to understand better the way young people behave. So that is why the whole staff has to have orientation in adolescent sexual and reproductive health matters.*

### ***Capacity Building and Manpower Development***

Programme managers were confronted with the problem of preparing staff that can provide adolescent-friendly services. In-service and pre-service training and orientation of front-line care providers were part of the Ministry of Health's capacity building strategy towards proper delivery of ASRH services as explained by the programme director:

*We are now training health care providers to offer services in a friendly manner not only curative services but preventive services as well. ASRH services were concentrated in the health care services at first but now we go to the school health clinics and school health nurses give services and counseling.*

### ***Staff Orientation and Training***

A change of attitude towards adolescents was reported after orientation on contemporary ASRH issues by a training coordinator:

*The staff attitude towards the youth has been improved through orientation and in-service training conducted for staff members.*

The Ghana Registered Midwives Association (GRMA) was also involved in restructuring ASRH service delivery among its members by training and reviewing the curricula through funding to increase coverage as buttressed in the excerpt by the training coordinator below:

*We received funding, to train all midwives about 500 to increase coverage. Numerous numbers of programmes were implemented with 20 districts in 100 communities of the five regions in the country including Accra.*

After receiving training on ASRH, nurses are allocated to work in clinics or hospitals to address adolescents' concerns and needs. This explanation was given by a nurse-midwife who had undergone ASRH training and was now in-charge of the unit:

*The programme started 2004, after the workshop on ASRH, 5 nurses was trained in several batches and I was transferred to this hospital.*

Orientation workshops and training were also used as a medium of exchange of new concepts such as ‘adolescent-friendly’ services to all relevant stakeholders. Adolescents also received training as peer educators. A youth-friendly approach to services was to be adopted by personnel involved in the welfare of young people as revealed during an interview with the training coordinator for SRH:

*A series of orientation and training were given to both medical and paramedical staff on Adolescent Sexual and Reproductive Health and on how to understand and handle the youth in a more friendly way. After the staff training, another opportunity was opened for our facility to select twenty peers, age fifteen to twenty two (15-22 years) to undertake an intensive training as peer educators and non-traditional condom distributors.*

#### ***Partnership with Relevant ASRH Stakeholders***

The key strategy used in Ghana towards the development of human resources in adolescent-friendly initiatives was through partnership. A concerted effort was made to involve various sectors and institutions providing SRH services to adolescents and young people and was not only limited to the health sector. Data from key informants in both government and non-governmental institutions highlighted the need for partnership in a joint implementation drive between the different bodies. According to a key informant from a UN Agency project, technical support and funding was provided to actualize this plan:

*The modus operandi, we identify partners and build their capacity and implement with them. The strategy was partnership. We identified ASRH with CHAG, National Population Council, Ghana Registered Midwives Association (GRMA), Federation of Female Lawyers in Ghana (FIDA) and build their capacity, we resourced them and enable them to implement their projects. PPAG, MOH also asked for financial assistance. We are also assisted Ministry of Education, Ministry of Employment and Youth in manpower development.*

### ***Multi-sectoral and Multi-disciplinary Approach***

NGO-based organizations, UN agencies, government, the private sector comprising of private practitioners and midwives in the community as well as religious bodies and adolescent representatives among others emerged as active forces for their involvement in ASRH according to a key informant responsible for planning:

*We had discussions with those in government institutions, quasi sector and tertiary institutions.*

This is in process and is ongoing through collaborative effort. Notwithstanding this, identification of gaps in policies and laws protecting adolescents was reported. The following quotation was retrieved on site from a recent Policy and Advocacy Strategy document to support the need for such partnership with the legal representatives in Ghana:

*From an analysis of the laws and policies on ASRH, it is obvious that there is a gap between the de jure framework and de facto legal protection of adolescents. There is also a gap between policy and implementation. Whilst Ghana is complying with some of its international and regional obligations on ASRH, it is to a large extent not fulfilling its obligations (AYA, 2004: 76).*

Lobbying was used to bring on board the legal arm to review existing laws, in line with policies protecting the SRH rights of young people and offences committed against them. Training was offered to the legal representatives on existing laws and contemporary ASRH issues in a form of partnership as explained by a resource person for ASRH projects in Ghana:

*We succeeded in forming partnership with National Population Council and Federation of Female Lawyers in Ghana (FIDA) challenge with them but knew the laws but do not have training in adolescent sexual and reproductive health but were later trained.*

Politico-legal consultations were also held to orientate lawyers into ASRH issues and the legal framework within which such policies operate.

### ***Inadequate Human Resources***

One recurring issue with regard to human resources was staff shortage. Staffing problems are experienced as a setback to the implementation of programme activities. The Ministry of Health facilities usually have one trained public health nurse or a midwife assigned for the provision of services to adolescents. Staff members have been transferred to other areas, some of them are leaving the country and thus the staff shortage is creating a problem for future ASRH implementation. The following quotes by respective informants in the service delivery settings highlight this problem:

*We are having problems with staff, in 2001, 3 people were trained and also in 2004 they received training in RH but they travel or some are transferred*  
(Unit Head, ASRH clinic).

*Four staff members were trained for the center, but just one or two members of staff are attached to the center, midwives/Public health nurses*  
(Unit Head, ASRH clinic).

*There is only one member of staff attached to this center. More staff should be trained, one specifically for the Adolescent Development Clinic to join me*  
(Unit Head, ASRH clinic).

*One of our weaknesses is staffing strength. At school level, a team of about five people are involved in the running of the programme but unfortunately some of them would be leaving*  
(Programme manager, ASRH center).

This problem was identified in the NGO programmes as well as one of the key informants expressed problems with staffing especially with the peer educators:

*The peer educators, they are few, money is spent to train peer educators then they leave. Sometimes getting dedicated young people to work at the community is a problem. The Network group cannot cover all aspect of the community. They drag their feet when you want to implement SRH programmes. The drop out rate of*

*peer educators, if the parents are transferred, or the uncle sends them to school to another community. They are always on the move. They do not remain a peer educator forever, he has ambitions, goals and he has to move on. They help for a while. We keep on training and training them and they go away.*

#### **4.2.5 Material Resources**

##### ***Funding of ASRH Programme***

Data from the study sites indicate that the financing of ASRH programmes in Ghana is mainly through UN Health related Agencies such as UNFPA, UNICEF, DFID, UNSAID, DANIDA, PATH, Policy-Project Futures group and other NGO-based projects as African Youth Alliance (AYA), IPPF, Pathfinder funded by the Bill Gates Foundation. The Christian Health Association Ghana (CHAG) provided funds for health institutions strictly owned by churches. Excerpts from the data from key informants' supports these claims as below:

*AYA was the founder, the project lasted for 5 years, it started in August 2000 – September 2005. A partnership was formed by UNFPA and two other NGOs in the States.*

*We received funding from government, UNFPA for 2 years, AYA support for 1 year. We also receive money from development partners such as UNFPA, UNICEF, Church of Jesus Christ of Latter Day Saints, USAID, DANIDA, Pathfinder, Ministry of Health, and Ghana Health Service. UNFPA initially funded the programme and funds from the RH votes were also obtained.*

*PPAG is an NGO who collaborates with Government. The main funder is IPPF, UNFPA, DFID and others.*

On analysis of the data, the African Youth Alliance, PPAG and UNFPA were the most cited sources of funding. Almost all of the government ASRH facilities and NGO-based programmes visited, were either donor supported or had at one stage received funding from a donor organization for the programme to take off.

### ***Inadequate Funds and Logistics***

Funding issues were highlighted as both a barrier and challenge by key informants in Ghana. Funding was recognized as a problem at both national and programme level and emerged as a common feature identified in all the interviews conducted as it cuts across all areas of programme development and implementation. A recurring theme extracted from the statements of key informants was related to material resources, inadequate funds and logistics to run the centres, according to a key informant:

*There is no regular source of funding and inadequate funding contributing to slow programme development and implementation levels. The available resources are provided by Government of Ghana mainly, UNFPA once provided some support but handed over to the African Youth Alliance Project.*

*We are experiencing difficulties in running the center effectively. All the necessary resources to enable the youth to visit the center are not yet available. Financial, logistics and other supplies will make accessibility easier as some of the villages in the catchment area are far away (Key informant, youth centre).*

Every one of the ASRH centers or clinics visited cited insufficient or lack of funding as a major limiting factor to programme development and implementation as illustrated in direct statements made by programme managers below:

*The major problem is funding. Programme development is slow as there is lack of funds from the sponsoring organizations.*

*Another thing is that most of the programmes do not have the money, because if you want to reach young people, the logistics involved, if no money is available it is kind of difficult to reach to the young people. On the part of the youth, we are kind of involved but most often because of finance, most of the programmes are not able to cover a whole group of people as expected.*

According to programme managers, lack of funds is causing a hold up on implementation and is hindering the active progress of their work. The following quote represents the

view of a programme manager of a newly opened ASRH centre in relation to logistical problems:

*The library set up is not yet completed for effective learning, no books, shelves, tables or chairs. There is lack of computers in the center, the youths get disappointed when they come and cannot access some of these services.*

### ***Sustainability of ASRH Programmes***

With regards to sustainability of ASRH programmes, key issues emerging from the data are: 1) community support; 2) collaboration; community ownership, fund raising activities; and 3) donor requests. The role of community support in sustaining ASRH activities in Ghana was illustrated in the following excerpt by a key informant:

*The community is our strength, once we get the support of the community; we see how best we can work with them. There is collaboration with other NGOs and CBOs, interested individuals in youth work. Strength is an outstanding reputation in providing SRH. Long term sustainability is constantly provided accurate information before withdrawal from the community and we hand over what ever programmes we have for sustainability to the community or government agency in the community to take over from there.*

Income generating activities, fund raising activities through the sale of condoms to sustain some of the project work was mentioned as ways in which programme managers and providers raise funds to run their programmes, as indicated in the excerpt provided by a key informant from an NGO youth centre:

*Funds are raised each year we have a fun festival. The committees in the programme write to donors and sponsors for financial support. The other groups, they collaborate with us (Franchise) and sometimes give us money or materials to use. They sell condoms and get a commission on each condom they sell as a form of motivation. Another form of motivation is distribution of bicycles given by JOICFP (Japan). Tee shirts are given to motivators.*



#### 4.2.6 Programme Evaluation

The results revealed that routine monitoring and evaluation is mostly carried in NGO-based programmes such as PPAG through baseline and end line evaluation or donor-based programme in this case, AYA. Perspectives from the various clinics and centers visited in terms of programme evaluation were more on the basis of donor request and institutional framework according to unit heads:

*Evaluation is done on a monthly basis. Monthly reporting is done to match against target that we set. We use the same tools that are used for the baseline (Impact) gaps left are then filled into the programme (Key informant, NGO youth centre).*

*The adolescent programme – evaluation was by the IPPF, regional office conducted an evaluation end of project. We do a PPAG Mystery Client Surveys where someone goes with a problem and see how the concerns are addressed if there are gaps we now have to address them. We conducted a baseline study before we start the project and at the end we conduct end line survey. Baseline – before we first look at it and then the needs assessment, we design the programme to address the identified needs of that community and then we go back to conduct an end line survey and to compare the results. We also evaluate the adolescent programme through exit interview where a young person visits the clinic and is asked later on how it went on. We now get information from these and can help you to put things together. These are monitoring tools to see how we are functioning (Key informant, NGO youth centre).*

The above extracts were provided by the key informants from the same programme which is funded by several donors. On the basis of information received, the following techniques were identified as evaluation tools for monitoring ASRH activities from statements obtained from key informants, mostly NGO-based programmes:

- Client Exit Surveys
- Base-line and End-line Surveys
- Mystery Client Surveys

On observation, use of research as an evaluation tool, was only made mention of in one of the NGO based centres, as supported by excerpts from the project manager:

*We do research as a way of finding out their knowledge level and the appropriate approach to deal with their problem is planned.*

Government programmes that received funding from donors are evaluated on the request of the donors at differing periods of time as derived from statements during the interviews of key informants:

*Assessment of the center was done in 2004 and 2005, 2004 by AYA and in 2005 by the Government (Unit head, government centre, funded by AYA).*

It is apparent from the findings that donor funded programmes are the ones monitored or evaluated at specific periods. Rigorous evaluations of ASRH programmes are yet to be done as indicated by a key informant at Ministry level:

*We are yet to do a country evaluation. The last regional resource team for ADHD was trained in May, 2005.*

The purpose of evaluations done was basically for the provision of information. These were not clearly explained by service providers in some facilities and documents on this were not easily accessed.

## 4.3 THE PROCESS OF ASRH PROGRAMMES GHANA

### 4.3.1 Technical Style: Theoretical Framework/Models

#### *Theory-Based Interventions*

Use of theory-based interventions aiming at behavioural change, were reportedly adopted in the youth centres. Concepts such as socialization, participation and volunteerism were identified in the statement from a key informant involved in programme planning and development. References are however made to concepts and principles such as *socialization, participation and volunteerism* and the *self-care model* reflecting derivatives from existing theories and models identified in the literature. Below are excerpts from two programme managers who were the only ones who showed knowledge of the concept:

*Theoretical framework or theories is from what we were taught. Facilitators books, mode of conduct, reaching to people. The intended outcomes are aimed at behavioral change. It is expected that after discussions they can pick out something. How do we know? After discussions, we decided to share experiences and some youths explained how they can now freely talk to their parents about sexual issues. The key concepts are: socialization, participation, and volunteerism*  
(Key informant, NGO-based youth center).

From a theoretical stand point, conscious use of theories or an articulated theoretical framework in ASRH service delivery is non-existent in the government sector and is not a common feature in most of the programmes visited. In fact, few programme managers attested to the use of a theoretical framework in guiding their services. An atmosphere of unfamiliarity with the use of a theoretical framework to guide ASRH service delivery and practice was demonstrated during the study by a key informant:

*.....so more or less, although we have not specifically put it down but it looks like Dorothea Orem's self-care theory guides our practice*  
(Key informant, University youth center).

The Planned Parenthood Association of Ghana has an established youth centre and ASRH clinic and offers multi-faceted services. This unit is identified as a model in place for young people and was used as a standard for the development of other ASRH centers in Ghana, based on findings from a programme director at Ministry level:

*We work closely with PPAG. We sent our people to catch a glimpse of what PPAG is doing. Staffs at national and lower levels are involved. We use their staff for training of our own.*

This is supported by another programme director below:

*Government sends national service personal paid by government, when there are some training programmes on ASRH, they invite us to work with them.*

Information on the above theme was limited and did not yield many answers.

#### **4.3.2 Programme Strategies**

##### ***Information, Education and Communication***

Findings indicate that various information sources are involved, through employment of a wide range of channels for dissemination of information about the activities of the facilities. Combined multi-media awareness through use of the mass media, posters, stickers, “Dubars” which are community gathering, peer education, health education talks, book sources, educational approaches through schools and the community were used as a way of advertising and providing information regarding ASRH knowledge and skills according to key informants in a youth centre programme:

*Adolescents get to know about the services through the media, brochures and fliers, posters, stickers, peer educator in the community selected by the community. Whatever information they receive and books they read in the library, the knowledge derived from them they pass on to others. They refer them to the center. The drama group also advertises the programme, out reach programmes. Advertises on TV and radio, a cartoon advertise on the use of condoms, educate*

*them on condom before distribution. Condom distribution is done by peer educators in the community. Advertisement is done in schools, in churches, within the community, through peers who know about the programme, health education programme, talks, distribution of condoms and by staff members.*

Help line services are provided in case adolescents want to make phone enquiries, curiosity was also reported as a way adolescents get to know about the services offered according to a peer educator:

*A commercial to advertise the programme is in the pipeline; all our brochures have the helpline numbers. The adolescents get to know about the services through youth classes that are held, through distribution of pamphlets, film shows, and cassette on STI/HIV/AIDS. Out of curiosity, the adolescents enquire about the programme.*

Outreach activities were also used as a means for information, communication and educating adolescents on ASRH issues. A peer educator from a youth centre explains how they carry out these activities:

*We also go on outreach programmes, in the project, letters come from other people requesting us to talk to them. We visit the schools, then groups e.g. drama, choir, media group, art committee group, sister's group – they all reach out to young people. The media group tells the people about the center, they are volunteers provided with a car, brochures and they distribute them. The drama group also writes letters to different institution to tell them they are coming. The drama and the media group will talk on the same topic". We deliver messages in the clinic, school talks, churches and peer education. We formed adolescents peer groups to sit and discuss, go into communities and schools to give talks.*

A public health nurse attached to one of the youth centres located within the clinic premises explained the effort made to reach out to sensitize adolescents and communities:

*We go to schools and talk to them and if they are interested, they come to the maternity homes. Community sensitization is also done, we also have sign boards. Services are offered in both outreach and static points.*

Sensitization and awareness-raising were used as promotional strategies. This promotion strategy was explained by another service provider in a University youth setting:

*We are planning an outreach within campus, we want to mount stands for every hall during their hall week celebrations. We have also realized that we need to create more awareness, so we are planning to write to the radio Universe to create more awareness among students and the community. The next milestone is setting up of the hotline services. We have peer educators in each hall of residence. They do motivation and refer students to us.*

### **4.3.3 Types and Levels of Service Delivery**

Various levels of services are delivered according to service providers. These include: a) preventive services at primary, secondary and tertiary levels. The level of service delivery of ASRH activities varied between facilities according to a key informant at Ministry level:

*The levels of service delivery are - Preventive services – primary prevention, secondary prevention, tertiary Prevention. Service delivery are: promotive services, clinical services, and rehabilitative services. Some of the adolescent centers do well in the static and others in the outreach, others in both static and outreach. They (service providers and center managers) are advised to start with what they feel more comfortable with.*

ASRH service providers in Ghana encounter young people in a variety of settings such as hospitals, polyclinics, clinics, youth centers and schools through static and outreach activities. Two types of service delivery for ASRH were identified: a) static – those provided in the centres or clinics and b) outreach – those provided to adolescents in schools, churches or community level as indicated by the programme director:

*The process is two way: (1) outreach and (2) static. The outreach depends on the strength.*

A comprehensive, integrated and participatory approach to the service delivery is adopted at static levels. Referrals are also done when necessary attention is required. Antenatal visits remain the dominant ASRH services patronized by pregnant female teenagers in the clinical settings as reported by key informants in the clinical areas:

*We deal with antenatal care, postnatal care, family planning, HIV counseling and education, teenage pregnancy, sexual abuse, assault, rape, STIs prevention, health education talks are given in the communities and schools. Some are referred by doctors with a particular problem*

*(Nurse-midwife, Government ASRH clinic).*

Differences were observed in the types of ASRH services provided. Different types of services are offered according to the type of facility and programme design. NGO-based SRH clinics seemed to offer a more inclusive SRH package than the government services as is supported in the excerpt below:

*We provide information on adolescent pregnancy, peer education, voluntary counseling and testing, pre-natal test (Pregnancy test), F/P, ANC/PNC. Counselling is given on menstrual cycle, management of STIs, general developmental changes. Counseling services is offered on this to help them make decision concerning their sexuality and reproduction*

*(Nurse-midwife NGO-based ASRH clinic).*

Pregnancy tests and emergency contraception are available in the family planning clinics. Males are offered reproductive health services in the area of testicular examination to rule out abnormalities such as cancer in some facilities such as the PPAG clinics. Due to the programme design, antenatal and postnatal services were observed to be excluded in the package for young people as explained by the nurse-midwife in-charge in an NGO-based clinic:

*We treat minor ailments, treat STIs, VCT/FP services, emergency contraceptives, abortion and post abortion counseling is done. There are no antenatal or postnatal services here, the other centers take care of this aspect. They work with teen mothers. We offer counseling, pregnancy test, High vaginal swab, BSE, testicular examination.*

Some aspects of SRH services needed by young people are not provided in some clinics.

One recurring issue in the interview was lack of abortion services at clinic levels.

The abortion law in Ghana restricts the provision of abortion services to adolescents except on a therapeutic basis. According to a key informant from an NGO-based clinic,

therapeutic abortion is only offered according to clinic protocol. Adolescents needing abortion services are sent to the main referral hospital as supported by excerpts from key informants in both the public and private sectors:

*We do therapeutic abortion and refer them to Korlebu Hospital (main referral hospital) for further counseling and abortion services. The therapeutic type of abortion we only offer to those who already have problems. Termination of pregnancy is not provided to others and they are referred to the main teaching hospital. Post abortion care is done but no abortion care and they are counseled and abortion laws in Ghana restrict these (Nurse-midwife, ASRH clinic).*

*Services are not provided in the area of post abortion and abortion at the moment, no antenatal care or postnatal care. We are planning to give immunization and VCT counseling when we have the necessary resources and logistics (Key informant, youth centre).*

### ***Types of SRH Problems Reported by adolescents***

According to service providers, the health of adolescents and young people in Ghana is threatened by multiple health problems affecting their sexuality and reproduction. The most frequently reported SRH problems at the clinics are notably problems related to: a) vaginal discharges, STIs; b) teenage pregnancy; c) menstrual disorders; d) contraceptive problems; e) rape cases; d) masturbation doubts and wet dreams are concerns for male adolescents as provided in the narratives from service providers:

*Common problems are vaginal discharges, they want to know what to do, and also the choice of contraception, they want to know about HIV/AIDS, painful menses. Physical assessment is done and they are referred to the hospital if there are any serious problems that we cannot cope with*  
*(Service provider ASRH clinic).*

*In this area, teenage pregnancy is the most common problem reported followed by rape and assault. The most common problems are teenage pregnancy and abortion. Over a thousand adolescents reported at the ANC and labor ward. At age 19 years there are some adolescents who have had three children*  
*(Service provider ASRH clinic).*



*They call in to talk about relationship problems, menstrual cycle, masturbation, abstinence, sexual harassment, rape, abortion and other sexual and reproductive health problems. They are referred to a sessional counselor on a one to one basis if there are unresolved issues needing special attention (Peer educator, youth centre).*

According to the service providers, adolescents visit the SRH facilities with a wide range of interrelated problems needing solutions. These are health-related. Relationship problems are also reported, as well as social problems which may directly or indirectly be seen as contributing to reproductive health risks identified during consultations with service providers as contained in the statements below by key informants in ASRH clinics:

*Most of them who reported here are for preventive measures. Some are having boyfriend problems and are afraid of their unfaithfulness. We provide information on STIs/HIV/AIDS, teenage pregnancy. Those who are sexually active, we give protection messages for them. The school ones, that is, those going to school are enlightened so they seek contraceptives and also seek doctors for treatment.*

*The most common problems here are boyfriend and girlfriend problem, lack of education, and early sexual activities. When they come here, at age 16 or 19 years, she has had two to three children.*

Exposure to pornographic materials and sexual experimentation also emerged as areas of concern. According to the service providers, the community is now referring disciplinary problems among parents and their children to the facility. This is apparent in the responses given by service providers with regards to service delivery below:

*The problems reported by the adolescents at this center are: lack of parental care, peer pressure, lack of education, sexual experimentation, watching of pornographic films, they do not get the right information, they are shy to come for condoms.*

*Other problems such as having a friend of the opposite sex is giving them problems at home with their parents so the parents come to see us and ask us to intervene, we go in and talk to the adolescent and explain to the parents as well to*

*resolve the matter amicably. They have individual discussions and we refer them to the counseling unit if they do not want to go to school.*

The absence of social workers and shortage of staff in most of the centers is giving ASRH service providers in the clinical settings an additional workload. Health care providers are now given the additional task of intervening in parent and child conflict or misunderstandings as they have to intervene and give advice to parents and the adolescents on social issues as well at clinic level. ASRH concerns for both males and females differ in some respect. Whereas female adolescents were observed to make use of contraceptive services and paid visits to the antenatal and post-natal clinics, utilization of ASRH services for males is linked to specific issues confronting them such as condom use, wet dreams and masturbation concerns as indicated by a nurse-midwife:

*The males have been buying condoms but it is more of the females that are reporting. Occasionally, the males do come and get some form of information. The males asked questions on masturbation and wet dreams.*

#### **4.3.4 Strategies and Approaches to Service Delivery**

Peer educators identified with strategies relevant in adolescent teaching. The contents are selected according to the relevance, needs specifications, cultural specification and age appropriateness:

*Services are provided according to age structures, cultural specifications, and other peculiarities as may be found in a catchment area. When it comes to educating the young people, we select topics and based on their age, we look for another convenient topic to look at for that day. We use the space around the main hall on the corridor outside for the older ones*  
*(Peer educator, youth centre).*

Segmentation according to interest groups using different approaches was reported by a peer educator:

*We segment the audiences. They are handled as a different group with different approaches and interests. "There is DSTV which serves as attraction to the center, they come and give the approach. Those who come to the library, we call together and give education.*

ASRH services offered by peer educators in the youth centres are basically for recreational and educational purposes. Peer educators have a limit in their roles in the facilities. Health related problems are referred to nurses in the clinics, and trained counselors are responsible for specific cases needing counseling on a one-to-one basis.

*It varies, it depends on the nature of the problem. If clinical, we refer to the nurse to provide services that are available, if not the sessional counselor has a one-one discussion with the person. A trained counselor deals with the major challenges the peers cannot deal with (Peer educator, Youth centre).*

In the clinical settings, adolescents who report SRH problems go through routine history taking as part of the unit protocol. The excerpts below by nurse-midwives gave a clinical perspective to ASRH procedures in one youth clinic which is part of an NGO-based youth center with multi-faceted services:

*We address these problems by asking them questions on the problem such as, their last monthly period, how long have they been sexually active, age, partner and then give them, we deworm them and give syndromic treatment and then they come for follow up visit then a high vaginal swab is taken, they are encouraged to complete the treatment and abstain from sex during treatment, bring their partner for check up if possible (Nurse-midwife, NGO-based Clinic).*

*When they come with a problem personally, we take them to the counseling room. Those who need treatment are sent to the doctor. After counseling you give them if they need follow up services, you ask them whether it would be okay to visit them in their homes. After getting their permission then we pay them a follow up visit (Nurse-midwife, Government clinic).*

Different approaches are used depending on the situation. Referrals are made for specific needs related to health or needing expert attention or are health related to the appropriate personnel.

### ***Approaches and Methods to Teaching/Learning***

A wide range of teaching methodologies, strategies, interventions and approaches related to adolescent teaching and learning were adopted at the clinics and youth centers visited. Sexuality and reproductive health messages, HIV/AIDS prevention, behavioral change and communication, condom use among others are provided through focus group discussion, demonstration, lectures, film shows, drama, songs, role plays and games in order to achieve the programme objectives as described by a key informant in a youth centre programme:

*We have focus group discussions, lectures, film shows, variety shows – talent shows, film shows and games. (on the way), drama, songs, and a game called “Journey of hope” in which there is an ocean with a lot of crocodiles e.g. representing diseases such as STI/HIV/AIDS, what are your hopes and aspirations as a young person, what would you do in the midst of the crocodiles in the ocean to make your vision materialize. The options are you either chose the faithfulness boat, the abstinence boat, or being faithful with condom use. You put a ladder to work on, do not condemn anybody as anyone can drop into the river at anytime. It’s not easy working on the ladder.*

Use of role play, drama, scenarios, outreach talks, peer to peer teaching, counseling, hotline services are all examples of techniques used:

*The main hall is used for discussions. We have the Pick and art. This task, which contains pieces of papers and what is on it. You act it out. For example, role plays like talking like the president, or a pregnant woman, just to entertain them. You ask them (older adolescents) to demonstrate how to use a condom then we ask more to do it again then followed by questioning (Peer educator, youth centre).*

Youth-friendly approaches are used in the dissemination of information and messages on ASRH. Life skills training and its components and values are also built into the programme activities according to a peer educator:

*One of the major strategies we use is Life-planning skills. This is a curriculum that has been structured. You have a group of young people with topics such as self esteem, sexuality, relationships, decision making. The young people facilitate the sessions or the staff who have received such training. Thirteen topics are included in the manual. Values, decision making, male/female reproductive system, physical and emotional changes during adolescence, communication, rape, sex, gender roles and stereotypes, teenage pregnancy, basic facts on HIV.*

Various changes have been made in programme design and implementation in order to make services attractive to adolescents and young people. Interactive approaches, behavioral and psychological dimensions are included in teaching activities:

*We organize on Valentine's Day a programme for the young people as they misconstrue the real meaning of Valentine's Day, as a day for just indulging in sex. Majority of the adolescent and young people age group are misled and tempted on this day (Nurse-midwife, ASRH clinic).*

*Trigger movies are some of the ways in which we address SRH problems on all the various SRH topics such as STI/HIV and afterwards, a discussion using the interactive approach through counseling is used. What is good for the client is reinforced. It is a multisectoral approach we use to entertain them to attract them. They are asked to discuss at the end what they learnt from the film and to come up with lessons they have learnt. At the end of it, there are questions that would come up for discussions (Peer educator, youth centre).*

Creativity and innovation formed a key attention-getting strategy in programme direction. Skills development, sports and recreational activities are also included as part of the package for young people visiting the center as reported by a programme director:

*There are various groups in the center. 1. The Drama Group, 2. The Music Group and 3. The Choir and Band. They are trying to launch a cassette.*

Programme managers and peer educators in an NGO based ASRH project addressed the practical problems affecting the particular community in which they were working.

Information is gathered on the problem and this is used as a teaching-learning and information dissemination platform as described by a key informant:

*One of the strategies we use to educate the peer is through community drama, we find out what contemporary SRH issues that pertains to each community, then come up and sketch the drama around that particular issue and we go back to the community and in the form of a 'Durbar', we perform to the listening crowd and then after that a resource person will come and throw light on the performance and the community is also allowed to ask questions that may be bothering them, and these questions are addressed by the resource person.*

### **Who Does What in the Programme?**

#### ***Roles and Functions of ASRH Service providers***

Various categories of service providers are involved in the provision of ASRH services. Nurse-midwives are mainly found in the clinical service area, while peer educators, youth volunteers and counsellors are in the youth centres or attached to the clinics with provision for youth activities. The roles and functions of ASRH programmes are not only limited to adolescent sexuality and reproduction but have noticeably extended into a multi-disciplinary area of work. Peer educators are involved in several ASRH activities. They are used mainly for outreach programmes in the communities. They also play a role in condom distribution at community level. Some are involved in peer education in some of the youth centres visited as explained by the programme director:

*There are peer educators at the community level. We have two types of peer educators: (1) non-Traditional Contraceptive Distributor – are those that distribute condoms to sexually active youths. The youths have discussions with at least 15 people in their group on agreed periods on when they should meet and topics discuss for the day are decided upon. (2) The Behavioral Change Communicators (BCC) promoters, these two groups are referred to as peer educators. For outreach programmes, the peer educators in the communities*

*organize their outreach programmes if they need medical support then they refer to us.*

Adolescent participation and involvement is noted mainly in the youth-centre based programmes visited. According to a key informant, youth representative bodies are set up to advocate on behalf of their peers and to plan the activities of the centre:

*The Youth Action Movement is the volunteer wing of the association. Their role is to advocate for SRH educational services and to give advice to the association. The governing body of the association has a youth representation in it. Three of them, each zone has a youth representative – Southern, Northern and Middle Zone. All the concerns of the young people are addressed through these bodies. The center has a Youth Advisory Board made up of young men and young women-odd number. They plan activities for the centers and the approaches, their educational level all are in school.*

One of the managers at top level in a youth center at university level pointed out that clinical skills are also acquired by nurses involved in the project as peer educators:

*Adolescents are involved in the running of our programme, some of the peer educators are students at the university and some of them are nursing students, this exposure will also help them in practical aspect of their studies such as physical assessment of clients. The students are involved in physical assessment practical and they examine youths in order to acquire techniques and go to the field.*

#### **4.3.5 Challenges in ASRH Programme Implementation**

Numerous challenges confronted service providers in implementing ASRH activities in Ghana. According to data sources, key issues related to programme implementation hinder innovative approaches and successful accomplishment of programme objectives. The following themes were identified on analysis: 1) Inadequate or lack of funds; 2) Rejection and negative perception of programme by communities; 3) Expanded roles of service providers. Lack of funding has been addressed in the preceding discussion on the structural components of programmes.

### ***Negative Public Perception of ASRH programmes***

Establishing ASRH programmes' activities was met with criticism, disapproval, suspicion, doubt and mistrust. Key issues identified were doubt, skepticism, lack of understanding and knowledge on the ASRH activities was displayed by communities.

The following statements below were pointed out with concern and dismay and illustrate the prevailing atmosphere and frustrations felt by some service providers as below:

*With the criticisms around, peoples' perception about the programme that children are being spoiled. Teachers and parents as well as leaders should be enlightened and they should know whether what they are taught or not, it is good to know and they should get it from the correct source. Sometimes those who come around say we are helping the youths to be promiscuous, whilst they are socializing they end up with boy and girl relationship (Peer educator, Youth centre).*

*The adults, some of them feel we are misleading, if they don't have the information on what we do here they should enquire. Those who do not know what the programme is about they kind of have a negative perception about the whole programme. But those who understand they accept and encourage their children (Peer educator, Youth centre).*

The above statements reveal a breakdown in communication and information dissemination on the existence, mission, objectives, and activities of ASRH programmes within communities. One of the questions raised by the researcher in the statement of the problem was that of not knowing how they operate and the processes involved in the running of ASRH activities. These verbalizations emerging from the interview phase tie up the concerns highlighted by the researcher previously in the problem statement.

### ***Gender differences/Gender Issues:***

The service providers in some of the centers observed that there were more adolescents boys utilizing the services provided than girls and reported poor participation of females.



*The male-female ratio is 3 females to 1 male. Sometimes, the ratio is female adolescents, 4 girls – 1 boy. The male turnout at the clinic is low – about 18 monthly, for the females it's high, about 45 (Key informant, Youth center).*

*Both sexes come together. The girl-child participation was quite low. The Sisters Club was created - the idea behind this was that young ladies were not coming to the center, the balance was not right, the boys were more and the girls activities, the boys outnumbered the girls (Key informant, Youth center).*

### ***Reasons for low Participation of Girls: Cultural Challenges***

Gender roles had an influence on participation of the girl-child in ASRH activities. This concern is illustrated in the statements below giving an explanation as to why female participation was generally low in Ghana by a programme director:

*The upbringing of the Ghanaian girl child in many homes is such that they are confined to taking care of the house chores and helping their mothers to keep the home after school, besides they fear that when they mix with the opposite sex during their adolescence could lead to early sexual contact and its accompanying consequences is usual put in the girl child. But the "guys" are most of the time allowed to go out and socialize with their peers. This factor as a matter of fact builds a low self-esteem in the girl child and makes her not confident enough to visit places where young men spend their leisure time. Lack of equal rights between males and females in many Ghanaian homes is one of the reasons why the adolescent girls have low levels of confidence in matters regarding accessing reproductive health services. A typical Ghanaian parent who is not rich enough to take both his girl child and boy child to school but could afford to educate one will not hesitate to give the opportunity to the boy child. He has the belief that the boy will continue to stay in the family but the girl will grow up and get married and be a part of a different family.*

Cultural differences are recurring themes observed across all components of the programmes. Sensitivities in issues regarding gender inequalities in the Ghanaian society with specific reference to the girl-child were pointed out by service providers. Gender-discrimination limits access to SRH information and services especially with the females. Cultural orientation leading to gender bias and inequity was cited as a reason why there is low female attendance in a recreational center according to a key informant:

*Cultural issues differ from place to place and the girl-child is mostly affected. Efforts were made to talk to opinion leaders to modify them (culture) so that can help the girl-child. We talk to the teachers, pastors, priests, and religious organization to bring out problems of adolescents.*

Various measures were undertaken to facilitate access of female adolescents to the services offered in ASRH. Strategies to attract all sexes to patronize the facilities were also put in place as explained in the excerpts below by a nurse-midwife:

*The response for the male adolescents is good and they are outspoken. The females are generally a bit shy so their response I would say is not so bad, above average but not as good as the males. The males are outspoken. For the females we do one-one counseling and we observed that they prefer talking to their peers. This brought about the sister's group which was set up to encourage female participation in the programme.*

### ***Problems Encountered by Service Providers***

The period of adolescence is a transition period in which young people are faced with developmental as well as physiological problems. Service providers expressed several problems encountered working with young people. Shyness, interest in television instead of messages provided, disturbances, truancy and other behaviours associated with teenagers:

*Working with adolescents is a bit challenging, because you actually have to get the information from them. They are shy, let them come freely and express themselves (Nurse-midwife, ASRH clinic).*

*Some of them when they come and want to watch TV or video, they feel that they know and they do not want to listen, they feel they already know. The television is on all the time, some come purposely to watch the television or play games or some come to the café. Some of them come and then stop coming to the center. The little kids come to look at the pictures and disturb others who are trying to read. They sit anywhere as there is no special partition for the different age groups here (Peer educator, youth centre).*

One issue of serious concern which emerged from the findings relates to missing out from school work. This is creating a problem among the adolescents, the school and service providers as mentioned by a nurse-midwife:

*Some children leave school and tell the teachers they were at the center when asked. There is a register, they read, school children come and she has not been going round to school, she tells the school teachers and they allow her to come during break or after they close. Morning and in the afternoon schools will report after school. The Head master complained about it, that they were missing school, so we decided they should come after school. They talk to them at school.*

#### **4.3.6 Barriers to ASRH Implementation in Ghana:**

Data collected from key informants such as service providers revealed that the socio-political, cultural, religious beliefs and values and structural contexts have an influence on the success or failure of ASRH programme implementation in Ghana.

##### ***Socio-Cultural and Religious Issues***

Analysis of the findings revealed socio-cultural disapproval and taboos' restricting sharing SRH information with young people prevailing in Ghana. Promiscuity of adolescents and young people was blamed on the provision of ASRH information as evident in the extracts from service providers below:

*Firstly there was rejection from the communities; people initially because of religious and cultural sentiments were not allowing the youths to access the service we provide but that particular issue was dealt with when we formed the advocacy group. In new communities the parents are skeptical about you educating their children about SRH issues.*

Religious and moral issues in the provision of ASRH services in Ghana were identified during the study as conflicting with church teachings and morality. Abstinence among

young people who are unmarried is promoted on religious grounds in a clinic run by one of the churches as verbalized by a key informant:

*Some religions do not encourage the use of contraceptives such as condoms. Even some of the youths questioned us on the issue of promoting sexual immorality when they see PSD and NTCDs distributing condoms. The attendance of Maternal and Child Health Services has been very encouraging from the day of opening, but family planning services initially posed a big challenge since the community members thought that the church has nothing to do with family planning practices. However, with strong determination and effort we have managed to erase this misconception totally from the minds of the community folks. The emphasis is on morals, and Christians being unmarried, why go into sexual activity?*

Discussing SRH matters with young people is seen as a culturally sensitive issue as illustrated in the extracted statements from the data obtained from programme managers and service providers. Societal norms surrounding ASRH issues came out as a key challenge. Shame and fear of adolescents being seen patronizing an ASRH service or visiting an adolescent center is illustrated in the statement of a service provider:

*The Nurses they meet here are the same people living in the community so the adolescents are ashamed to come to the clinic. The adolescents come once in a while. They are shy to come maybe they will meet relatives here. Sometimes they come and ask questions and go. They are shy, they hide their family planning card and feel shy to come to you and tell you their problem. The atmosphere is not conducive for them so they want to sneak in quietly; they might bump into their relatives and are shy because they do not want them to know they are involved in sexual activities.*

SRH was initially fraught with controversies from various stakeholders at different levels. Relationships between parents and adolescents, service-providers and adolescents, and the community in general came up as an issue of concern in the following discussions with service providers:

*Conflict between parents and adolescents are causing serious challenges for young people. A lot of barriers have been created for youth services and this is time for us to remove the barriers and welcome them the way they are. Lack of*

*provider-client communication, poor treatment by service providers, unexplained procedures, lack of privacy and confidentiality, provider, teacher, and community attitudes about youth and sexuality must be reformed (Nurse-midwife, ASRH clinic).*

#### ***Inadequate Physical Infrastructure***

A common feature shared by most of the government centers or clinics is that of improper ASRH structures. One service provider lamented over inadequate structures causing lack of privacy during service delivery, and made this report:

*There is no privacy here to interview adolescents. They are shy to express themselves about certain issues so we adopt friendly attitude towards them.*

#### **4.3.7 Response to Programme**

Both positive and negative responses were accounted for in the findings extracted from key informants on the response to the programmes. Low patronage was reported in some of the clinics and efforts made to resolve this problem through outreach activities.

*The adolescents do not come here; they always expect me to come to their houses. They don't care much about certain things (Nurse-midwife, ASRH centre).*

One nurse-midwife was disappointed by the poor patronage at a clinic as she reported:

*The response is poor, unless I have to go and meet them. I usually go to the community to talk to them about early marriage, teenage pregnancy in the community. There is poor participation, they do not come, they are not serious about it because of the illiteracy they don't catch up with the training and do not understand what they tell them. Because of the difficulty in getting the young people to come to the center, a general announcement is made with a moving van early in the morning or in the evening.*

Extra efforts were made by service providers to increase coverage. Making the service attractive to young people was seen as a way of increasing the turn out. Another service provider in one of the centres located within the hospital clinic had this to say:

*We need more activities to bring them together, you won't get them easily, and unless you make an activity to bring them together then you can get them to talk about problems or concerns they want to know about. They want to come to watch other movies but we tell them we don't deal with things as such.*

Issues of privacy and cost of telephones was restricting usage of the hotline facilities provided by a youth centre. A service provider felt that more needs to be done on information sharing and programme expansion and she expressed her views on this:

*The response to the help line counseling programme, they are excited but they complain about the phone charges and the inconveniences, issue of privacy to make calls is an issue as some of them do not have access to personal phones and call from telephone booths which are expensive.*

School activities affected the use and time services are utilized by school going adolescents. In one of the ASRH clinics, the nurse-midwife reported on adolescent participation at the clinic as good:

*The response is good but during school hours very few come to the clinic. The number depends on a lot of factors about 30-60 are seen in a month, this varies.* Another service provider had this to say about the response to the services:

*The utilization of services is sometimes poor and sometimes good. We have about 5 -30 adolescents visiting per month. This figure ranges.*

#### **4.3.8 Programme Strategies: Overcoming Barriers**

Programme development and implementation was threatened by a host of problems. Key strategies identified were: 1) community knowledge; community consultation, and participation; 2) advocacy, information, education and communication (IEC); and 3) collaboration. Community empowerment and lobbying, joint consultation and community sensitization and awareness, were also employed as a means of creating a common understanding and goal sharing platforms to gain communities approval. The following

excerpts below highlight the various strategies used to resolve some of the problems identified:

*.....these and many other factors prompted the formation of the girls group with an aim of building their levels of confidence and self-esteem through sensitizations, mentoring among other strategies. But prior to that, we formed the 'Parents Advocacy Networks' in all our project communities. Their capacities were built to identify some of the Adolescent rights that were not respected and advocate against these practices (Programme director, NGO-based Centre).*

Parent advocacy, network groups, religious advocacy, traditional advocacy groups were established in an effort to resolve some of the challenges confronting programme implementation according to excerpts from key informants in an NGO-based programme:

*We established the "Network Groups", they advocate for ASRH. In each project intervention area, there is a network group of parents (15) on average. They as parents receive SRH education, and their duty is to educate other parents thus creating an enabling environment for the young people. The group (1) is called "Parent Advocacy Network". Then we formed (2) the RAN "Religious Advocacy Network" made up of pastors, Imams, Heads of Fellowship within the church, leaders of fellowship groups, women, men, and youth. We also have (3) the 'Traditional Advocacy Network' – In the community, sometimes the Chief Linguist, the Chief is a member, Queen Mother, Family and Clan Heads, the Assembly Men, that is the government structure. They also advocate among themselves.*

Coordination and networking between government, private, and NGO based institutions seemed to exist at some levels. Supportive structures existing in the communities were seen as links by the service providers for successful ASRH implementation in Ghana. Community support, parental inclusion, school assistance, outreaches and peer support are strategies used by managers and service providers to involve the community into its activities as explained by a key informant:

*We visited them constantly at their homes, churches, schools and sometimes during child welfare clinic and Out-patient department (OPD) talks. These strategies used are to ensure that the community members believe and accept concepts and importance of these services.*

**4.3.9 Success Stories: Accomplishments, Strengths:** Programme managers and service providers considered as success stories those accomplishments that are attributed to programme gains in terms of benefits and impact on young people's lives: 1) Behavioral changes, 2) skills acquisition, positive change in community attitude towards the programme, condom purchasing and use, are identified by service providers as success stories. Evidence of success stories differ from facility to facility and programme to programme. Behavioral changes, life skills and skills acquisition were highlighted by a key informant as she explained some of the successes achieved:

*What we consider success stories at this moment, is when someone wants to commit suicide and call to say they okay and have changed their minds and then abortion, the person makes a personal decision after exposure to counseling. In terms of individual success some of the adolescents have been involved in leadership, computer training and they know how to type, write and many more. They are now speaking on air for example, and representing adolescents at conferences when previously they were shy before coming to the programme, because of these issues they were shy when put on the spot but you have to demonstrate your ability now. Being able to talk to other young people is a success. We also distribute condoms and they buy.*

Skills acquisition, personal decision on the future, condom sales, among other accomplishments at programme level were recollected and accounted for as successes by a nurse-midwife:

*A certain boy accepted ownership of pregnancy, follow up of the girl till safe delivery, and also, parents sought help in child care when their child is truant. One girl dropped out of school and I talked to her because her father rejected her and she started schooling again. Another girl wanted to do hairdressing but her mother forced her to do catering instead as she herself is a caterer. This brought about difficulties in the relationship between mother and child. I had to go and talk to the girl and mother in order for her to see things from the perspective of the adolescent. A 19 year old boy also wanted to be a mechanic and we identified someone who can give him the necessary skills development.*



Another key informant had this to say:

*It was not easy at first. Adolescents were shy, but now they can approach the midwives for education, counseling and other services and we are happy about the progress.*

Successes are accounted for in different areas of accomplishments ranging from responsible behaviour, change in attitude, skills, trade and knowledge acquisition; openness about reproductive health concerns and seeking help from service providers. Some of the success stories are unique to a particular facility or setting, others cut across the various services provided.

*Most of the youths who come with their parents after discussions with them, they might be a communication breakdown between parent and adolescents but afterwards the parents learn and even bring their child to be taken care of by the center. They recommend a change in the child's position, that they are knowledgeable now and have gained confidence in themselves (Key informant, ASRH centre).*

*When they come to the centre, after the life planning skills, they are less shy. The programme brings out the talent of people because here you can see young people talking freely. The participation, education, getting choices and making choices here, training is also part of our strengths (Peer educator, youth centre).*

Awareness creation, community sensitization and participation were recounted as success stories by a peer educator:

*Yes, one unique success story is the Advocacy network that we formed. Initially there are some communities that were hard to penetrate. These communities are now cooperating. The Muslim community, it is difficult with them on ASRH issues but with the formation of the advocacy group, the communities are now cooperating.*

A positive response to the programme was lauded as a success and referred to as good by service providers. Others attributed a success story to unique circumstances experienced in the following quotes by key informants:

*The response rate of the adolescent to the programme is encouraging, they are more aware, education will help them to reach them. I will say the response rate is good so far.*

*The Helpline – we have more calls. The life planning skills changes young people's lives. Well for instance, the groups that we have are very successful stories we have. The Drama group kind of reaches or had an impact on the youth. The choir, also because of inspirational songs in schools, and at the programme, through this, more people kind of come to understand the concept of the youth center.*

Exposure to ASRH information is seen as empowering young people as to their reproductive rights of information to issues on sexuality, reproduction and freedom in other respects and change of lifestyle as acclaimed by key informants in the excerpts below:

*The interest of the students, previously they were shy to talk about these things, now they are empowered they approach the counselors willingly. Information is now catching on well as they are now asking questions. They ask questions about sexual urges, because of civilization now people know more.*

*I'm impressed about the way the young ones come freely for condoms and the reduction in teenage pregnancy in the community.*

Through counselling, drugs, sexual risk taking behaviours and related problems brought about a change among young people as indicated by a service provider:

*The ANC record for 10-24 years, four youths insisted on having abortion, with counseling and encouragement, they went through a normal and successful delivery. Two young males were on drugs, they've stopped taking drugs now after counseling and support. They have learnt a lot about the consequences of unprotected sex and premarital sex. Those who cannot abstain promised to practice safe sex.*

The use of peer educators is seen as a potential resource in spreading ASRH information and services delivery in Ghana to their fellow age group. Use of the Youth participation

approach to their health and wellbeing impacted on service utilization and information sharing and was perceived as a success story by a key informant:

*The youth involvement or participation has to a large extent led or contributed to the massive patronage of the adolescents in our facility for services.*

Detection of an abnormality during physical assessment by nurses was given as an example of a success story by the programme director in a nursing centre:

*We have added physical assessment as part of the services we offer in our programme. During physical assessment, one of our students who was a client at our ASRH clinic was having congenital abnormality of the heart without knowing this and it was picked up and she was then referred to the Cardio-thoracic Unit.*

According to one of the Heads of the Adolescent Unit within a health center, the effort of establishing a center and adopting the ASRH concept was innovative, as her personal contributions as the head of the project, helped in the actualization of setting up the new unit.

*The center and design itself is a major accomplishment. This even opened the mind of some people. In 2003, our hospital was selected as an "Adolescent-Youth friendly Center" under AYA-CHAG sponsorship.*

#### **4.3.10 Suggestions for Programme Improvement**

The perceptions of ASRH personnel regarding ways in which the services can be improved yielded various suggestions: a) physical and human input and b) programme design and methods of approaches used.

##### ***Physical and Human Input***

The following excerpts dealt with suggestions and recommendations made by service providers directed towards structural inputs and logistics improvement in the facilities:

*A large center is needed to accommodate more adolescents; this structure cannot contain more people. If they able to maintain the facilities that we have and then improve upon the programme that are held within and outside, I think that will help (Key informant, ASRH centre).*

A demand for structural adjustments in order to provide a more adolescent-friendly service, in a user-friendly atmosphere was identified in these responses derived from the interviews by key informants:

*We should have different cassettes in the centre as well as film shows on adolescents' health. Through viewing the films they would understand it better. Those who are not educated would follow the picture and understand. You can also explain to them whilst watching. This approach will prompt them to come to the clinic. A lot of educational films are needed to enhance behavioral change. We need to equip the community centers to offer similar services.*

### ***Changes in Programmatic Approach***

A programme manager in one of the youth centres had doubts about the effect on ASRH activities in terms of behavioral outcomes and challenged existing methods and approaches used in teaching and learning in these institutions. He demanded visible evidence of programme impact in measurable forms as verbalized below:

*There is the need to take a critical look at what is the best approach. We need to do a serious analysis as to the impact the programme is making to make them smart. There has been an instance wherein a peer educator has made a girl pregnant. We begin to ask if it is worth the salt. What is happening with the information they are receiving? That is something we should begin to look at. HIV – the issue of HIV, the knowledge is so high but we need to know what they (adolescents) actually know, and though the prevalence is dropping and 90 % are knowledgeable about HIV, what do they know? Effort is made, but there is a point in time when the young people are coming for emergency contraceptive pills which mean they are having unprotected sex.*

Regarding the public's perception of ASRH programmes, a call for demystifying ASRH was made with concern by a peer educator in a youth centre in a single statement:

*We have to demystify the facility!*

The education of parents was suggested in providing basic education in the early childhood years and the involvement of relevant stakeholders in ASRH programme development and planning was also suggested by a service provider:

*..... but I think another hurdle they have to deal with is also educating the parents. Some of the parents are ignorant, if the parents know; they can start the basics before they go to school and hospital. The opinion leaders in the communities should participate in adolescent sexual and reproductive issues.*

**Table 4.2: Programmatic Element: The Process (Ghana).**

SOURCES	THEMES	EMERGING ISSUES
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Documents</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Technical style:</b> Theoretical frameworks and models</li> </ul>	<ul style="list-style-type: none"> <li>○ Orem self-care theory</li> <li>○ Not clearly described, concepts: socialization, volunteerism</li> <li>○ Non-existent</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Documents</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Information Strategies on Services and Activities</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Mass media - TV, DSTV, radio, hotlines, film shows, advertisements, brochures, cartoons, pamphlets, posters, stickers, sign boards.</li> <li>○ Educational – library, schools, communities, outreach programmes, reading materials, books.</li> <li>○ Health education - Peer educators/volunteers, staff members, churches, health talks, Durbars, community gatherings,</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> <li>• Documents</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Types and Levels of Service Delivery</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Primary – preventive - promotive</li> <li>○ Secondary - clinical – curative.</li> <li>○ Tertiary - rehabilitative</li> <li>○ Static and Outreach.</li> <li>○ Types of problems <ul style="list-style-type: none"> <li>- Multiple, interrelated</li> <li>- STI/HIV/AIDS, teenage pregnancy, rape, unsafe sex</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Approaches to Teaching and Learning</b></li> </ul>	<ul style="list-style-type: none"> <li>○ Multiple/combined approach</li> <li>- Interactive approach</li> </ul>

		<ul style="list-style-type: none"> <li>○ - Role plays, discussions, participatory, Age appropriateness</li> <li>○ Coordinated, Segmentation</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> </ul>	<ul style="list-style-type: none"> <li>• Approaches to Service Delivery</li> </ul>	<ul style="list-style-type: none"> <li>○ Comprehensive, Integration</li> <li>- Adolescent participation</li> <li>- Needs specification Referrals</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> </ul>	<ul style="list-style-type: none"> <li>• Interpersonal Style</li> </ul>	<ul style="list-style-type: none"> <li>- One-to-one counselling</li> <li>- Client centered</li> <li>- Culture sensitivity</li> <li>- Adolescent-Friendly</li> <li>- Roles and Functions</li> <li>- Education, treatment, counseling, Advocacy, medical, preventative</li> </ul>
<ul style="list-style-type: none"> <li>• Excerpts from key informants</li> </ul>	<ul style="list-style-type: none"> <li>• Challenges and Barriers</li> </ul>	<ul style="list-style-type: none"> <li>○ Religious, socio-cultural, gender-differences</li> <li>○ Response</li> <li>○ Positive and negative</li> <li>○ Behavioural changes, other areas.</li> <li>○ Success stories</li> <li>○ Suggestions: Structural improvement, logistical, monitor programme impact, changes in approaches.</li> </ul>

The structural and process components of programmes in the findings are interrelated in several aspects as information obtained in one component covered some aspects in the other. The recipients' reactions or responses to the structural and procedural input were accounted for in this section. The output component of Ghana is presented below.

## FINDINGS: THE OUTPUT GHANA

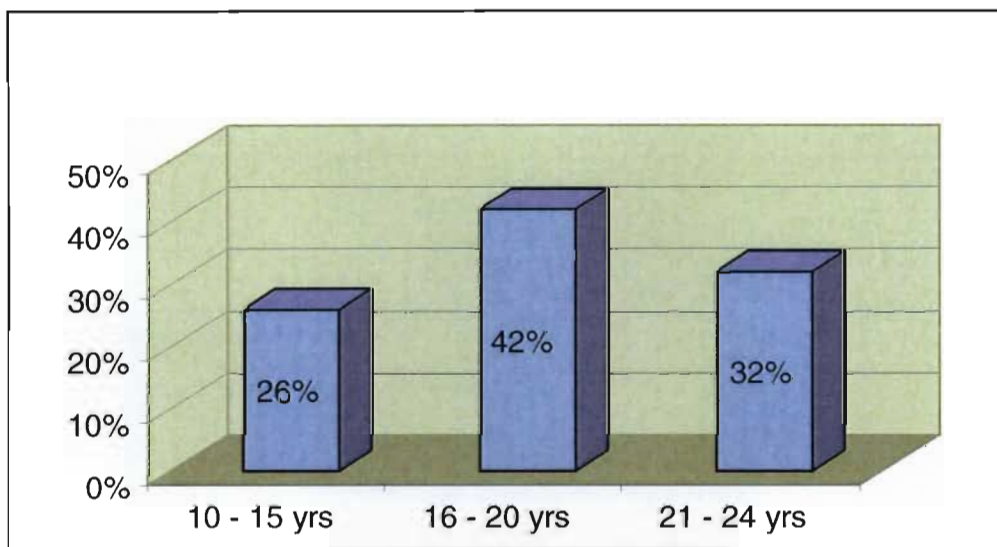
### 4.4 RESULTS: CLIENT-EXIT SURVEY

#### 4.4.1 Socio-Demographic Data of Participants

One hundred adolescents from SRH programmes in Ghana participated in the client exit survey through the use of a semi-structured questionnaire. Variables such as age, gender, marital status, educational status and the type of facility visited were included in the socio-demographic section of the instrument.

#### *Age Range of the Participants*

On analysis of the findings, the ages of the participants ranged from 10 to 24 years. Age 10-15 accounted for 26% of the sample, ages 16-20 years constituted 42%, while participants within the ages, 21-24 formed 32% of the total sample (see Figure 4.1).



**Figure 4.1: Ages of the Participants (N=100)**

### ***Gender and Marital Status of Adolescent Participants***

In relation to gender distribution, out of a total number of 100 participants, females constituted 59%, while males accounted for 41% of the participants. With regard to marital status, the majority of adolescents, 83%, were single, while 17% of them were married. Out of those who were married, 16% were females, while only one male participant was married (see Table 4.3).

**Table 4.3: Gender distribution and Marital Status**

<b>Gender Distribution</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Male	41	41.0
Female	59	59.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

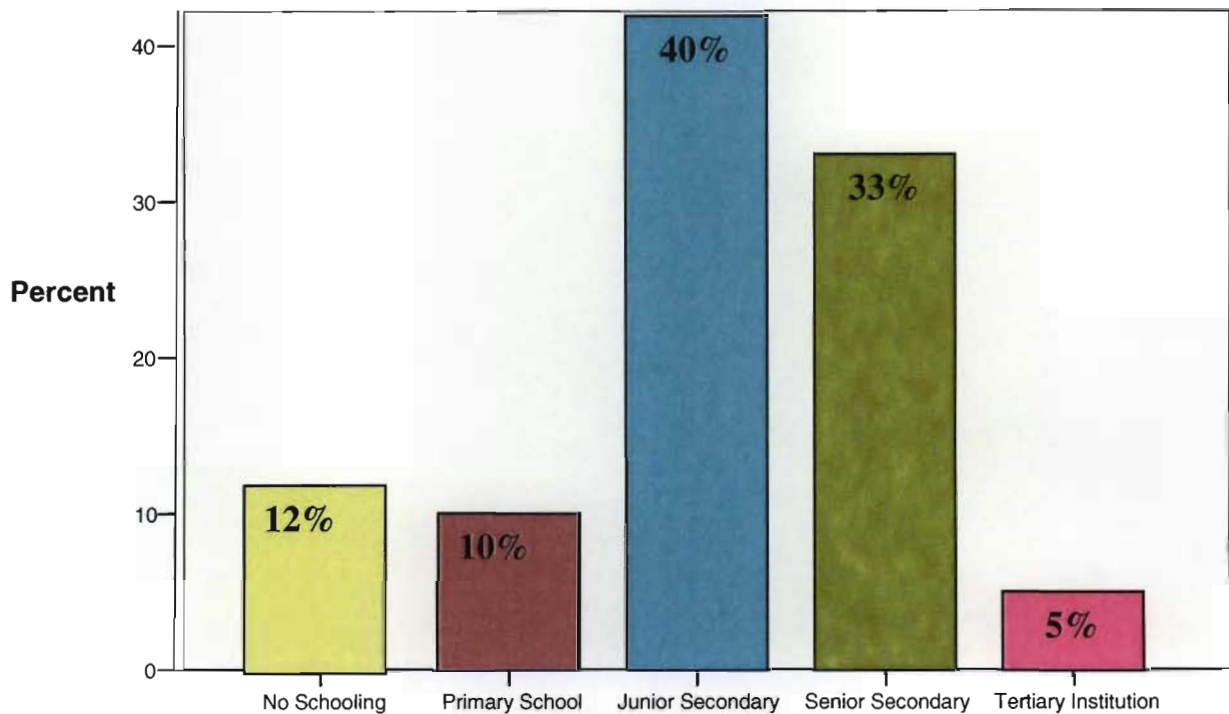
  

<b>Marital Status</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Single	83	83.0
Married	17	17%
<b>Total</b>	<b>100</b>	<b>100.0</b>

### **Educational Status of the Participants**

The majority of the participants, 88%, indicated that they had received some form of formal education. Out of this number, 40% of them reported completion of up to Junior Secondary School (JSS) level of education, while 33% had completed Senior Secondary School level (SSS) education. University students accounted for those currently in tertiary institutions (5%). Only 12 (12%) of the participants mentioned that they had had no formal schooling (see Figure 4.2).





**Figure 4.2: Educational Status of Participants (N=100)**

### **Type of ASRH Facility Visited**

Two types of ASRH facilities with different characteristics were identified during the study. These were “youth-friendly” centres, located within an NGO based facility or as part of a government clinic, which were multi-faceted or existed as a stand alone centre offering a wide range of services including educational, recreational and clinical services. The other type of ASRH facility was referred to as “adolescent-friendly” clinics or corners. These were usually located within the antenatal clinics, family planning units or general services. On analysis of the data, a little over half of the participants (55%), were

recruited from youth centres in government and NGO programmes, while, 45% of them were recruited from an adolescent-friendly clinic.

#### 4.4.2 INFORMATION AND KNOWLEDGE OF ASRH SERVICES

##### 4.4.2.1 Sources of Information on ASRH Services

Participants were asked to indicate their sources of information on the existence of ASRH services in the facilities visited. Analysis of the data revealed that the participants got to know about the ASRH facilities through various sources. Friends accounted for 31%, representing a large number when compared to the other sources of information; nurses constituted 17% of the sources, whereas mother and neighbour as sources, accounted for 11% each (see Table 4.4).

**Table 4.4: Information Source of ASRH Services**

INFORMATION SOURCE ON ASRH SERVICE	FREQUENCY	PERCENTAGE
Mother	11	11.0
Aunt	3	3.0
Friend	31	31.0
Neighbor	11	11.0
Nurse	17	17.0
Doctor	3	3.0
Peer educator	7	7.0
Sister	3	3.0
Radio/television	7	7.0
Husband	2	2.0
Brother	5	5.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

#### **4.4.2.2 Reason for Visiting ASRH Facility**

Individual responses given by the adolescents indicated that they had various reasons for visiting the facilities. The reasons for attending were as follows: Thirty-one of them said they were seeking information on SRH issues (31%); twenty, 20%, were pregnant adolescents visiting the antenatal clinics for routine check ups, 23% indicated that they paid a visit to the family planning section for contraceptive services. Feeling unwell and needing treatment was reported by 8%, use of the library and computer (14%), while recommended by nurses was made mention of by 4% of the participants as their reason for visiting the facilities.

Further analysis of the findings revealed that visits for antenatal care and contraceptive services were predominantly the main reasons given by female participants for visiting the clinic-based ASRH services. Mention was made of visits to the youth centre's library and computer section (14%), which formed part of the services offered by an NGO-based ASRH center in Ghana, as a way of attracting school-going adolescents to the programme.

#### **4.4.2.3 Information Received at Facility**

A variety of information related to SRH matters was received by adolescents during visits to the facilities. Overall findings indicate that all of the participants (n=100) in the study had received some information on HIV/AIDS/STIs prevention, giving a 100% response. Information on teenage pregnancy and risks (n=40), life skills, changes during puberty,

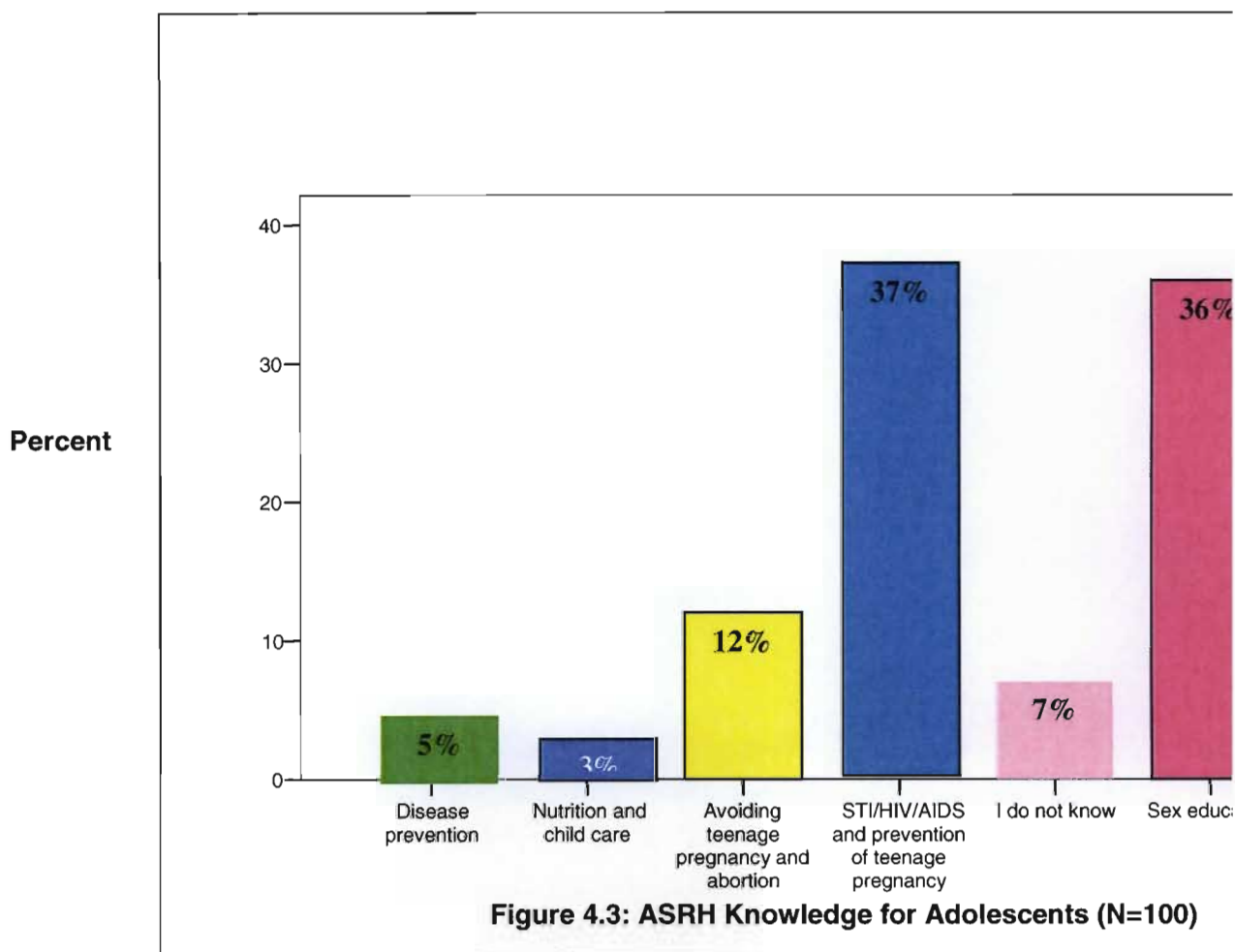
personal hygiene, family planning (40%), good nutrition, self care and care during pregnancy were also provided (see Table 4.5).

**Table 4.5: Information Received (N = 100)**

<b>INFORMATION RECEIVED</b>	<b>FREQUENCY</b>
HIV/AIDS/STIs education	<b>100</b>
Teenage pregnancy, abortion and risks	40
Family planning	40
Good nutrition	30
Life skills, self esteem and values	20
Changes in the body during puberty, wet dreams, masturbation	12
Personal hygiene of the genital area	4
Self care	14
Care during pregnancy for self and baby	20

#### **4.4.3 Relevant ASRH Knowledge for Adolescents**

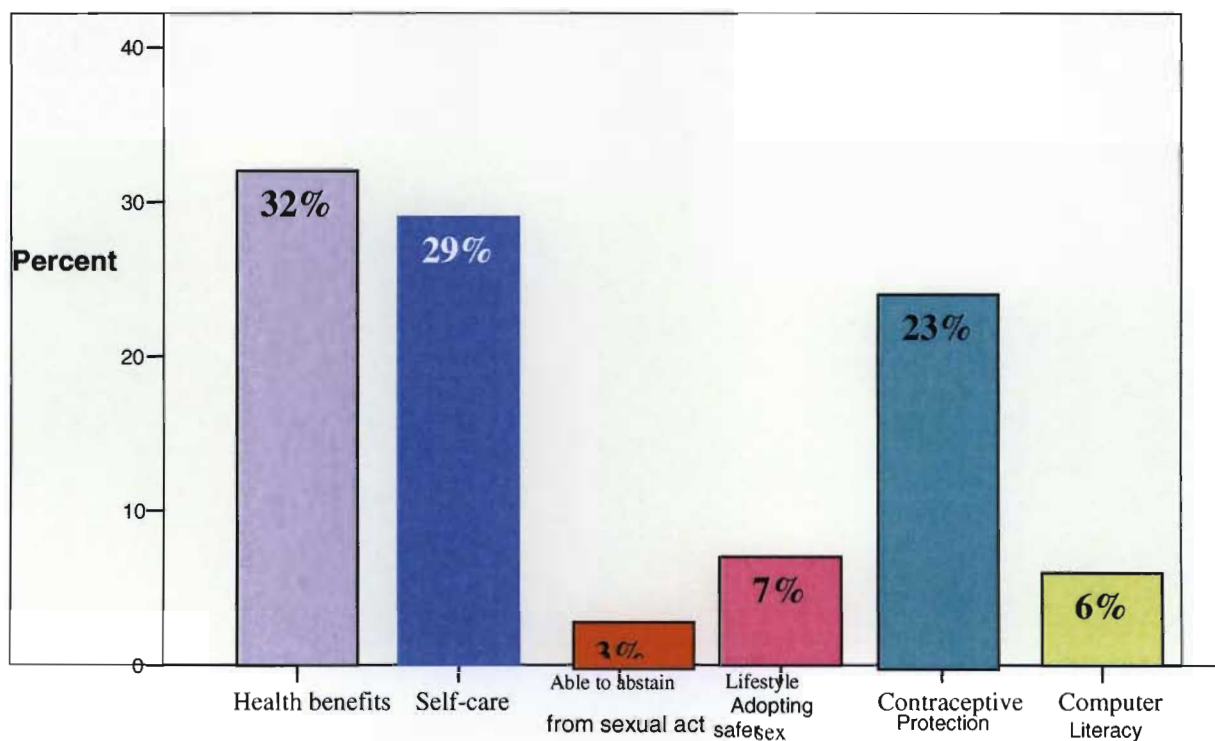
In response to the question on what the participants felt adolescents need to know regarding their sexuality and reproduction, several SRH topics were highlighted as being of relevance by the participants. Knowledge on HIV/AIDS/STIs was mentioned by 37%, knowledge in sex education was listed as relevant by 36% of the participants, while knowledge of teenage pregnancy and abortion accounted for 12%. Seven percent indicated that they did not know, possibly because they were shy or hesitant to suggest topics of a sexual nature (see Figure 4.3).



## 4.5 USEFULNESS AND RELEVANCE OF PROGRAMME

### 4.5.1 Benefits from ASRH Services

Participants were asked to identify areas in which they have benefited whilst making use of ASRH services offered in the facilities visited. Health benefits which included preventative messages and health promotion were recorded as beneficial. The family planning section and counseling units were listed as the most important areas for reproductive health. The benefit of attending family planning services was acknowledged by the participants, as it was linked to one not becoming pregnant (see Figure 4.4).



**Figure 4.4: Benefit from ASRH Services (N=100)**

#### 4.5.2 Relevant ASRH Service

Key aspects of the services provided by the facilities were identified as relevant to their needs by the participants. Information of reproductive health and counseling services was indicated by 49% of the participants as the most relevant part of the programme, family planning 27%, HIV/AIDS/STIS prevention (18%), antenatal care was cited as a relevant service by 6% of the participants.

#### 4.5.3 Any Information/Material Received?

With regards to the question on whether they had received any information, educational materials or drugs during visit to the facilities, all of the participants, (n=100) indicated that they had received some form of information or educational material during their visit. Table 4.6 gives a breakdown of the type and form of information or material received. Forty-one of the participants received educational pamphlets and leaflets, 16 said they received contraceptives, health talks was given to 15 of them. Drugs and vitamins were provided to eight of the participants who had initially indicated they visited the facility because they were feeling unwell.

**Table 4.6: Information/Material Received**

<b>INFORMATION/MATERIAL GIVEN</b>	<b>FREQUENCY</b>	<b>PERCENTAGE (%)</b>
Drugs – Vitamins	6	6.0
Educational pamphlets and leaflets	41	41.0
Clinic record card	8	8.0
Drugs and Educational materials	14	14.0
Health talks	15	15.0
Contraceptives	16	16.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

#### 4.5.4 Any Difficulties Encountered in Discussing SRH Issues during Visit

Participants were asked whether they had difficulty explaining their needs to the service providers and to give reasons why. The responses indicated that the majority of the participants (95%) did not encounter any difficulties except for a few (5%) who mentioned that they encountered difficulties discussing ASRH issues with the service providers. Out of this group (n=5), four of them indicated that they were too young too

become pregnant and this made them conscious of their surrounding, while one of them mentioned that it was her first time visiting the facility.

#### **4.6 ADOLESCENTS' PERCEPTIONS OF USER-FRIENDLINESS OF THE SERVICE**

Questions were directed at specific areas of ASRH output to analyze the user-friendliness of the facility in relation to the following areas: Location of the clinic; convenient clinic hours, comfortable attending programme, privacy respected, comfortable environment, welcome at facility, information given, attitude of the staff, adequacy, satisfaction with the services provided, reasons for dissatisfaction and suggestions for future improvement of the services.

##### ***Location of the Facility***

Two options were provided in response to the question on the location of the ASRH facility or service whether within the reach of the participants, a “Yes” and a “No” answer. The majority of the participants in Ghana (82%), responded that the clinics and youth centers were located within their reach, except for 18% (n=18), who indicated that the facilities were far out of their reach.

##### ***Opinion on Clinic Hours: Are the Opening and Closing Times Convenient?***

On analysis of the data, the majority of the clinics and centers visited extend their services to adolescents from 9am to 4pm daily, and in some from 8am -5pm. With regards this time schedule, the majority of the participants, 92%, reported that service



times allocated was convenient for them, only 8%, of them (n=8) indicated the clinic times were not convenient for them.

### ***Clinic hours not convenient***

Out of the group of participants who indicated the clinic hours were inconvenient (n=8), the following reasons were given as to why the hours are inconvenient: the nurses should begin work on time because some of us come from far places (n=2); not that convenient because there is no service provider in the evenings (n=1); the clinic should be open in the night (n=1); the service hours should be increased with a permanent service provider who will be there 24 hours (n=1); it was closed up for sometime (n=3).

### ***Comfortable Attending the Programme***

The participants were asked whether they felt comfortable attending the programmes and if so, they were required to give reasons for such a response. On analysis of the data, all the participants (n=100) indicated that they were comfortable attending the programmes. The following reasons were provided by them as to why they felt comfortable with the programmes: They taught of lots of things (38%), friendly nurses (19%); welcomed by staff (29%); they explain everything to us (4%) and the environment is good (10%).

### ***Feel Welcome during Visit?***

With regards to whether the participants felt welcomed during visits to the facilities, almost all of the participants, 99%, who formed an overwhelming majority, indicated that they felt welcomed during visits to the clinics or youth centres because of the welcoming

attitude of the nurses and service providers, with the exception of one participant who felt unwelcome.

### ***Views and Perceptions of ASRH Programmes***

The participants were asked to give their views on the programme and services offered. Of the total number of participants, the majority, 72%, described the programmes as good, while 11 participants said they are excellent, six on the other hand, described them as welcoming. Nine of them on the other hand, said they did not know and only two of them viewed the programmes as bad. Reasons for this view were not mentioned.

### ***The Environment: Comments on the Environment***

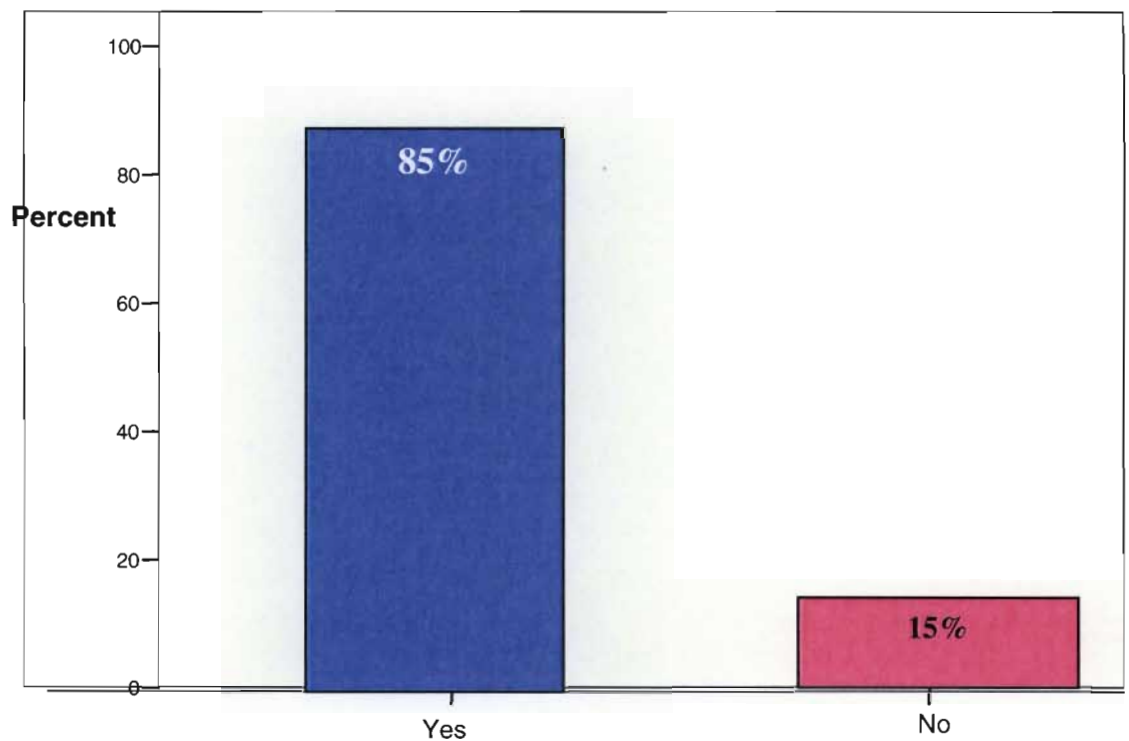
Out of 100 participants, the majority, (85%), commented that the environment in which the services were provided was comfortable, while 15 of them commented that the service environment was not comfortable for them (see Figure 4.5).

### ***Attitude of the Service Providers***

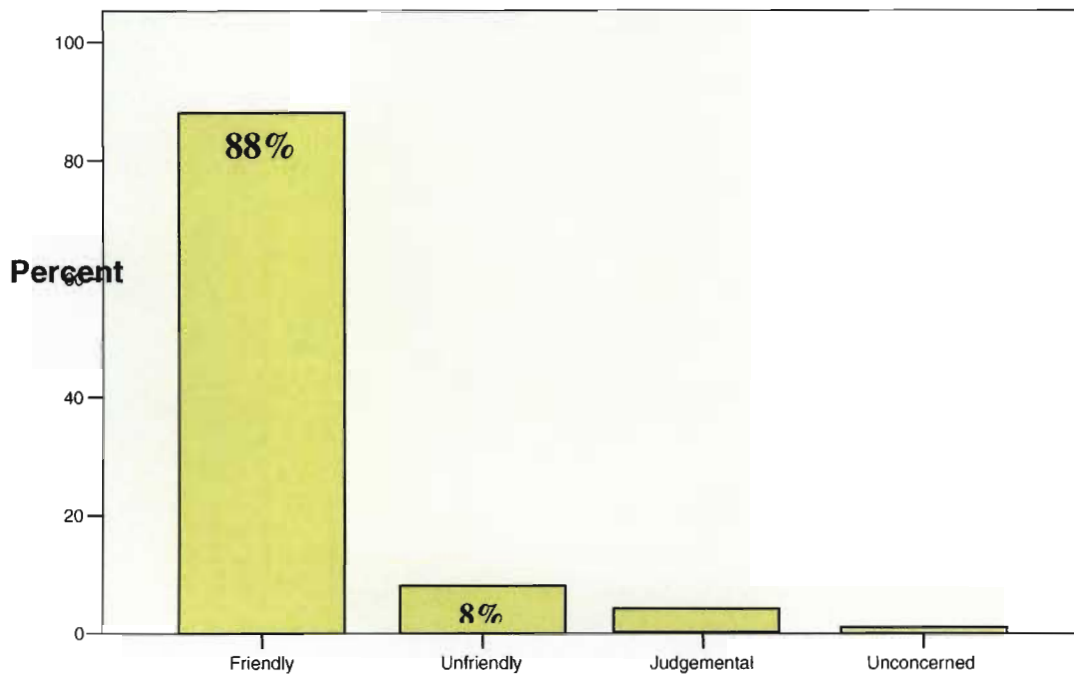
Participants were asked to rate the attitude of the service providers as follows: 1) friendly; 2) unfriendly; 3) judgmental; and 4) unconcerned and 5) other. The majority of the participants, 88% described the attitude of the service providers as friendly, whereas 8% of them referred to them as being unfriendly; only one said they were unconcerned (1%). A judgmental attitude on the staff was recorded by 3% of the participants (see Figure 4.6).

### *Privacy Respected During Visit*

In response to the question whether their privacy was respected during visits to the facility, the majority of the participants (89%) indicated that they were accorded the necessary privacy, while 11% of them felt that their privacy was not respected. Reasons given for lack of privacy were as follows: the presence of other people in the room during consultation time (n=5); sensitive ASRH issues were presented at group discussions and (n=4); inadequate infrastructures or space to maintain privacy (n=2).



**Figure 4.5: ASRH Environment Comfortable (N=100)**



**Figure 4.6: Attitude of Staff (N=1000)**

### ***Satisfaction with Services Provided***

Out of a total number of 100 participants, the majority (91%) indicated that they were satisfied with the services provided to them. Only nine (9%) of the adolescents stated that they were dissatisfied with the services. Out of those who were dissatisfied (n=9), a breakdown of the reasons was given by the participants below.

### ***Reasons for dissatisfaction with services***

Dissatisfaction was expressed in specific areas of service delivery (n=9). One area of RH services that came out as not being user-friendly was the labour and delivery section. The

participants who were mostly pregnant teenagers were critical of the staff attitude towards pregnant adolescents. Hurried examinations by the doctors; lack of patience by nurses in the delivery section; treatment of adolescents during their visit to the labour ward were cited as reasons for dissatisfaction by pregnant adolescents attending the antenatal clinic. Paying a lot for services that are pregnancy related such as laboratory tests was a cause for dissatisfaction (see Table 4.7)

**Table 4.7: Reason for Dissatisfaction with Service (N = 9)**

<b>Reasons for Dissatisfaction with Services</b>	<b>Frequency</b>
If you have a card but came for delivery they should attend to you first before demanding the card.	1
Lack of patience with pregnant adolescents during delivery	2
Whenever there is a problem in delivery, they are angry with you, if you call them they don't come.	1
Some of the doctors and nurses must be patient.	1
Sometimes the nurse on night duty work slowly.	1
I spend several hours waiting for my turn to receive service.	1
The doctors come and take a look and when they come, they rush a lot, they are in a hurry.	1
I'm not happy; I paid too much money for the lab tests.	1

***Suggestions towards Improving ASRH Services:*** Recommendations or suggestions as to how the services could be improved from the user's perspectives yielded the following responses from the adolescents: Infrastructural improvement, additional facilities and programmes; provision of adequate human resources and more trained youth to assist with service delivery (see Table 4.8).

**Table 4.8: Suggestions towards Improving ASRH Services**

<b>Suggestions towards ARSH Services: Areas to Improve</b>
The computer room should be enlarged as well as the library
The programme must help the youth against HIV and pregnancy
Adding new services for the youth will help a lot.
The youth corner or the adolescent unit should be separated from that of the family planning so that, they can act independently.
There should be a center with a separate building for both family planning and the youths.
My view is that sex education should be enhanced.
Mass education should be the priority.

## **4.7 FOCUS GROUP DISCUSSIONS - RESULTS: GHANA**

### **4.7.1 Characteristics of the Informants**

Data from the focus group discussions were transcribed verbatim, analyzed, interpreted and reported as narratives, in the form of excerpts to support similar themes or patterns or differences obtained from that of the client-exit survey. Seventeen informants who were adolescents visiting adolescent-friendly facilities took part in focus group discussions. A total number of four (4) focus group discussions were held with mixed groups within the ages of 15-23 years, comprising of males and females, all single (n=17) and attending school at different levels of education. A group of five, which included three females and two males, participated in the first discussion, another group of five adolescents (three males and two females) in the second group, and a group of four males and three female adolescents respectively. The following excerpts below also provide narratives of data gathered during the focus group discussions.

#### **4.7.2 INFORMATION AND KNOWLEDGE OF ASRH SERVICES:**

##### **INFORMANTS GHANA**

The discussion focused on the following areas: a) sources of Information; b) reasons for visit to ASRH facility; c) lessons learnt during visit to the facility; and d) what information adolescents need to know on SRH.

##### ***Sources of Information (Excerpts Informants Ghana)***

Themes emerging from the focus group discussions on the information sources available to the informants were similar to those listed in the client exit survey. Mention of the drama group and choir master was noted as additional sources of information to those previously mentioned in the survey. Excerpts on the above theme from the informants were as follows:

*Actually the clinic was introduced to me by a friend at school.*

*I was introduced to the library by one of my friends when I needed badly a study place.*

*I got to know about the services through a drama performance, from the 'Young and Wise' drama group.*

*Peer educator.*

*The facilitator and choir master.*

##### ***Reasons for Visit to ASRH Facility (Excerpts Informants Ghana)***

Several issues were highlighted by the informants as to their reasons for paying a visit to the facilities: a) visiting out of curiosity; b) to learn more about reproductive health topics and to obtain preventive information; and c) because of publicity. Some of the responses are provided in the extracts from informants as follows:

*I visited out of curiosity!*

*To have most ideas on how to protect myself and the importance of staying out of the dangers of involving in unprotected sex.*

*To study and get information about SRH.*

*I visited the services because of their publicity.*

### ***Lessons Learnt during Visit to the Facility***

Lessons learnt during visits to the facility identify with several components of reproductive health issues. Several themes under SRH issues emerged as follows: a) sex education and HIV/AIDS prevention messages; b) abstinence; c) contraception; d) teenage pregnancy and risks; e) puberty, personal hygiene and cleanliness; and f) peer pressure and lifestyle. The following quotes represent similarities in views expressed by the informants under a specific theme with regards lessons learnt:

Sex education and HIV/AIDS/STIs prevention emerged from discussions as indicated in the extracts below:

*Causes of HIV/AIDS and its effects, how the human penis erect and how it goes inside the vagina.*

*I learnt that if you sleep with a girl, you will get AIDS*

*I learnt that Gonorrhoea and syphilis are caused by sexual attitudes, to learn to use condom when the desire comes.*

*We should not take girls, use condoms, do not share blades with our friends.*

Abstinence: The informants associated the knowledge gained as making them stay away from sex, enabled them to stay healthy and withholding their feelings when having sexual urges through abstinence:

*Abstinence helped me gain a lot of my strength and also makes me stay healthy since energy is not wasted.*



*I have learnt many things e.g. importance of staying away from sex, this has helped me most in my life time example in abstaining from sexual immoralities.*

*I shouldn't sleep with girls when my feelings come but go and play.*

Contraception and prevention of pregnancy was mentioned by the informants in the extracts provided:

*I got to know that injection can help prevent pregnancy.*

*I got to know about the effective way of preventing pregnancy especially being married.*

*I have the opportunity to observe the female condom, so my curiosity about it was satisfied.*

Puberty and self-care: Mention was made of personal hygiene during menstruation by an informant:

*During menstruation, I should take good care so that I don't smell bad.*

Peer Pressure, lifestyle changes was acknowledged by some of the informants:

*It has made me understand that as an adolescent we may be influenced by our sex partners or friends and for this reason I am ready to move away from such people.*

### ***What Adolescents need to know Regarding SRH issues?***

The following themes emerged during analysis of the data: a) reproduction/ puberty/the menstrual cycle; b) sex education/abstinence/HIV/AIDS/STIs prevention; c) pregnancy/abortion; d) family planning and contraception and; e) life skills/values and education. According to the informants, knowledge on the reproductive systems including information on the menstrual cycle was seen as important and relevant for young people towards future care of their bodies:

*They need to know how the reproductive system functions and how they can take control over it.*

*Young people need to take care of their reproductive organs and their health.*

*Any girls who come to the center should be taught how to calculate the menstrual cycle.*

Self-care, personal cleanliness and maintaining one's virginity were emphasized as relevant knowledge for young people by some informants:

*Take good care of their private parts.*

*An adolescent has to know the his/her primary sections of maintaining her virginity clean so that certain diseases should not attach to that part as well.*

Sex education was seen as a relevant component of reproductive health; prevention of pregnancy, abstinence, early sexual activities and HIV/AIDS/STI were also acknowledged as important information for young people by the informants:

*The sexual and reproductive needs of adolescents are, to be educated on sex in order to prevent them from indulging themselves into any moral act which can lead to pregnancy or AIDS.*

*Abstinence is the best.*

*They need to know the dangers of unprotected sex. This may result in admitting certain viruses and diseases which are dangerous in the immune system like STD's, AIDS.*

Pregnancy/Abortion/Unsafe Sex and consequences and family planning also emerged from the discussions as an important area of knowledge for the informants:

*They need to know that unprotected sex can lead to pregnancy and possibly HIV/AIDS.*

*Young people need to know about the implications of abortion and pre-marital sex.*

*They need to know the various contraceptives more especially how to use the male and female condom properly.*

Life Skills/Values and education was mentioned as a relevant area for adolescents, as provided in the excerpts from the informants:

*Needs counseling on SRH issues, need to build good values that will help them in the future.*

*Avoid bad friends and peer pressure.*

Trust was seen as an essential component in SRH issues. Knowledge on the right information was needed to make informed decision and choices by an informant:

*Young people need to know who they can trust when it comes to SRH issues, they need right information to make informed choice on SRH.*

Interestingly, dress codes came up as a lesson to be learnt by young people, as mentioned by one of the informant:

*Know to dress properly in order to avoid rapist.*

According to some of the informants, empowerment of young people through education was seen as the best weapon to addressing all other needs of young people.

*I think education is the main tool to addressing the needs of the adolescents.*

#### **4.7.3 RELEVANCE OF ASRH PROGRAMMES**

##### ***Benefits of Knowledge in SRH Issues***

Major themes were identified in the focus group discussions with regards benefits derived from visiting the facilities. Benefits gained include: (1) health awareness leading to abstinence and adoption of safer sex practice; (2) improvement in knowledge; (3) contraceptive benefits; (4) self-control over sexual urges, self empowerment, self discipline; and (5) changes in attitude and behaviour.

The following excerpts below give an insight into the benefits of acquiring knowledge in SRH issues as expressed by the informants. Abstinence and adoption of safer sex was seen as beneficial and giving one protection from sexual infections and was further linked to benefits such as development of the youth:

*I don't think of having sex again. Abstinence from sex will bring improvement in the youth.*

*It has prevented me from carrying out unprotected sexual act.*

*If they should think of having sex, they should come to the center to discuss their problems.*

*I want to finish my course before having children.*

Contraceptive benefits: Not becoming pregnant and child spacing was given as some of the benefits of contraceptive services provided to adolescents at the family planning section. The responses from the informants indicated the benefit contraception offers:

*The benefit stems from the fact that I have sex but not become pregnant.*

*For some months now, I have not become pregnant.*

*Family planning, because it has helped us to maintain our first child for long period, I was able to maintain and sustain the first born for long.*

Wet dreams, self discipline and control over sexual urges emerged from the findings as supported by the statements made by the informants:

*I learnt that wet dreams are normal and we should come to the center when we have wet dreams.*

*I now know that sex is inevitable but we have to control ourselves as youth and wait.*

Educational benefits: The library section of the youth centre was perceived as beneficial because of the potential of addressing educational gaps. Education was also listed as the key to success for young people by the informants:

*Since I started coming to the library, I always feel convinced that my head is not empty and it encourages me.*

*I have realized my potential.*

*Education is the best key to success.*

Building of self-esteem and confidence was mentioned by informants as a benefit:

*The facility has affected my life – how to improve on my self esteem and confidence.*

*I have more confidence now.*

*I'm not shy in discussing issues concerning sex and reproduction.*

#### **4.7.4 USER-FRIENDLY PERSPECTIVES ON THE PROGRAMMES**

##### ***Location of the Facility***

The location of the clinic was perceived as within reach, due to issues of: a) accessibility; b) proximity in terms of nearness to place of work or school by the informants in the excerpts provided:

*Because I'm working in town, it is near to my place of work.*

*It's not too far.*

*I was passing by and decided to visit the clinic because I always pass on my way to work.*

*Because it's on my way to school.*

### ***Convenient Clinic Hours***

Convenient clinic hours were determined by accessibility - in terms of opening of the facility at periods or specific times when other activities are in session. This was seen as convenient to some of the informants, because other students or persons will not be able to identify where exactly they are going or coming from, also in terms of nearness of the services to the school they are attending, as contained in the excerpts below from the informants:

*Yes, the center is opened at the time for lectures so nobody knows whether you are attending lectures or the clinic*

*I study and work casual, so I can get here on breaks before classes, except the queues are hectic.*

*This is okay because even after school. I can still go there.*

### ***Reasons for inconvenient hours***

The informants felt that the clinic hours were not convenient due to the following concerns: a) inconsistency on closing and opening of one youth centre; b) insufficient staff, irregular shifts, and c) closure of the facility most of the time, as contained in the statements by the informant below:

*We should have a fixed time students can be allowed and we should have some peer educators running evening shifts to occupy the place and they must be paid from the funds.*

*This center is most often locked because we do not have regular shift to replace peers when they are in lecture”.*

*(Adolescent from Youth Centre at University).*

*The clinic hours are not good; they should open in the evenings.*

Informants also expressed their dissatisfaction with the clinic hours as illustrated in selected excerpts below:

*No, I think the clinic hours are not convenient to me, I think they should come early and close early, and instead, they come late and close early*

*They should not delay people, yes, wasting too much time for a service.*

### ***Comfortable Attending Programme***

The location of the RH facility and service hours contributed to one's feeling comfortable when seeking reproductive health services according to the informants:

*Yes, I feel comfortable, because it is located at a place where people cannot tell why you have visited and what you have possibly gone to do.*

*I am comfortable with the clinic without missing lectures.*

Lack of cooperation and boring sessions came up as reasons for informants feeling uncomfortable:

*No, I do not feel comfortable attending this programme because most of them do not cooperate with the leader thereby making it boring (Adolescent, Youth Centre).*

Lack of Understanding on ASRH issues by some peers in a youth centre was responsible for not feeling comfortable whilst visiting the centre according to one of the informants in the extract below:

*Yes, I feel comfortable attending programme but sometimes no, because many of*