Access of Adolescent Sexual and Reproductive Health Services in Ghana: A Health System Perspective

Nana Abena Kwaa Ansah Apatu

Ghana

55th Master of Public Health/International Course in Health Development (MPH/ICHD)

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Access of Adolescent Sexual and Reproductive Health Services in Ghana: A Health System Perspective

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

Nana Abena Kwaa Ansah Apatu

Ghana

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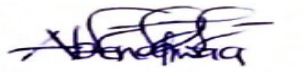
Signature: 

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ABSTRACT

Background: Adolescents in Ghana are faced with several sexual and reproductive health issues which require special attention. Sadly, access of sexual and reproductive health services by these adolescents remain poor. Several factors influence adolescents' access of sexual and reproductive health services including demand-side and supply-side factors.

Objective: This study sought to investigate the legal, policy environment supply-side factors influencing access of adolescent sexual and reproductive health services in Ghana and identify evidence-based best practices to address the problem.

Methodology: The study was a literature and desk review study for which detailed analysis was done using the adapted Levesque et. al access of health care framework.

Results and Conclusion: Policies that conform to international commitments exists, however, some of the policies are ambiguous. Ingrained religion and culture also influences effective implementation of the policies. Weak accountability to policies and to the adolescents, inadequate and unavailable services as well as unfriendly and discriminatory health provider attitudes affect access. Infrequent government of Ghana funds, shortage of medical supplies and equipment and weak multi-sectoral collaboration also influences service provision and access. Suggested initiatives discussed include African Youth Alliance, South African National Adolescent Friendly Clinic Initiative, Programa Gerçãcao Biz, legal and policy reforms.

Ambiguous policies, ingrained culture and religion affects implementation of policies and in turn influences access in Ghana.

Recommendations: Effective multi-stakeholder and multi-level mechanisms are key to promoting adolescent sexual and reproductive health rights.

Keywords: Adolescents, access, attitudes, Ghana, health provider, sexual and reproductive health and rights, sexual and reproductive health services

Word count: 12, 891

LIST OF ABBREVIATIONS

ADHD	Adolescent Health Development
AHSPS	Adolescent Health Service Policy and Strategy
ANC	Antenatal Clinic
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYA	African Youth Alliance
AYFHS	Adolescent and Youth Friendly Health Services
CHAG	Christian Health Association of Ghana
GBV	Gender Based Violence
GFF	Global Financing Facility
GHS	Ghana Health Service
GHS-ADH-MAPP	GHS-Adolescent Health-Mobile Application
GOG	Government of Ghana
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
NGOs	Non-Governmental Organisations
PGB	Programa Gerçãcao Biz
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SANAFCI	South African National Adolescent Friendly Clinic Initiative
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage
WHO	World Health Organisation

GLOSSARY

Access: "Access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs" p. 1 (Levesque, et al., 2013)

Accountability: "A virtuous circle, with built in learnings for continuous improvements in delivering on promises made about people's health and rights" p. 1474 (Barrosso, et al., 2017)

Adolescents: Individuals aged 10 -19 years (WHO SEARO, 2019)

Adolescent Friendly Health Services: "Represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Such services are accessible, acceptable and appropriate for adolescents. They are in the right place at the right time at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are equitable because they are inclusive and do not discriminate against any sector of this young clientele on grounds of gender, ethnicity, religion, disability, social status or any other reason." p. 25 (WHO, 2002)

Health System: "All the activities whose primary purpose is to promote, restore, improve or maintain health" p. 5 (WHO, 2000)

Sexual and Reproductive Health and Rights: "Is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. All individuals have a right to make decisions governing their bodies and to access services that support that right." P. 2646 (Starrs, et al., 2018)

Sexual and Reproductive Health Services: "Essential sexual and reproductive health services must meet public health and human rights and standards, including "Availability, Accessibility, Acceptability, and Quality" framework of the right to health." p. 2646 (Starrs, et al., 2018)

INTRODUCTION

Adolescence is a critical period because it is at this period that individuals go through several biological, psychological and social changes (WHO, 2015). Adolescents are vulnerable and should be educated to enable them to attain a level of maturity (UNFPA, 2014). Understanding their sexuality is key and will as well protect them from risky sexual behavior, unintended pregnancies and sexually transmitted infections (UNFPA, 2014). Adolescent sexual and reproductive health and rights (ASRHR) have been found to influence physical and mental health, future employment, economic wellbeing and a person's ability to reach his or her potential (WHO, 2012; Chandra-Mouli, et al., 2013; Patel, et al., 2007).

However, studies have found that adolescents defined as people between the age of 10 and 19 years globally often times do not access reproductive health (RH) services due to a number of reasons including staff attitude, availability of services, information on available services, individual and socio-economic factors (WHO SEARO, 2019; Chandra-Mouli, et al., 2015; Odo, et al., 2018).

Working with the Ghana Health Service Research and Development Division and with my office located close to a polyclinic that provides RH services, I have witnessed on numerous occasions what adolescents experience for accessing these services. The question that keeps coming to me is why sexual and reproductive health (SRH) services are available, yet we still record high incidence of teenage pregnancy, unsafe abortions, among other adolescent reproductive health problems.

Consequently, this thesis reviewed and analysed literature in relation to the legal and policy environment as well as supply-side factors influencing the access of adolescent sexual and reproductive health services in Ghana and as well identified best practices that influence adolescent sexual and reproductive health (ASRH) in Sub Saharan Africa; discussed its possible application in the context of Ghana and made recommendations to inform policy on areas of intervention to improve provider attitudes and ASRH services in general.

This thesis comprised of 5 chapters. Chapter 1 entailed background information on demographic data, health and social context in Ghana. Problem statement and justification was discussed in chapter 2 which was followed by objectives, methodology and a conceptual framework that was used for this study. The results of the review and evidence-based interventions were also discussed in chapters 3 and 4 respectively. The discussion was presented in chapter 5 followed by conclusions and recommendations in chapter 6. The study limitations were discussed under both methodology and discussion sections.

1.0 CHAPTER 1 BACKGROUND INFORMATION

This chapter provides general information about Ghana including the health system and health indicators related to adolescents' sexual and reproductive health and rights.

1.1 Country Profile/ Demographic information

Ghana is centrally located on the West African coast, bound on the east by Togo, on the north and northwest by Burkina Faso, on the West by Cote d'Ivoire and south by the Gulf of Guinea. The total land area is 238,537 square kilometres. It has a tropical climate with varying temperatures and rainfall patterns (Ghana Statistical Service, et al., 2015). The country until recently had 10 administrative regions with Greater Accra region as the capital but currently has 16 regions after the presentation of Constitutional Instrument on the creation of six additional was successful (Ghana Statistical Service, et al., 2015; Ghana Statistical Service, 2019).

Figure 1: Study Location (Map of Ghana)

Source: Ghana Statistical Service, Geographical Information Systems (Ghana Statistical Service, 2019)

1.2 Religion and culture

In Ghana, religion and culture highly affect almost all aspects of life. The major religions are Christianity, Islam and traditional beliefs and practices which differ across the regions. The predominant ethnic groups include Akan, Mole Dagbani, Ewe, Ga-Dangme with the major local languages spoken being Akan, Dagbani, Ewe, Ga (Ghana Statistical Service, 2012).

1.3 Socio-economic situation

According to the 2010 Ghana Statistical Service Population census results, 54.2% of the population are economically active[1] of whom 95% are employed. Adolescents make up the highest proportion of the economically inactive[2] population, 66.6% (Ghana Statistical Service, 2012). Employing 41.2% of population aged 15 years and over, agriculture comprising fishing and forestry constitute the major industrial sector (Ghana Statistical Service, 2012). The adolescent age structure has obvious economic implications which in turn will affect access of health service in terms of cost (Ghana Statistical Service, 2012; Ghana Statistical Service, et al., 2015).

1.4 Literacy and Education

Education is key to development for every country. The national literacy rate in Ghana is 67.1% with varying levels of literacy among the regions. Urban dwellers are likely to be more educated than rural dwellers; 25% males and 35% females in the rural areas have no education compared with 10% males and 18% females in the urban areas. Despite an improvement in female education, variations still exist between males and females; 67% women and 82% men aged 15-49 are literate, an improvement from the 2008 literacy levels of 63% and 77% respectively (Ghana Statistical Service, 2012; Ghana Statistical Service, et al., 2015).

1.5 Health System

Ghana has a relatively well-developed health care system with decentralised management up to the district level (Ministry of Health 2018). Even though there exist private and religious mission health service providers, government is the agency responsible for managing the health system through Ministry of Health (MOH) headed by a Minister. MOH controls Ghana Health Service (GHS) which is governed by the Director General. GHS has the mandate to implement national health policies (Ministry of Health, 2018).

Health system is organised administratively at three levels comprising national, regional and district levels. Functionally though, the system is run at five-level structure (community, sub-district, district, regional and national) which has three categories namely, primary, secondary and tertiary. The district hospitals, Community-based health planning and services, faith-based, private and traditional facilities make up the primary level and the district hospitals serve as the referral facilities for the health centres. At the secondary level, the regional hospitals which have several specialised services serve as the referral hospitals for the district hospitals. The highest healthcare delivery happens at the tertiary level which has the capacity to offer advanced specialised services (Ministry of Health, 2018).The health workforce in 2017 was estimated at 107,985 with nurse to population ratio at 1:505 (midwife to women in fertility age ratio 1: 704) and doctor to patient ratio also at 1:7,374. Distribution of health workforce across the country is uneven;

[1]Economically active: Employed and unemployed (But actively seeking for jobs)

[2] Economically inactive: Unemployed but not actively seeking for jobs

urban areas and southern Ghana have the highest numbers (Ghana Health Service, 2018; Ministry of Health, 2018).

1.5.1 Health Financing

Despite the Abuja declaration in 2001 which recommended 15% of annual budget allocated to the health sector, Ghana is one of the low and middle income countries that fail to live up to this target (WHO, 2015). In 2016, the domestic total health expenditure as a percentage of the gross domestic product was 6%, 2% of domestic general government health expenditure as a percentage gross domestic product and 7% general government health expenditure as a percentage of general government expenditure (WHO, 2014).

National Health Insurance Scheme (NHIS) introduced in 2004 substituted out-of-pocket payment with the aim to achieve universal health coverage (UHC) while protecting citizens from bearing health service costs. However, citizens continuously bear cost of health services – about 47% as a result of failure of the scheme to reach nationwide coverage. Out of this 47%, 37% are out-of-pocket and 10% private insurance. The NHIS contributes about 30% of the total health spending (National Health Insurance Authority, 2013; Schieber, et al., 2012).

1.5.2 Adolescent Sexual and Reproductive Health

Findings from the 2017/2018 Multiple Indicator Cluster Survey (MICS) indicate that, national adolescent birth rate is 75 per 1000 adolescents (15-19 years) with a total fertility rate of 4.4 (Ghana Statistical Service, 2018). The adolescent reproductive health services policy developed in the year 2000 provides framework and context through which adolescents will receive information and services on sexual and reproductive health (Savanna Signatures, 2018). The legal age for marriage for both boys and girls as indicated in the 1992 constitution of Ghana is 18 years, whereas the age of consent for sex as enshrined in the Children's ACT and the Criminal Procedure Code (Act 30) is 16 years (The Parliament of The Republic of Ghana, 1996; Ghana, 1998). The constitution of Ghana acknowledges customary laws of the country as provided in Article 26 clause 2, hence customary practices must submit to the laws (The Parliament of The Republic of Ghana, 1996).

1.5.3 Sexual and Reproductive Health Services in Ghana

The Reproductive Health Department of the Family Health Division, Ghana Health Service is mandated to provide sexual and reproductive health services in Ghana (Ghana Health Service, 2017). Private health facilities as well as Christian Health Association of Ghana (CHAG) facilities also provide SRH services (Ministry of Health, 2018).

The following components are outlined as SRH services offered; safe motherhood such as antenatal, safe delivery and postnatal care particularly breastfeeding, prevention of mother to child transmission (PMTCT) of HIV, contraception/family planning, prevention and management of unsafe abortion and post abortion care, prevention and management of reproductive tract infection such as sexually transmitted infections (STIs) including HIV and AIDS, management of cancers of the reproductive system such as cervical, breast, testicular and prostatic cancers, responses about menopause concerns, prevention and management of harmful traditional practices that affect the reproductive health of men and women including female genital mutilation, information and counselling on human sexuality, responsible sexual behaviour and parenthood, pre-conceptual care and sexual

health which is consonance with the essential services outlined in the Lancet Commissions report (Ghana Health Service, 2017; Starrs, et al., 2018).

1.5.3 Adolescent Sexual and Reproductive Health Services in Ghana

In addition to the aforementioned SRH services, identification and management of common health problems affecting adolescents such as rape, gender-based violence, teenage pregnancy, provision of services comprising of, information, education and counselling which are focused on adolescent and referral are amongst the services offered to adolescents (Ghana Health Service, 2017).

2.0 CHAPTER 2 PROBLEM STATEMENT AND JUSTIFICATION, OBJECTIVES AND METHODOLOGY

2.1 Problem Statement and Justification

The adolescent stage in the human life cycle is seen to be the most critical for young people and is characterised by various physiological, psychological changes as well as several health problems (Patton, et al., 2016; UNFPA, 2014). They include sexually related, reproductive health as well as HIV and AIDS and socio-economic, cultural barriers to achieving their sexual and reproductive health (SRH) potential (Starrs, et al., 2018). Yet their SRH needs receive less attention in many societies (Chandra-Mouli, et al., 2013; Abajobir & Seme, 2014; UNFPA, 2014).The extent to which adolescents are able to manage these changes are dependent to a large extent on their health status as well as human rights, gender equity and equality, awareness and skills and provision of healthcare (Bankole & Malarcher, 2010; Barroy, et al., 2015).

In Ghana, adolescents (aged 10-19 years) constitute 22.4% of the national population and are faced with a variety of challenges such as early sexual debut, STI, sexual coercion, forced sex, unintended pregnancies and child marriages (Ghana Statistical Service, 2012; Awusabo-Asare, et al., 2006; Doku, 2012). The 2014 Ghana Demographic and Health Survey (DHS) suggested that about 14% of females had already begun child bearing at age 15-19 years, of whom 11% had live births with 3% pregnant at the time the survey was conducted (Ghana Statistical Service, et al., 2015). Additionally, an occasional report by Awusabo-Asare et al. indicated that 2 out of 3 young women and 4 out of 5 young men with STI symptoms did not seek treatment whereas about half of sexually active unmarried female adolescents and over one third of their male counterparts do not use contraceptives (Awusabo-Asare, et al., 2008). In the same report, 5.2% female and 3.4% male adolescents reiterated having contracted STI (Awusabo-Asare, et al., 2008).

Key to the prevention of teenage pregnancy and STIs is delayed sexual debut, however, some adolescents are sexually active (Starrs, et al., 2018; Awusabo-Asare, et al., 2006). There is the need to therefore make available to them relevant information and services, life skills and comprehensive sexuality education (Bankole & Malarcher, 2010).These interventions play a vital role in equipping adolescents with knowledge to make informed sexuality decisions (Kirby, 2011; Melaku, et al., 2014).

Adolescents in their attempt to obtain quality SRH information and services are faced with several social, gender, cultural and legal barriers (Bankole & Malarcher, 2010; Delany-Moretlwe, et al., 2015). For instance countries that prohibit sexual activity amongst adolescents less than 16 years, may not allow healthcare providers to ensure patient confidentiality; hence hampering adolescents access of SRH information and services (Woog, et al., 2015).

This year marks 25 years since adolescent sexual and reproductive health needs were put on the global policy agenda after the 1994 International Conference on Population and Development in Cairo, Ghana was one of the countries who were entreated to introduce measures to improve the situation (Starrs, et al., 2018; Ghana Health Service, 2015). Following this endorsement, Ghana has implemented health services for adolescents to increase access of services (Ghana Health Service, 2015). However, according to the 2016-2020 Adolescent Health Service policy and strategy, these services "…are largely not integrated, are of poor and uneven quality and coverage, with inequity in access and

utilisation, are generally limited to Sexual and Reproductive Health (SRH), HIV and Sexually Transmitted Illness and do not fully address the broader health and health-related problems faced by adolescents, especially adolescent girls" p.3 (Ghana Health Service, 2015).

Improving adolescents' access and utilisation may require a holistic approach which may include health service factors (availability of adolescent friendly services, knowledge and attitudes of providers) individual and socio-economic factors. This is supported by a review conducted by World Health Organisation (WHO) on creating demand and community support for SRH services for young people. It indicated that for ASRH services to meet the needs of adolescents, it is important to combine the intervention needs from the supply side with the activities from the demand side; thus resulting in a more supportive care seeking environment for adolescents and eventually increasing access of services (Chandra-Mouli, et al., 2015). Therefore, this study sought to investigate the legal and policy environment as well as supply-side factors influencing the access of adolescent sexual and reproductive health services in Ghana because the need for the policy makers and health professionals to put in more efforts at improving ASRHR is eminent.

2.2 General Objective

To explore the legal and policy environment as well as supply-side factors influencing access of adolescents' sexual and reproductive health services in Ghana and identify best practices that can improve ASRH services and access.

2.3 Specific Objectives

i. To explore Ghana's current legal and policy environment for ASRHR.
ii. To analyse the health service (supply-side) factors influencing access of ASRH in Ghana.
iii. To identify best practices that influence provision of ASRH services in Sub Saharan Africa and discuss the possible application in Ghana.
iv. To make recommendations to inform policymakers on areas of intervention to improve SRH services and provider attitudes

2.4 Methodology

A literature review search and desk study were conducted using peer reviewed articles, books, grey literature including reports from organisational websites. The study was descriptive in nature.

2.4.1 Search Strategy and Keywords

The search strategy was done using appropriate keywords through the following sources of reference libraries to retrieve available published scientific articles; PubMed, Vrije Universiteit (VU) library, Cochrane library, Guttmacher Institute, Research gate, Google Scholar. To obtain policies, reports, factsheets and grey literature, organizational websites such as WHO, UNFPA, Ministry of Health of Ghana, Ghana Health Service, and Ghana Statistical Service were also used. The titles and abstracts of all studies retrieved were screened to ensure that they met the inclusion criteria. The Boolean operators (AND, OR and NOT) were applied in the search strategy by using separately some of the words or by combining with keywords such as adolescent sexual reproductive health, providers, Ghana, adolescent or youth-friendliness of health services (Refer to table 1 for detailed keywords used). Also, snowballing was done with some of the references of selected studies or articles.

Table 1: Search Terms

Source	Issues		Factors		Context
Reference Libraries 1. PubMed, 2. Vrije Universiteit (VU) library, 3. Cochrane library, 4. Guttmacher Institute, 5. Google Scholar 6. Research Gate **Organisational Websites** 1. WHO, 2. UNFPA, 3. Ministry of Health (Ghana), 4. Ghana Health Service, 5. Ghana Statistical Service	Sexual and reproductive health and rights OR Adolescents Sexual and reproductive health and rights OR Adolescents Sexual and reproductive health services OR Adolescent/Youth friendly services	AND	Legal and Policy Environment Approachability; Transparency, information and screening; Outreach; Acceptability; Professional values, norms, culture; Gender; Availability and Accommodation; Geographic location; Accommodation, opening hours, appointment mechanisms; Provider characteristics, qualification, contact procedures and virtual consultation; Affordability; Direct, indirect and opportunity costs; Appropriateness; Technical quality; Interpersonal quality; Adequacy, coordination and continuity; Accountability; Best practices or interventions	AND	Low- and Middle-Income Countries OR Sub-Saharan Africa OR Ghana

2.4.2 Inclusion Criteria: The study included studies or articles on adolescent sexual and reproductive health services published in English from the year 2001 to 2019 because they were found to be relevant for the objectives. The preferred language was English because it is the only international language the author of this thesis could read.

2.4.3 Exclusion Criteria: Articles or reports published in other languages were excluded as well as those that did not grant full access.

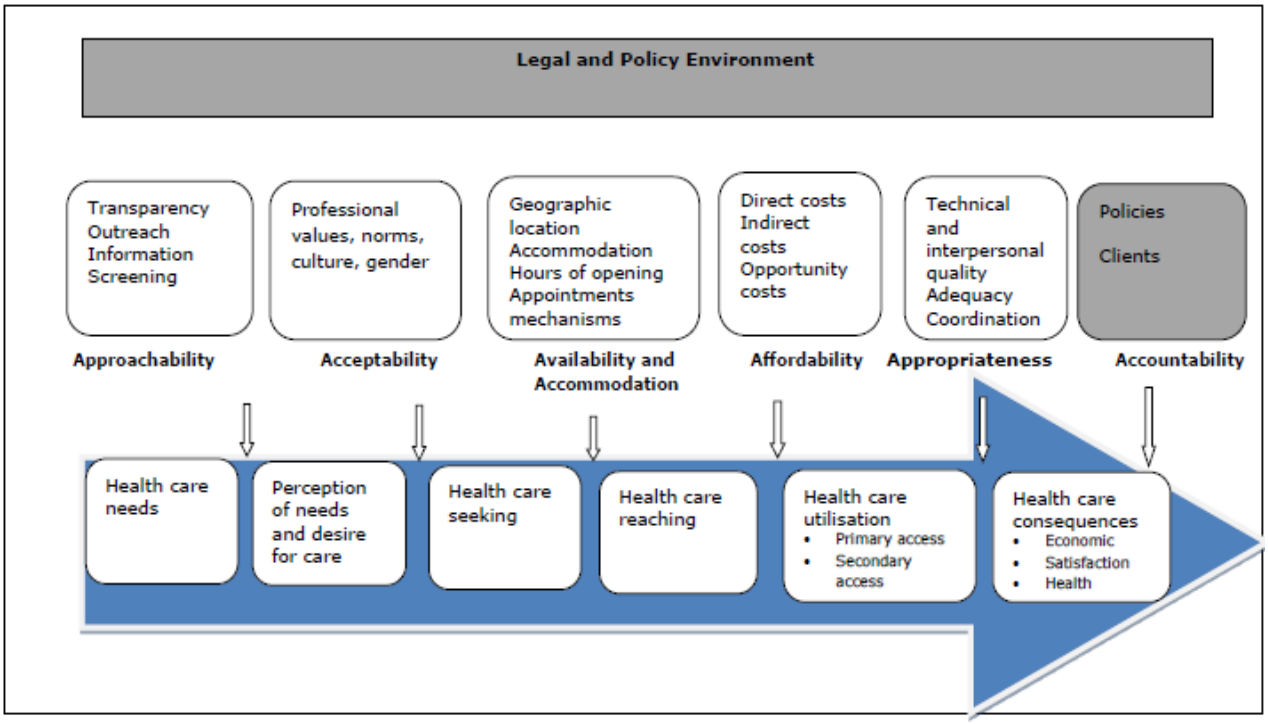
2.5 Conceptual Framework

In order to respond to the objectives, three frameworks including the revised Levesque et. al's access of health care model, revised Andersen model and the WHO six building blocks were explored (Levesque, et al., 2013; Andersen, 1995; WHO, 2010). However, the revised Andersen model and WHO six building blocks framework were excluded because they were too generic or broad respectively for the scope of the study and hence did not fit well with the specific objectives.

The Levesque et. al (2013) model was adapted for analysis. The model has 5 dimensions of accessibility and 5 corresponding population abilities which interact to create access as presented in the appendix 1 (Levesque, et al., 2013). The analysis excluded the dimensions that relate to various patients' abilities, that healthcare services characteristics interact with in providing care along the continuum of healthcare seeking because it is not the focus of the thesis. This is because, the demand side factors have been widely researched and documented. Key among the factors that affect adolescents utilisation or access of SRH services highlighted in these studies are individual, environmental and social cognitive (Krugu, 2016; Abugri, 2015; Aladago, 2016; Alabani, 2017). Even though the demand side was not the focus of this thesis, it was used to determine the supply side factors and so were discussed partially in the results and discussion sections.

Essential dimensions – the legal and policy context as well as accountability (to policy and adolescents) was however missing from this framework and was included as an overarching and standalone components respectively influencing all the model factors.

Figure 2: Adapted Access of Health Care Framework from Levesque et al.



Source: A Conceptual Framework of Access of Health Care: 2013 (Levesque, et al., 2013) **(Adapted by Author)**

2.5.1 Approachability

Approachability considers the point that people with health needs can identify that services exists, can be reached and as well influence the health of the person in need. Despite services' own ability to make themselves known among the different populations, components such as transparency, outreach, information and screening can also go a long way to influence how approachable the service is (Levesque, et al., 2013). How accountable are health services to adolescents?

2.5.2 Acceptability

Acceptability responds to how cultural and social factors determine how acceptable services are to people (example; sex of service providers) and how appropriate it is for people to seek care. Services that are deemed inequitable in its organization may be unacceptable to some community members for whom the service are meant for (Whitehead, 1992). Professional values, norms, culture and gender constitute acceptability (Levesque, et al., 2013).

2.5.3 Availability and Accommodation

Availability and accommodation refer to whether health services – physical space or health providers can be reached physically and timely. They comprise availability of health resources with adequate ability to provide services (Frenk, 1992). They also emanate from facility characteristics such as "density, concentration, distribution, building accessibility, decentralization, urban spread and transportation system; duration and flexibility of working hours" p. 6 (Levesque, et al., 2013). Characteristics of health providers and the methods of service provision are also related to availability and accommodation; example presence of providers, their qualification, contact procedure and virtual consultations possibility (Levesque, et al., 2013; Whitehead, 1992).

2.5.4 Affordability

Affordability encompasses the varying costs incurred for the appropriate type of health care service being run and capacity to raise resources (Levesque, et al., 2013). It includes costs incurred from providing health service – direct and indirect costs, which ultimately influences price of care.

2.5.5 Appropriateness

Appropriateness indicates the type of services provided and the degree to which it addresses the needs of the target group (Frenk, 1992; Krishnan, 2000). It is the relationship between services and clients' needs, timeliness, time spent diagnosing health problems, deciding on the exact treatment and the quality of services offered (Frenk, 1992).

2.5.6 Accountability

Accountability deliberates how health services are accountable to the policies and adolescents.

2.5.7 Legal and Policy Environment

Legal and policy dimension considers relevant laws and policies governing ASRHR in relation to international commitments.

2.6 Study limitations

The results of the study were solely based on published and grey English literature. This means the study missed out on literature that were published in other languages like French in Sub-Saharan Africa. Literature reviewed were accessed online; the implication of this is that relevant literature that were not available online might have been left out.

Additionally, the study did not use primary data, and this might limit the replication on actual and current situation on the ASRH issues in Ghana. Information on appointment mechanisms, screening in relation to approachability of the study were difficult to find.

CHAPTER 3 RESULTS/FINDINGS

This chapter discusses the legal and policy environment in Ghana and further discusses results from reviewed relevant literature using the Levesque et. al's Access of healthcare framework. The five supply side dimensions of the framework described above are discussed. For each subheading, the dimensions are also explained in connection with ASRH services.

3.1 Legal and Policy Environment

How is the legal, policy and political environment, how do they influence policies and to what extent do they make health service accountable to ASRHR?

3.1.1 Legal and Policy Context

The Ghana government has endorsed and is committed to numerous international commitments and local initiatives such as International Conference on Population and Development's 1994 programme of action, Universal Declaration of Human Rights (Act 25), International Covenant on Economic, Social and Cultural Rights (Act 12), Sustainable Development Goals (SDG). These commitments acknowledges the right to health for all, inclusive of adolescents and youth as well as entitle everyone to "available, accessible, acceptable and quality health care facilities and services" p. 22 (Awusabo-Asare, et al., 2006; Ghana Health Service, 2015).

Universal Health Coverage and Sustainable Development Goal: In conformity with the overall subject matter – "Leave no one behind", the SDG 3 on health focuses on the attainment of UHC (WHO, 2017). This proposal encapsulates a number of propositions which includes entreating countries to provide the populace with access of crucial health services such as information and counselling in maternal and child health areas, nutrition, family planning, prevention and management of infectious diseases as well as non-communicable diseases (WHO, 2017). However, several SRHR services including adolescent services are exempted from the target and indicators. Consequently, governments may not prioritise them (Starrs, et al., 2018).

Subsequently, Ghana recently joined the Global Financing Facility (GFF) for women, children and adolescents. GFF with the goal to help countries achieve UHC and SDGs has prioritised SRHR in every investment case with focus particularly on adolescence, family planning and geographical areas that are being left behind in service delivery (Global Financing Facility, 2019). This implies government may be keen on responding to adolescent health needs in Ghana.

3.1.2 Ghana Adolescent Health Service Policy and Strategy

Prior to the development of the Adolescent Health Service Policy and Strategy (AHSPS), adolescent health issues were incorporated in the National Reproductive Health Policy and Standards, the 2000 National Adolescent Sexual and Reproductive Health Policy and the 2010 National Youth Policy. The focus of these policies was largely on SRH with emphasis on HIV and AIDS and adolescent unintended pregnancies prevention. The objective of the AHSPS is to improve adolescents and young people's quality of life in Ghana; and through integration of information and gender-sensitive and responsive health services, contribute to the cognizance of adolescents' full potential.

Amongst the strategies outlined to achieve this goal include; i) improving access of age and gender specific health information and services, ii) building capacity of health providers and support staff, iii) ensuring an enabling environment to support provision of

ASRH services at all service delivery levels. These strategies go beyond SRH, HIV and STIs to provide a range of strategic guidance towards promoting, preventing, and managing health and development of adolescents in Ghana. The policy also mentioned the need to strengthen research to ensure evidence-informed interventions in ASRH services (Ghana Health Service, 2015). Although the policy indicated adolescent involvement, it was not clear the extent to which they will be involved. Additionally, the adolescents themselves were not included in the development of the policy and strategies. Hence, if they are not included in the 'what[3]', they cannot be included in the 'how[4]' (Personal observation).

3.1.3 Ghana Reproductive Health Policy and Standards

The Ghana Reproductive Health Policy and Standards address pertinent aspects of reproductive health such as safe motherhood including antenatal and postnatal care, prevention and treatment of reproductive tract infection, unsafe traditional practices, human sexuality information and counselling, responsible sexual behaviour, postconceptional care and sexual health as well as prevention and management of unsafe abortion and post abortion care (UNICEF, 2017). It also indicates that adolescents can access family planning services, however the age was not specified leaving providers to decide who is eligible or not (UNICEF, 2017). The policy, nonetheless was silent on the availability of modern contraception.

3.1.4 Ghana Abortion Law (1985)

Abortion before 1985 was illegal under all conditions. The law since the amendment in 1985 postulates that abortion is now legally permitted if it is performed by a qualified medical practitioner under any of the following situations: *where pregnancy occurred as a result of rape or defilement, where there is substantial risk of a physical abnormality or disease occurring in the unborn child, where continuing with the pregnancy would risk the mental and physical health or the life of the pregnant*. p. 18 (Hesse & Samba, 2006). Although the law in its current state allows access of abortion services by women and girls, these services are not easily accessible because health service providers are not aware of the provisions in the law (Hesse & Samba, 2006). Lack of enabling environment for adolescents hinders access of services as adolescents in general and specifically those who are not married are stigmatised (Singh, et al., 2018). Additionally, most of the people who may require these services reside in rural areas and even if the facilities are available, the health workforce who have the mandate to provide the services are inadequate hence, restricting access of services (Hesse & Samba, 2006).

3.1.5 National HIV and AIDS and STI Policy

The amended HIV and AIDS and STI policy is premised on *the principles of social justice and equity, which includes equitable people-oriented development, derived from the recognition that adequate healthcare is an inalienable right of each person in Ghana, including those infected and affected by HIV and AIDS, STIs and also based on the assumption that appropriate legislation will be enacted and administrative guidelines made to complement the provisions in this policy. p. 5* (Ghana AIDS Commission, 2013). The policy promotes creation of a conducive environment for all facets of HIV and AIDS, prevention of STI as well as care and support, and places special emphasis on adolescents. Adolescents below the legal age of consent (18 years), require consent from a legal guardian, parent, partner or next of kin to access HIV and AIDS care. In cases where this is not feasible for adolescents 16 -17 years, the medical practitioner may initiate the

[3] What: Development of the policy, process and what goes into the policy

[4] How: Accessing SRH services

essential care in the best interest of the adolescent (Ghana AIDS Commission, 2013). It is the right of everyone including adolescents to access appropriate sexual and reproductive health services information and counselling irrespective of parental consent (United Nations, 2016; Starrs, et al., 2018).

3.1.6 Domestic Violence Act

The domestic violence act, 2007 Act 732 has the objective to protect people especially women and children from domestic violence. It strives to minimize domestic violence incidence in Ghana, improve quality of service provided for victims/survivors, ensure perpetrators are held accountable for their actions and to support community engagement as far as addressing issues of domestic violence is concerned. The forms of violence in the section 1 of the Act include; harassment, physical, sexual, economic and emotional abuse (Human Rights Advocacy Centre , 2014). Findings of this report indicated that generally, people including adolescents, lack the understanding of what Gender Based violence (GBV) is and hence may not know they are victims or recognise an act of GBV as so. In relation to service provision, integration poses a challenge since GBV is interlinked with other SRHR issues (Human Rights Advocacy Centre , 2014).

3.2 Health Service/Supply-side Factors

Findings under this section were made based on the supply-side dimensions in the framework as earlier stated.

3.2.1 Approachability

The extent to which clients are aware of the services available goes a long way to influence their desire to access these services and are empowered to hold policymakers and implementers accountable.

3.2.1.1 Transparency, Information, Screening

Access of health information influences how people reason and as well influences confidence in making strategic choices and decisions (Aseweh, et al., 2011). Health care providers in Ghana for dissemination of health-related information, depend primarily on interpersonal communication[5], media including radio, television, print and recently social media (Sokey, 2016). Unfortunately, majority of adolescents generally and especially those in rural Ghana do not have access to these information due to several challenges (Boamah-Kaali, et al., 2018; Sokey & Adisah-Atta, 2017).

In Sokey and Adisah's study, it was reported that 91.8% could not access the health-related information including reproductive health related information and services because there was no structured information, 88.9%, 81.3% and 89.5% also mentioned language, geographical location and access of mobile phone and internet networks respectively as barriers to access of health information. However, this study did not establish if these challenges were peculiar to only adolescents in the rural areas. Furthermore, a qualitative study conducted among decision makers and health providers in Kintampo also revealed that adolescents face barriers from service providers and that they are regarded as wayward children when they visit the facilities to seek for information (Boamah-Kaali, et al., 2018).

[5]Interpersonal communication: Communication between healthcare provider and client through hospital visit, outreach services, durbars, seminars (Sokey, 2016)

Similarly, another qualitative study in West Gonja found that adolescents in and out of school have little or no understanding about ASRH services and choices (Kyilleh, et al., 2018). It is worth noting that these studies used smaller sample sizes hence, extrapolation should be done with tact. Nonetheless, some of the respondents in the study by Kyilleh et. al mentioned abstinence, use of condoms and other contraceptives as a means of preventing unintended pregnancies. This proposes that they have some information about SRH. They identified peers, parents, nurses, teachers, radio and television as their main sources of information. Out of school respondents indicated their peers as their source of information (Kyilleh, et al., 2018). The following quotes represent some of the responses from adolescents in and out of school;

> *"…we get some information from the schools we attend. Sometimes too, our parents give us some of the information we need in the form of a warning. I think most of the time when we discuss about it with friends we get to know more about the issues" (Male, FGD, in-school).*
>
> *"When we meet our friends, who are more experienced they teach us how to protect ourselves from becoming pregnant. If you have a problem then you bring it out and people will advise you appropriately" (Female, FGD, out-of-school).*

This suggests that some adolescents especially those in the rural areas depend on other sources of information rather than health service for health-related information.

3.2.1.2 Outreach

This term "outreach services" refers to the deployment of health workers to provide health services to people outside of the health facility (Roodenbeke, et al., 2011). Outreach services are provided especially for hard-to-reach areas by community health workers (Family Health Division, 2016). Health promotion services are provided during the outreach services which includes going to schools to enhance information on health and access as well as preventive services (Family Health Division, 2016). The report did not indicate if outreach services are offered in relation to other SRH services.

In Kyilleh's study, health providers mentioned the need to furnish adolescents with reproductive health information and services. Healthcare providers indicated that they organise health education sessions in schools in order to offer students with SRH information and services. It was revealed that health providers unfortunately face opposition from the school authorities as well as community members and are blamed for promoting promiscuity (Kyilleh, et al., 2018). One public health nurse in an in-depth interview reiterated that;

> *"In one of the communities here, we noticed that teenage pregnancy was very common resulting in high school dropout rate among female adolescents. So we organised to go and educate them and also provide them with some contraceptives at the school, but the school authorities did not agree. When the community heard about it, they sent a delegation to warn us to desist from such acts. They said we wanted to encourage premarital sex. But you see, the teenagers were becoming pregnant and when you ask about the one responsible, you see it is usually an adult not a colleague teenager" (Pubic Health Nurse, IDI)*

Outreach providers in another study however, stated that the lack of resources for activities, predominantly, educational materials and transport were some of the challenges they faced (Koster, et al., 2001).

3.2.2 Acceptability of Services

How are adolescent friendly services provided? Health workers attitudes towards adolescents are predisposed to their professional values, norms, culture and gender. Adolescent-friendly health services are the aspects of health system that may attract adolescents to them by creating a conducive or enabling environment that meet the need of the adolescents. How acceptable are the services and their surroundings to the clients?

3.2.2.1 Professional values, norms, culture

In the advent of the national Adolescent Health Development (ADHD) strategy 2009-2015, several capacity building exercises were undertaken before and after to equip frontline health service providers with the requisite knowledge and technical know-how needed to provide adolescents with appropriate SRH services according to their needs (Ghana Health Service, 2015). However, low competence and unprofessional attitudes of health service providers towards adolescents, staff attrition as well as inadequate number of providers trained in adolescent and youth friendly health services (AYFHS), limited legal knowledge on regulatory matters on ADHD are dominant challenges (Ghana Health Service, 2015).

Similarly, health providers outlined unfriendly attitudes of service providers, shortage of staff as some of the setbacks in establishing adolescent friendly centres ((Boamah-Kaali, et al., 2018; Kyilleh, et al., 2018; Kumi-Kyeremeh, et al., 2014). Health care providers tend to be unfriendly to adolescents who wish to seek abortion services and SRH information and tag these adolescents as "spoilt" and also tend to breach privacy of adolescents (Biddlecom, et al., 2007; Boamah-Kaali, et al., 2018). Consequently, because of these unfriendly health provider attitudes, adolescents are unable to express themselves and lie about the problems for which they visited the health facilities with to avoid being tagged (Boamah-Kaali, et al., 2018).

As indicated in the background, in most Ghanaian communities, religion and culture affects every aspect of people's lives. Consequently, socio-cultural, religious norms and practices are also found to influence the promotion and provision of AYFHS which includes condom use as well as other contraceptives (especially for unmarried adolescents) (Ghana Health Service, 2015; Boamah-Kaali, et al., 2018; Ahanonu, 2014). Moreover, there is evidence that adolescents face different forms of stigma and discrimination in trying to access SRH services (Biddlecom, et al., 2007; Kumi-Kyeremeh, et al., 2014). This is supported by a study in Nigeria, which reported that adolescents are discriminated against by providers in service delivery. The study found that some providers were hesitant to provide contraceptives to unmarried adolescents with the notion that it would encourage promiscuity. Some providers mentioned that adolescents should refrain from sexual activities as it was against cultural and religious beliefs (Ahanonu, 2014).

3.2.2.2 Gender

More attention seems to be given to the sexual and reproductive health needs of the female adolescents than the males (personal observation). This is supported by a study by Koster et.al. in which key informants reported that boys lacked information on public health services including SRH especially for out of schoolboys (Koster, et al., 2001). Studies conducted in Uganda and Kenya also reported similar findings (Nattabi, et al., 2011; Ouma, et al., 2015; Godia, et al., 2014). In the Kenyan study, boys' perception of the SRH services were that services were designed for women or girls and children; hence

they were uncomfortable accessing the services (Godia, et al., 2014). In the Koster study, adolescent boys preferred to consult a male health worker when seeking services. However, key informants indicated that there were no male service providers in the facilities (Koster, et al., 2001). This suggests a violation on their SRHR because adolescent boys may not access services if there are no male providers present.

3.2.3 Availability and accommodation

Availability and accommodation entail ASRH services being physically present in a proximal distance and correlates with factors such as geographical location, flexible opening hours and appointment mechanisms. Is the service available, what services are available, when are they available, for whom are they available?

3.2.3.1 Availability of services

As already outlined in the background, there are several health services and interventions that are offered to adolescents and youth primarily by the Ghana Health Service (GHS), supported by several non-governmental organisations (NGOs) (Ghana Health Service, 2015). The 2013 RH report postulates that 291 adolescent health corners which are designed to provide a friendly environment for adolescent SRH counselling and services delivery were instituted both in public and private facilities; 276 and 15 respectively (Ghana Health Service, 2013). Most of the health facilities, however, did not have these youth corners at the time of the publication of the report (Ghana Health Service, 2013). This is in consonance with a recent study in Kintampo which found that there were no adolescent friendly centres (Boamah-Kaali, et al., 2018). Similar findings were reported in Nigeria where SRH services are not necessarily for adolescents (Godia, et al., 2013; Odo, et al., 2018).

There seem to be regional variations (rural/urban) in service availability generally as well as for adolescents as most of the facilities are concentrated in the urban areas. Rural communities are faced with numerous health related setbacks which includes limited healthcare facilities and limited health information as discussed in the previous dimension, which negatively affects healthcare access (Ayanore, et al., 2016; Boamah-Kaali, et al., 2018; Sokey & Adisah-Atta, 2017). Adolescents may also not access health services if the health facilities are not well-resourced, not sufficiently clean, as well as where there is deficient privacy and confidentiality and convenient opening hours (Ambresin, et al., 2013; Geary, et al., 2014; Senderowitz, et al., 2003; Schriver, et al., 2014).

Moreover, the overview of Ghana's mental health system reported that 14% of all patients who received treatment in the outpatient department of the mental health facilities were adolescents below 17 years, in spite of non-existent services earmarked solely for adolescents (Roberts, et al., 2014).

Consequently, the Family Health Division 2015 annual report indicated refurbishing and equipping 71 adolescent health corners across Ghana in order to increase access of ASRH services. The report also indicated that logistics were purchased and distributed to 158 public health facilities (Family Health Division, 2016). Additionally, school health programmes exist in some parts of the country but are sometimes irregular where they exist (Koster, et al., 2001; Appiah, et al., 2015; Boamah-Kaali, et al., 2018).

3.2.3.2 Geographic location

Recognising geographic areas and types of services that are unavailable may benefit governments to better aim resources and technical support (Guttmacher Policy Review, 2015). The distance between the health facility and the clients have been found to

influence access of service including ASRH services (Peters, et al., 2008). There is a relatively high coverage (from 82% in year 1988 to 97% in 2014) of ANC services in Ghana (Ghana Statistical Service, et al., 2015). However, clients complain of travelling longer distances to reach the health facilities owing to a synthesis of the degrees of bad conditions of roads as well as road traffic and the distribution of the service delivery facilities (Adanu, et al., 2012; Aryee, 2014).

In Adanu et al's study, participants reported travelling 30 minutes to two hours to reach the facilities (Adanu, et al., 2012). In contrast, adolescents in the Tema metropolitan area revealed that the location of the adolescent friendly corners was convenient for them; 57% of the respondents representing majority's view (Anaba, 2017). This study was conducted in an urban setting with smaller size and so generalisation of findings should be done with caution. Data collection was also done in the clinics hence responses may be subject to response bias.

3.2.3.3 Accommodation, Opening Hours and Appointment mechanisms

Are the services organised to meet the needs of the adolescents? Convenient service sites and flexible working hours have been found to be enablers that promote service utilisation (Camlin, et al., 2016). Majority of the respondents (69%) stated that they were comfortable with the opening hours of the facilities (Anaba, 2017). This contradicts the study that revealed that the adolescent targeted services which correspond with school hours and for adolescents who are out of school their working hours hence hampering the adolescents from accessing the services (Koster, et al., 2001). Both studies were small and may not be genrelisable. The Anaba study however was conducted in the health facility and may be subject to response bias.

There is an existing eTracker system with the objective for healthcare providers to use tablets or laptops to track clients, follow them up, create schedules for visits and set SMS reminders for clients. The eTracker gives healthcare providers more time for direct service delivery. However, this mechanism is only limited to TB management[6], maternal and child health services (RDD-GHS, 2016). In improving adolescent healthcare quality, it is important for the health facilities to provide services for adolescents with or without appointment (Nair, et al., 2015). In public facilities especially, appointment systems do not work, hence patients/clients tend to wait for longer periods to be attended to. This may be due to location of the health facility and inadequate human resources as indicated in the health provider ratio in the background (This is my personal observation and may be subject to bias). It is worth noting that information on appointment mechanisms was not found for Ghana.

3.2.3.4 Characteristics of providers; Qualification, contact procedures and virtual consultation

To offer better and effective adolescent health services necessitates health providers who are equipped with specialised consultation skills, good interpersonal communication and interdisciplinary skills (WHO, 2015). Conversely, studies reveal that health providers sometimes are deficient of these knowledge and skills to offer adolescent friendly services (Tilahun, et al., 2012; Ghana Health Service, 2013; Family Health Division, 2016). These deficiencies influence their ability to offer age appropriate services to the adolescents (WHO, 2015). Furthermore, healthcare providers desire to improve these skills in order to

[6] TB screening, TB care and Treatment, TB Dots

provide effective services for adolescents, however, these needs tend to be unmet (WHO, 2015). The deficits in knowledge and skills have been attributed to undefined work process and absence of resources (WHO, 2015).

As indicated above under professional attitudes, norms and culture, frontline health providers' capacities were built to have the requisite knowledge and skills to be effective and efficient in the ADHD programme. As a result of this, 604 health care providers received pre and post training before and after the development of the ADHD strategy. The 2013 District Health Information Management System (DHIMS) – 2 data recounted that 764 health service providers received the training on the ADHD programme which suggests an underachievement compared to the 90% service provider target (Ghana Health Service, 2015). Inadequate qualified staff is likely to affect quality of services provided for adolescents. In consonance to this, service providers admitted to not being well oriented and so they tend to restrain themselves from providing services for adolescents (Boamah-Kaali, et al., 2018).

Although the introduction of GHS-Adolescent Health-Mobile Application (GHS-ADH-MAPP) which is an educational application designed for use by providers of adolescent health programme in Ghana and also a communication mechanism for adolescents and these providers (virtual consultation), seem to be making impact, it is faced with challenges such as "poor internet connectivity, distraction of normal service delivery, inability of clients to afford or use smart phones" p. iii (Ereng-Muo, 2017). Results of the study revealed that the evidence-based practice at the point of care has been made appropriate and convenient through GHS-ADH-MAPP. This study however, was a qualitative study and could not quantify achievement of the application. The study was also conducted in one region and so may not be generalisable to the whole of Ghana.

3.2.4 Affordability of Service

This refers to costs incurred from providing healthcare service which encompasses both direct and indirect costs and eventually determines the price of care.

3.2.4.1 Direct, Indirect and Opportunity costs

Health service delivery system is an integrated process by the Ministry of Health and the Ghana Health Service as stated in the background. It is highly dependent on partner support or donor funding with minimal and sometimes infrequent contribution from Government of Ghana (GOG). One of the challenges outlined in the Family Health Division of the Ghana Health Service 2015 report is the difficulty in scaling up insurance schemes (Family Health Division, 2016). Studies have found that women as well as adolescent girls who are covered by the NHIS have better health seeking behaviour leading to increase in access of services (Asante-Sarpong, et al., 2016; Enuameh, et al., 2016; Arthur, 2012).

However, coverage of NHIS among adolescents across the country is low (MOH, 2014). Annual premium, challenges in registration, perceived low quality of healthcare received at health facilities by NHIS subscribers, lack of trust in the scheme were some of the reasons participants in a cross-sectional study by Kusi et. al (2015) gave for not subscribing to the scheme. Koster et al., (2001) found that adolescent services were expensive and that hospital cost such as laboratory investigations could be problematic.

Although family planning commodities are free, clients still pay service charges and efforts are being made by the government to make services free in the NHIS benefit package. This however, is being delayed by the revision of the NHIS law and cost of the policy concerns (Bainson, 2015).

Factors such as economic constraints, longer travel distance to access services were reported to be vital to accessing safe motherhood services (Ganle, et al., 2014; OlaOlorun, et al., 2016).The cost of safe motherhood services such as antenatal, deliveries, postnatal, obstetric care, spontaneous abortion and post abortion care are borne by the NHIS. This initiative was put in place to end out-of-pocket payment for maternal health services in order to stop clients and their families from expenses that may be catastrophic to them and to also increase maternal health services access. However, induced abortion care is not covered by the NHIS, hence pregnant women or girls have to bear the costs of these services themselves (Ofori-Adjei, 2007).

Similarly, it was reported that even though maternal health services are free for NHIS subscribers, subscribers sometimes pay for certain services such as ultrasound scan, laboratory investigations mainly because they have to seek for these services in private facilities since these services may be unavailable or inadequate in the public facilities (MamaYe, 2015). This is not strange because GOG contributions are limited and irregular, hence it affects service provision as indicated earlier.

These may be contributing to the causes of mistrust in the scheme and hence its low coverage. In Ghana, most women especially adolescents are financially dependent, therefore they are faced with financial difficulties while accessing induced abortion (abortions that are requested by the clients themselves) (Baiden, 2009). A study in Ghana on access of abortion services reported that 71% of women in the top quintile in terms of wealth had access to safe abortion in comparison to 38% of those in the bottom part (Sundaram, et al., 2012). Similar findings were reported in the abortion factsheet in Ghana (Guttmacher Institute, 2013).

3.2.5 Appropriateness

Technical and interpersonal quality, adequacy, coordination and continuity regulate how appropriate services received by clients are (Levesque, et al., 2013). Experience of care once service is accessed. Is patient/client fully engaged in care and interaction with service provided?

3.2.5.1 Technical Quality

Many low- and middle-income countries continually are faced with quality of healthcare challenge to a large extent due to inadequate resources (logistics and human resource) (Alhassan, et al., 2015). In order to improve health service quality, the government of Ghana since 1988 has employed numerous interventions including infrastructure, development of protocols and training manuals, health staff capacity building, monitoring and evaluation policy development and provision of incentives to health staff (see table 2 below for detailed information of interventions).

Table 2: Description of Health Interventions in Ghana

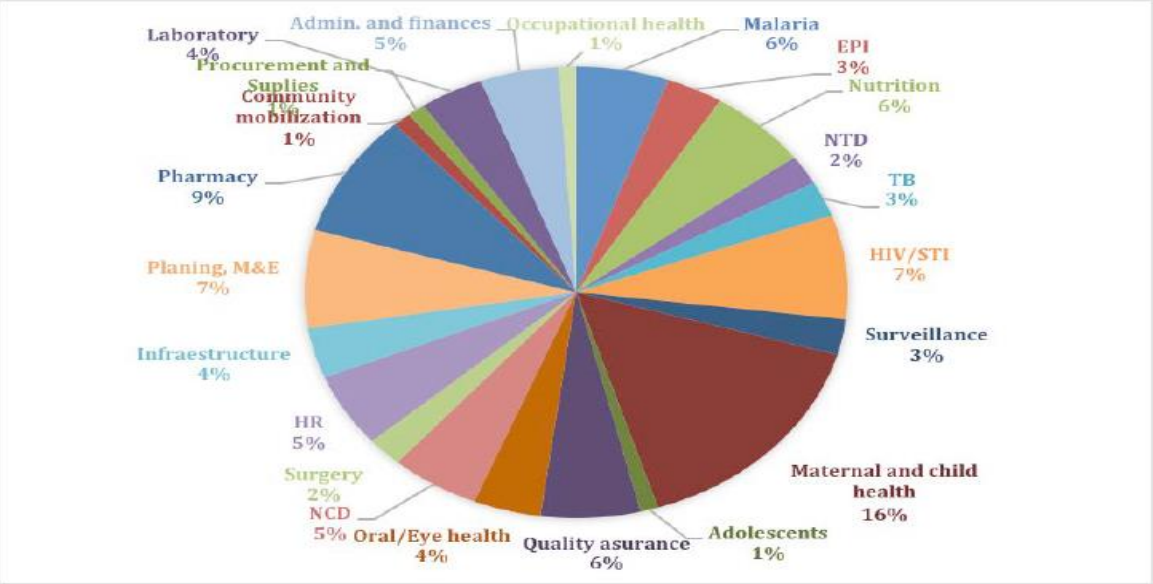
Type of Interventions	**Description**
Regulations	Laws, standards and accreditation
Policies and strategies	Documents describing long term goals and strategic lines
Protocols and guidelines	Describe steps to follow to guide practice
Training manuals	Development of training manuals
Technical assistance	Includes specialist outreach programmes, telemedicine and external support to a particular task or post

Community mobilization	Interventions to increase community education, awareness and participation
Staff training	Mainly in-service training
Health information	Includes supervision and monitoring and evaluation
Process and continuous improvement	Projects dealing with change and addressing processes and systems
Equipment and infrastructure	Purchasing commodities, equipment and infrastructure supported by health partners during the period comprising 2014. Contributions from the government are not captured here.
Monetary incentives	Performance based financing

Source: (Escribano-Ferrer, et al., 2016)

Adolescent health received the least attention (1%) of all the interventions as presented in figure 3 below (Escribano-Ferrer, et al., 2016). It is therefore not surprising that adolescent friendly corners are faced with numerous challenges as inadequate staffing and skilled staff, unavailable corners, costly services, insufficient logistics as discussed earlier under the other components of the framework.

Figure 3: Interventions with the main purpose to improve quality of care in Ghana by themes



Source: (Escribano-Ferrer, et al., 2016)

Strengthened and use of accountability mechanisms at all levels of care in SRHR may ensure that goals and commitments set out by the service are achieved (Starrs, et al., 2018). The 2016 Family Health Division reported that supportive supervisory and monitoring visits were conducted in 4 regions in Ghana (Family Health Division, 2016). This indicates that majority of the regions in the country were not visited, implying weak supervision of services. However, reasons for visiting only the 4 regions were not provided in the report. In attempt to reduce maternal mortality in Ghana, Plan International Ghana

established a project known as the Young Voices Project, a medium to encourage young adolescents in rural Ghana, to hold health providers accountable to ensure effective service delivery. The project reported positive results as far as the attitudes of health providers were concerned (Plan International-Ghana, n.d.). This supports the assertion that accountability mechanisms may ensure that set targets are met.

3.2.5.2 Interpersonal Quality

The cadre of health care providers available and their attitudes may influence the health outcomes of clients and as well as client satisfaction (Levesque, et al., 2013). This is supported by a study conducted in the Ashanti region of Ghana where adolescents reported that they may not access health services because of health provider attitudes (Appiah, et al., 2015). Hence health provider attitudes as mentioned earlier may either facilitate or deter clients from accessing quality health services. According to Ganle et. al. (2014) in a qualitative study conducted among women in Ghana, women prior to visiting the health facilities wish to have a good rapport with health care providers. This is because by so doing, they can freely express themselves in order that healthcare providers may understand their conditions as well as that of their babies. Unfortunately, the opposite is often the case whereby women are met with unfriendly health provider attitudes including maltreatment especially during antenatal clinic (ANC) and labour. The study also reported healthcare provider-client relationship as being poor in Ghana which may intend affect negatively maternal health services uptake. This study however, was not limited to only adolescents but women of child bearing age generally.

Another qualitative study by Yakubu et. al. (2014) found several forms of maltreatment experienced by clients in rural Ghana during labour by midwives. These included shouting/screaming at clients, beating as well as ignoring them even during labour. The story is no different for their urban counterparts and is even worse for adolescent girls (Personal observation). Being a mother of two, I have witnessed on many occasions where adolescents especially are maltreated by health providers at ANC or during labour (Personal observation). Consequently, the midwives in the study indicated that they are responsible for the pregnancy outcome hence they tend to maltreat the women especially those at the second stage of labour who refuse to push in order that they do not lose either the baby or mother or both (Yakubu, et al., 2014). The study however was a small study with a small sample size and hence may not be generalizable. It also failed to explore a variety of healthcare settings as well as urban regions. Health providers due to the patient provider ratio tend to not spend so much time with clients.

3.2.5.3 Adequacy, Coordination and Continuity

Adequacy has to do with whether services provided are enough and how they are provided, integration and continuum of care.

As earlier indicated in the background, a wide range of services including FP, HIV and other STIs, comprehensive abortion care are provided mainly by the GHS and other NGOs across the country (Ghana Health Service, 2015). Although there are several services in existence, access of these services remain poor even though there have been some improvements (Ghana Health Service, 2015). The exact figures for this assertion, however, was not indicated. There is evidence that service integration proved to reduce cost in service delivery, increase knowledge of clients and increase the use of modern contraceptive methods (Haberlen, et al., 2017). However, data to fully evaluate the effect of SRHR/HIV integration on unintended pregnancies in comparison to outcomes from integrated to non-integrated sites was not available in this study.

Additionally, integration of health services, evidence stipulate, can enhance health system efficiency, increase access of a variety of vital and critical services, improve client satisfaction and improve health outcomes (Dudley & Garner, 2011). According to the Lancet Commissions report, abandoning vertical administration of SRH services does not necessarily imply providing "one-stop-shop" kind of services. But rather, making sure that referrals and linkages function sufficiently in order that missed prospects will be avoided by the services. The report also indicates that several sexual and reproductive health issues are "connected along the life course and overlap at specific stages; thus integrated services are better positioned to address multiple needs" p. 2678 (Starrs, et al., 2018). An example is the provision of contraceptive services as part of ANC, PNC and abortion care.

This however, is the practice in some health facilities depending on the capacity of the facility like Marie Stopes in Ghana (Family Health Division, 2016; Ghana Health Service, 2017). It is also noteworthy that some or most of these services are not tailored specifically to adolescents (personal observation). Nonetheless unavailable services along the continuum and medical equipment as well as commodities may be barriers for adolescents as this may discourage them from accessing the services or discontinue using the services and hence should be addressed adequately.

Providing more holistic, unified services to the adolescent sexual and reproductive needs requires a multi-sectoral response and coordination between the health system and other sectors (WHO & LSHTM, 2010; Chandra-Mouli, et al., 2013). The Ghana Health Service in this regard, collaborates with various sector ministries, international organisations and NGOs (Ghana Health Service, 2015). However, this collaboration needs to be strengthened to ensure that adolescent sexual and reproductive health needs are adequately responded to (Family Health Division, 2016). However, as discussed under the earlier components, there is evidence that services or continuum of care are limited and, in some cases, non-existent and as well are not well coordinated. Additionally, integrated services are not necessarily targeted at adolescents. This eventually may affect access.

3.2.6 Accountability to Policies

Accountability is a mechanism to ensure that powerholders are responsible for their actions and provide justification for their actions. It does not involve people's active participation or engagement but it also ensures quality of care through citizen empowerment, protection of rights, corruption prevention; thereby improving governance in the health sector (Sidibé, et al., 2010). Most of the policies in Ghana mention accountability and engaging the people, however the extent of the engagement is not explicitly mentioned.

In summary, Ghana seem to have a conducive political and legal environment as well as policies that are consistent with international standards and supports ASRH services. Implementation of these policies at all levels may be a drawback of ASRH services as health service providers, teachers, parents, adolescents and community in general lack knowledge of the existence of policies, strategies as well as health needs of adolescents (Awusabo-Asare et. al, 2004). Right health provider attitudes, hence, is not the only resolution needed to deal with the problem (Starrs, et al., 2018). Addressing SRHR issues therefore requires multi-sectoral, multi-level responses (Starrs, et al., 2018). Effective accountability may also have progressive repercussions on diverse reforms that may improve quality, accessible and equitable ASRH services along the continuum.

3.2.6.1 External Accountability[7]

Accountability is at the centre of relating human rights to health and development (Hunt, et al., 2003). In recent times, accountability has become top-priority in United Nations network through its interactions with governments. "Every Woman, Every Child" initiative for instance recommends that countries create and enhance all inclusive, transparent accountability strategies (WHO & UNICEF, 2012). The policies discussed earlier offer the basis for multi-stakeholder engagement and adolescent participation in relation to government affair. However, there are gaps in the interpretation and implementation of this inclusive strategy in the health system. GHS provides quality assurance oversights for facilities (GHS, 2004). Clients role in monitoring and improving quality of care are limited (Van Belle & Mayhew, 2014). Even though they are supposed to have representation.

[7] External accountability also known as social accountability is when citizens through active participation hold policymakers and implementers accountable for their actions and decisions.

CHAPTER 4 EVIDENCE-BASED INTERVENTIONS

This chapter presents evidence-informed or evidence-based interventions that have worked, interventions implemented in Sub-Saharan Africa and have responded to one or more components of the framework.

4.1 Successful Interventions

4.1.1 African Youth Alliance (AYA)

Table 3 Evidence-based Interventions for Improving Access

Name of Intervention	Country	Description of Intervention	Evaluation Design	Outcome of Interest and Results	Data Gaps	Component(s) of framework addressed
AYA	Ghana	African Youth Alliance, designed to improve ASRH, decrease incidence and stop the spread of STIs including HIV and AIDS. The following six strategies were used to achieve the goals: · Policy and advocacy · Youth-friendly services · Life planning skills (both in and out of school programmes) · Behaviour change communication (interpersonal communication, folk media, social mass marketing campaigns) · Institutional capacity . Coordination and dissemination	Longitudinal assessment of health service utilisation from clinics	Total number of visits: (Interval) Q3 8,000; Q4 15,000; Q5 17,000; Q6 13,000; Q7 16,000; Q8 16,000	Data for comparison to control clinics and significant testing in service utilisation were not presented. Also, data for clinic attendance from first year was not available	Policy, Availability and accommodation, Appropriateness, Affordability, Acceptability
	Tanzania		Longitudinal assessment of health service utilisation from clinics	Total number of visits: (Interval) Q 5 8720; Q6 11,197; Q7 11,103; Q8, 16900	Data for comparison to control clinics and significant testing in service utilisation were not presented. Also, data for clinic attendance from first year was not available	
	Uganda		Longitudinal assessment of health service utilisation from clinics	Total number of visits: (Interval) Q1 16383; Q2 37980; Q3 40161; Q4 12509; Q5 14201; Q6 16037; Q7 13096	Data for comparison to control clinics and significant testing in service utilisation were not presented	
	Botswana		Longitudinal assessment of health service utilisation from clinics	Total number of visits: (Interval) Q0 130; Q1 347; Q2 424; Q3 461; Q4 375; Q5 351; Q6 449	Data for comparison to control clinics and significant testing in service utilisation were not presented	

Source: Compiled from a systematic review (Denno, et al., 2015) by the author of thesis

AYA and governments of the 4 countries (table 3) through a collective effort worked together to strengthen the health system to establish sustainable quality AYFHS, (Posner, et al., 2007). Many successes were recorded including increased awareness and clinic visits, transportation for supportive provider supervision. Additionally, health providers

were trained, training manuals were developed, and some health facilities were also refurbished to create consulting rooms for young people, with some facilities also having waiting rooms which were equipped with electronic and print media as a way of providing educational information for young people who visited the facilities. Clinic attendance differed by country; ranging from increases in attendance initially with successive decrease, evening out and sturdy increment as presented in table 3.

To create awareness of the presence of these facilities, advertisements were also placed. Furthermore, interpersonal quality between health providers and clients as well as parents were also improved. The six components were not tested to establish that they were all necessary to achieve best impact, results however indicated that comprehensive and integrated interventions may lead to positive outcomes. (Posner, et al., 2007).

Since Ghana was part of this project, lessons learnt from across the other countries as well as in Ghana can be used in scaling up the intervention to improve access of services.

4.1.2 South Africa National Adolescent Friendly Clinic Initiative (SANAFCI)

Health system strengthening such as improving interpersonal and technical quality, infrastructure, provision of equipment and supplies are necessary for the improvement of access of quality health care (Wekesah, et al., 2016). This intervention responds to the following components of the framework; availability, accountability, acceptability and policies

The SANAFCI was planned as a national programme right from the onset to improve the quality of health services to adolescents and youth in public facilities. The public clinics were identified and used as means of providing HIV services. The results by the end of 2005 revealed that, after 18 months, 350 clinics were participating, with 171 associated clinics. Affirmative adolescent health polices, strong leadership, political support, stakeholders' collaboration, youth and community involvement as well as technical support facilitated the success of the programme (Ashton, et al., 2009). It was reported that most of the clinics that were externally accessed conformed to 80%-90% standards. These standards were developed based on challenges adolescents outlined (poor provider attitudes, poor quality services, client-provider confidentiality, etc.) in order to decrease challenges. Community engagement was mentioned as very crucial to the success and is in consonance with an evaluation of Zambians AYFHS programmes. Results of the evaluation suggests that health facilities can implement policies irrespective of size or location of the facilities. Providers together with community leaders joined hands with adolescents to find solutions to ASRH issues in their community. Also, health provider attitudes changed, their capacities were also built to provide quality of care and accountability improved. Adolescents' access was also reported to have increased (Ashton, et al., 2009). There were no control groups to ascertain outcome as a result of the interventions. Significance testing and adjustments for confounders were not presented.

4.1.3 Programa Geração Biz (PGB) – Mozambique

PGB is a national multi-sectoral and multi component initiative in Mozambique that aimed to create an enabling environment for ASRHR by intensifying gender cognizance, decreasing unintended pregnancy incidence as well as reducing adolescents susceptibility to STIs, HIV and unsafe abortion through advocacy and development of policies with supportive implementation comprising of building capacities of technical staff, institutional partners to design, execute, monitor and evaluate ASRH multi-sectoral interventions. Results of the longitudinal assessment revealed a significant impact on knowledge, attitudes and behaviour of young people. Also, it was reported that there

was a national network of high-quality youth-friendly health services, utilisation among youth was also reported to be high (In Maputo city for example, youth visits increased from 11,800 in the year 2000 to above 24,000 in 2003) and also reported services met their needs. The evaluation would have been more accurate if the control sites or denominator information were used for the measurement of the impact of the intervention (WHO, 2009).

4.1.4 Policy Reforms to Improve Sexual and Reproductive Health and Rights

Moving the SRHR agenda forward necessitates more than just developments in health care. According to the Lancet Commission report (Starrs, et al., 2018). Legal and policy reforms are essential to advance the agenda as well as broadening the basis for which abortion is permitted. Reform of the abortion law provides room for provider training in safe abortion care, access of abortion services and "destigmatising the practice" p. 2676 (Starrs, et al., 2018). This is exemplified in South Africa after the liberal abortion law was passed. There was a decline in the incidence of unsafe abortion complications and 91% reduction in deaths resulting from abortion between 1994 and 1999-2001 (Jewkes, et al., 2005). The multicentre, prospective, descriptive study reported immediate progressive influence on morbidity especially among adolescents. The reform paved way for abortion service availability which in turn influenced access (40,000 compared to 400-1000 pre-law era) Liberalisation of policies hence can foster the promotion of SRHR.

Interventions that are planned for adolescents do not sufficiently reach them (Chandra-Mouli, et al., 2015; Denno, et al., 2015). Albeit, there is increasing evidence that directs us to interventions that work and those that do not in terms of addressing these needs (Chandra-Mouli, et al., 2015; Denno, et al., 2015). Evaluations have proven that ASRH services access can be improved especially by harmonising the following four complementary approaches:

i. Training and supporting providers to provide non-judgemental and friendly services to adolescents;
ii. Ensuring that health facilities have friendly and attractive environments;
iii. Ensuring that information and outreach services provide information on services available for the adolescents and as well embolden them to access the services;
iv. Ensuring and engaging community members to acknowledge the importance of providing adolescents with the services and to be supportive of it (Lee-Rife, et al., 2012; Berg & Denison, 2012; Johansen, et al., 2013).

Much as interventions may aim to achieve 100% impact, this aim may be unrealistic and hence interventions can be designed to focus on the most vulnerable and/or marginalised and later scaled up to the entire target population (Chandra-Mouli, et al., 2015; Denno, et al., 2015; Salam, et al., 2016).

CHAPTER 5 DISCUSSION

This section is the interpretation of the findings in respect of Ghana and an exploration of appropriate practices that may be applicable in the context of Ghana to improve ASRH services and access. Strengths and limitations of the analytical framework adapted are also indicated.

As presented in the findings, Ghana has a variety of laws and policies that are in conformity to international commitments specifically for sexual and reproductive health generally and of adolescents. Hence, ASRH services are provided in accordance with these laws and policies. Laws and policies by themselves may not improve access of ASRH services and provision of the services in its entirety. For policies and laws to achieve positive outcomes, programmes must be implemented effectively (Chandra-Mouli, et al., 2015). Implementation seems to be the major setback of the health service in relation to adolescent SRH in Ghana.

It was revealed that health providers sometimes do not know about the existence of these policies (Boamah-Kaali, et al., 2018). This mirrors the extent to which providers can understand and provide youth friendly services. Some of the laws are ambiguous; for example, the abortion law. The law did not specify the age of people for whom the services should be provided. Service providers therefore may use their own discretion which may be influenced by religion and culture to either permit or deprive adolescents from seeking the services. This suggests an infringement on the rights of the adolescents and is contrary to the international commitments outlined in the results (Awusabo-Asare, et al., 2006; Ghana Health Service, 2015).

Additionally, abortion, use of contraceptives by unmarried adolescents is regarded as a taboo or morally wrong, despite the legal context. This is because of ingrained culture and religion that affects all aspects of people's lives in Ghana as indicated in the background. Hence, it may affect health providers decision to provide the services if they are left to the providers' discretion. There is the need to reform policies in order to improve the ASRHR as revealed in South Africa after the abortion law was reformed (Jewkes, et al., 2005).

More so, effective accountability is likely to have a positive correlation with positive health outcomes as the accountability mechanisms will ensure that targets are achieved (Starrs, et al., 2018). However, across all these policies, it is not clearly indicated how accountability to the adolescents as well as to the policies will be ensured. As well, the ASRH policy does not indicate the extent to which adolescents will be engaged. Poor supervision as revealed in the 2016 Family Health Division report affirms that accountability is not prioritised. Subsequently, health providers may not provide good quality care for adolescents since they will not be held accountable. Supportive supervision may go a long way to enforce or enhance accountability thus influencing positively ASRH services. AYA's supportive supervision can be emulated to ensure accountability. Because not only will it ensure active participation or engagement of adolescents but also quality of care (Sidibé, et al., 2010).

Availability of ASRH services is key to access. The findings stipulate that there are services available but are not necessarily tailored to adolescents (Family Health Division, 2016; Ghana Health Service, 2013; Boamah-Kaali, et al., 2018). Rural and urban disparity in the availability and distribution of services and human resources were also revealed in the literature (Boamah-Kaali, et al., 2018; Aryee, 2014; Ayanore, et al., 2016). These suggests inequity and deprives adolescents of their entitlements (rights) and hence make access of healthcare problematic. However, it was also discovered that outreach services

as health promotion are provided for hard-to-reach areas through school programme in order to enhance their knowledge about access of healthcare and preventive services (Family Health Division, 2016). Nonetheless, health providers are constrained by resource challenges such as shortage of educational materials and transportation issues (Koster, et al., 2001). Not only are they faced with resource constraints but also they encounter opposition from community members who claim that providing adolescents with SRH information is tantamount to promoting promiscuity (Kyilleh, et al., 2018). Hence for a country where culture and religion play a key role, even if providers have the zeal to provide the services, once they encounter the opposition, they may not go contrary to the wish of the community.

It was revealed that adolescents depend on informal sources of information rather than health service because they are not existent or infrequent (Boamah-Kaali, et al., 2018; Sokey & Adisah-Atta, 2017; Kyilleh, et al., 2018). Even where they are available, adolescents in their bid to access the information may encounter challenges such as; geographical location, inaccessibility of emerging technology among others as revealed in the results. This is particularly so for out-of-school adolescents and those who are in the rural areas. These challenges may deter adolescents from accessing health services and will in turn rely on informal sometimes inappropriate sources of information. Additionally, bad conditions of roads, road traffic, distance to and distribution of facilities likewise confer accessibility issues for adolescents.

Unfriendly attitudes, discrimination and incompetency of health providers were some of the reasons found to influence adolescents' access of health services (Ganle, et al., 2014; Appiah, et al., 2015; Yakubu, et al., 2014). It was found that lack of skills of providers tend to affect their ability to provide adolescents with SRH services as some of them restrain themselves from providing services because they are deficient of the skills to do so. Despite the policies acknowledging that adolescent services should be friendly and health services must be provided by qualified providers, this is not consistent with the practice because some stakeholders in this case health providers are not aware of the existence of these policies, hence their roles (Boamah-Kaali, et al., 2018). Insufficient workforce was also found to be a factor influencing access. Adolescent boys were reported to have preferred male providers to females and for this study, male providers were not available in the facilities (Koster, et al., 2001).

Adolescent health received the least attention of all the interventions instituted as already indicated under interpersonal quality (Escribano-Ferrer, et al., 2016). It is therefore not startling that there are shortages of staff, logistics among other difficulties faced by the adolescent friendly corners which hamper quality of care and eventually may deter them from accessing the services or discontinue its use. The findings point to the fact that there is low coverage of NHIS among adolescents due to several challenges as annual premium, registration issues, perceived low quality of care received by NHIS holders as well as lack of trust in the system (MOH, 2014; Kusi, et al., 2015). This will eventually impact on access negatively.

Safe motherhood services are covered by NHIS; however, this does not include induced abortion services (Ofori-Adjei, 2007). Additionally, even though safe motherhood services are free, sometimes patients must pay for services such as laboratory investigations, ultrasound because these services may not be available in the public facilities. Hence, patients may access them from private providers. Further, most adolescents are financially dependent and may be faced with financial difficulties if they must pay for services.

Consequently, this may lead them to resort to unacceptable health service seeking behaviours which may be detrimental to their health.

SRH services relies mostly on partner support or donor funding with low GOG's contribution and sometimes not forthcoming. Inadequate funding affects all aspects of quality of care. With Ghana recently joining the GFF, it is hoped that difficulties with funding will be finally resolved.

Service integration has been proven to decrease cost in service delivery, increase knowledge as well as increase access of services (Haberlen, et al., 2017). It was revealed that continuum of care in Ghana is dependent on the capacity the facilities and so is not available in all areas (Ghana Health Service, 2017). Addressing adolescent sexual and reproductive health needs requires multi-sectoral collaboration (Chandra-Mouli, et al., 2013; WHO & LSHTM, 2010).

As indicated in the background, GHS collaborates with other ministries and NGOs but the family health division 2016 report postulates that the relationship between all the stakeholders need to be strengthened to ensure that ASRHR are adequately addressed. However, adolescent health needs have been tagged as a problem that may require only the health system's attention and due to territorial interests, the other sectors outside of the health sector may not be willing to get involved. Also, because of limited budget across all the sectors, they may not want to invest in health if it is not their primary objective.

Interventions aimed at health system strengthening are necessary for the improvement of access of quality health care (Wekesah, et al., 2016). The AYA, SANAFCI, PGB interventions and the abortion policy reform in South Africa demonstrated that health system strengthening interventions involving health providers, adolescents and community members as well as incorporating culture of the people are effective in making services approachable and acceptable. In the case of SANAFCI, community leaders were involved in the pursuit to address ASRH issues. Once these stakeholders are involved right from the beginning of the design and implementation of the intervention, it gives a clear understanding and creates a sense of ownership.

These interventions nevertheless were not without challenges and could be used to make informed decisions should Ghana adapt them. The challenges outlined for the SANAFCI for instance included equipment and supplies problems, resistance from clinic staff and community members. They were likewise challenged with resources limitations as is the case in most Sub-Saharan Africa. That notwithstanding, several strategies were adopted. Quality improvement approach was used to resolve the problems related to equipment and supplies. In dealing with clinic staff commitment to the intervention, youth crisis awareness was increased, value clarification, all categories of staff were included (Ashton, et al., 2009). Engagement of adolescents and community leaders who were key stakeholders was one of the strategies adopted. The aforementioned lessons learned from the best practices can be adapted by Ghana and designed to best fit the context. This however requires more research.

Study Limitations

Most of the literature found were qualitative, used smaller sample sizes and were conducted in selected regions in the country. Hence, more researches are needed among a sample that will be representative of Ghana in order to allow for generalisation. The limitations imply the need for more studies on how to best improve ASRHR and deliver ASRH services.

Strengths and Weaknesses of the Framework

The revised Levesque et. al. model used for the analysis of the results section indicates how the 5 dimensions of accessibility and 5 corresponding population abilities interact. It further details a range of components from the supply-side to the demand-side. It also makes it possible to identify the major areas that may need interventions to be tailored towards in order to address ASRH services issues. The framework however missed an essential dimension which is the legal, policy and accountability (to polices and the people). Again, funding of health services was also missing from the framework. Accountability is mentioned in parts of the dimensions or components, but it is not mentioned explicitly. Additionally, some of the subheadings under the components were not clearly explained as well as contextual factors (rural/urban) not sufficiently covered. Subsequently, it becomes cumbersome to follow through in the analysis

CHAPTER 6 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

Adolescents in Ghana are faced with several sexual and reproductive health issues which requires special attention. Sadly, access to sexual and reproductive health services by these adolescents remain poor and if not addressed will hamper the attainment of the SDGs. Numerous factors influence adolescents' access of SRH services including demand-side and supply-side factors. This thesis, consequently, studied the supply-side, legal and policy environment as well as accountability issues influencing access. The Levesque et. al 2013 framework of access of healthcare steered analysis of the study.

To begin with, for the objective one of the study, the review of the literature suggests that there are policies that adhere to international commitments and as well conducive political environment to ensure the successful implementation of the policies. However, some of the policies like the abortion policy are ambiguous and leaves the decision of provision of service to the discretion of the service providers. Ingrained culture and religion influence effective implementation of the policies hence policies are not effectively implemented. Accountability which may not only ensure quality of care and will also ensure active participation and engagement of adolescents is also not prioritised.

Secondly, regarding the objective 2, the framework discussed health service factors influencing access of ASRH services in Ghana. Unavailability or inadequacy of services; the findings indicate that several ASRH services such as safe motherhood services including modern contraceptives, among others are available. However, not all the services are tailored to the adolescents' needs. Additionally, unequal distribution of the facilities; rural urban disparity does not ensure equity and may compromise access. Limited resources such as shortage of educational materials, transportation difficulties as well as opposition by community members hamper provision of outreach services for adolescents. Similarly, inadequate medical equipment and supplies also hinder service provision and subsequently access.

While adolescents may wish to access SRH services, they are often faced with barriers such as geographical location, inaccessibility of emerging technologies, bad conditions of roads, road traffic, distance to and distribution of facilities, inconvenient working hours. Negative, unfriendly and discriminatory attitudes of health providers also compromise access. Thus, leading them to rely on informal sources of information as well as unacceptable practices.

Low coverage of NHIS among adolescents was also found. Reasons for the low coverage include perceived low quality of services received by NHIS holders and payment of premiums. Besides, some services as induced abortion are not covered by NHIS in the free maternal care. Hence, they may resort to unacceptable practices to terminate pregnancies among other risky activities. GOG funds were also found to be infrequent and limited and the endorsement of GFF is a step in the right direction to improve the financial situation of the health system by the government.

Undoubtedly, a multi-sectoral approach is required for more effective, improved ASRH services or programmes through a holistic and comprehensive approach. A multi-sectoral

approach based on implementation and funding in order to improve ASRH services is required.

Lastly, in responding to the last objective, a variety of evidence-based successful interventions were explored, however this study analysed and discussed only health system strengthening interventions that could apply in the context of Ghana for consideration. These included AYA and SANAFCI which sought to improve adolescent access of SRH services by building capacities of providers, engaging and empowering adolescents and community members to ensure acceptability of services, redesigning facilities to be adolescent friendly and developing protocols and standards to guide service provision. Rather than focusing on the entire target population, interventions can be designed with focus on the key groups before they are scaled up.

6.2 Recommendations

Subsequent to the preceding issues discussed in this thesis, the following recommendations are proposed to the key stakeholders including MOH and GHS.

Policy Framework

1. Policies should be reviewed to be explicit. For instance, the abortion law currently is ambiguous and should be made clearer. The law can also be reviewed to allow for abortion when requested or based on financial reasons in order that adolescents can access safe abortion care rather than resorting to unsafe abortion as exemplified in South Africa.

2. Include induced abortion and contraceptives in the free Safe motherhood services to resolve the financial barrier faced by adolescents in accessing these services. The services should also be free to all regardless of whether they are NHIS holders to ensure access of quality of care.

3. Development of policies that affect adolescents like the ARH policy should have complete stakeholder involvement including the adolescents and community leaders in the development process in order to capture their actual needs and how they wish for them to be addressed and to also create a sense of ownership.

4. Guidelines and strategies for implementation of ASRH services should be designed to ensure that policies and interventions are properly implemented. Engage community leaders in the design and implementation of interventions to provide culturally and religiously acceptable and accommodative services. The SANAFCI approach can be emulated in this instance.

5. Policies should be designed to ensure effective oversight institutions and equip adolescents with the requisite knowledge to insist on their rights and entitlements. This will in turn unbridle their power by engaging them implicitly in making decisions that affect them. This will ensure accountability to adolescents.

Supply side

1. Strengthen multi-sectoral collaboration or relationship so that the other sectors would acknowledge that ASRHR is not only the health sectors concern.

2. Refurbish health facilities to be more adolescent friendly to improve access of the services.

3. Build capacity of health provider to equip them with the requisite skills needed to provide adolescents with appropriate services and reallocate health workforce across the country to ensure availability of providers as well as equity.

4. AYA intervention should be revived and scaled up in the regions which did not receive the intervention. This will entail devoted institutions and funding.

Research

Conduct operational research to generate more evidence on the best practices, evaluate the interventions to better understand mechanisms and impact particularly of definite programme components to inform policymakers and implementers. The research findings will provide knowledge on how to improve services and access through proper implementation of policies and interventions; and to form the basis for multi-sectoral and multi-level approaches to addressing the ASRHR issues.

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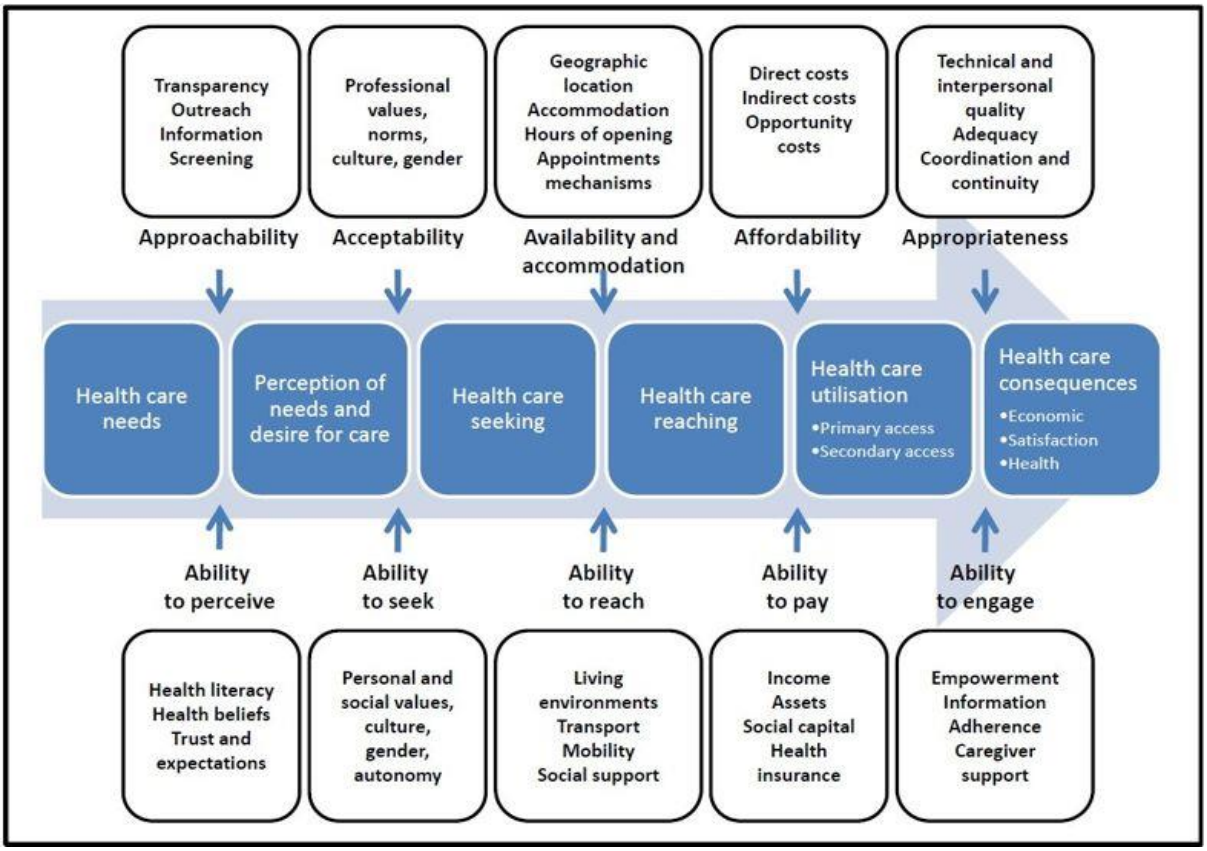
Appendix 1: Access of Health Care Framework



Source: A Conceptual Framework of Access of Health Care: 2013 (Levesque, et al., 2013)