Understanding the barriers and enabling factors for access to sexual and reproductive health services among young people
Final Report
Utrecht, March 2016
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Suggested citation:
Abdul-Rahman L., Thomissen D., & Reeuwijk M. van, 2016, “Understanding the barriers and enabling factors for access to sexual and reproductive health services among young people”, Rutgers & Simavi

The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.
ACKNOWLEDGEMENT

I will like to acknowledge the Dutch Ministry of Foreign Affairs for providing funding for this research through the Access, Services and Knowledge programme.

The research benefitted a lot from the technical inputs made by Miranda van Reeuwijk (PhD) of WFP Rutgers. Kantjil Janssen of WFP Rutgers and Dorine Thomissen of Simavi (Ghana Country Lead for ASK Programme) also provided support for the successful implementation of the research. The role of Mr. Alex le May in the training of the young researchers for the data collection and Mr. Kenneth Danuo, (National Coordinator of ASK-Ghana) in the coordination of all activities and facilitation of communication with the project partners is acknowledged.

The research also benefited a lot from the cooperation and support of Messrs. John Abugri (General Manager, Presbyterian Health Services-North); Alhassan Mohammed Awal (Executive Director, NORSAAC); Johnson Kefome (Executive Director, Theatre for a Change); Albert Wuddah-Martey (Head of Programmes, PPAG); M.M. Ziblim (Executive Director, Simli Aid) and Samual Kissi (Executive Director, Curious Minds). Madam Cecilia Senoo (Executive Director, HFFG) also provided great support to the process.

The ASK Ghana operation research (OR) team made up of Tia Abdul-Kabiru Mahama (NORSAAC); Ms Clara Atsu Djadou (PPAG); Mohammed Awal Abdallah (TfaC) and Matthew Alale (PHS-N) provided a technical support throughout the whole process and also supervised the young researchers in the collection of the data. Other members of the OR who made same valuable contribution were Munkaila Mohammed (HFFG); Jafarat Mahama (Simli Aid); Emmanuel Arthur (Curious Minds); Mercy Amkwandoh (HFFG) Eric Anaba (Savana Signatures) and Alhaj Rashid Bawa (Simli AID).

Ms Jolene Nyaku and Mr Eliasu Yakubu are acknowledged for their support in the analysis of data.

The effort of the young people in conducting interviews and focus group discussions and their peers who shared their views during the process is acknowledged.

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Accra – Ghana
April 2015
LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>ASK</td>
<td>Assess, Services and Knowledge Programme</td>
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<td>ASK-Ghana</td>
<td>Assess, Services and Knowledge Programme (Ghana)</td>
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<td>CHPS</td>
<td>Community Based Health Planning and Services</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
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<td>GSS</td>
<td>Ghana Statistical Service</td>
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<td>HFFG</td>
<td>Health for Future Generations</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IE&amp;C</td>
<td>Information, Education and Communication</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NORSAAC</td>
<td>Northern Sector Action on Awareness Centre</td>
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<td>PHC</td>
<td>Population and Housing Census</td>
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<td>PHS-N</td>
<td>Presby Health Service - North</td>
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<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual Reproductive Health and Rights</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TfaC</td>
<td>Theatre for a Change</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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EXECUTIVE SUMMARY

According to the 2010 Ghana Population and Housing Census (PHC), young people (aged 10-24 years) make up 31.8% of the total population, with majority (50.5%) being females.

To help address the Sexual and Reproductive Health (SRH) challenges of young people, the Access, Service and Knowledge (ASK) programme was developed by the Dutch Youth Empowerment Alliance and funded by the Dutch Ministry of Foreign Affairs with the main objective of helping young people to access SRH information and service directly. To achieve this objective, various innovative strategies such as the use of new media, village health committees, peer educators, etc. are being adopted.

In Ghana, the ASK programme is implemented by 7 local Non-Governmental Organisations in seventeen (17) districts in the Northern, Upper East, Brong Ahafo and Central regions. ASK partners have adopted both old strategies (such as the use of peer educators and counselors to build the capacity of health workers) and new strategies (such as the use of new media- social media, text messages, help lines, etc.) to get the young people to improve their knowledge on and to use SRH services. The ASK partners are still in need of information that would help them sharpen the innovations/strategies they are using in order to better reach the young people and to get them to access SRH services directly. As it stands now, it is not clear how these strategies are addressing the concerns of the young people and how they have contributed to getting the young people to access SRH services.

This operations research was therefore conducted to get information and insight that would help ASK partners to better enhance the effectiveness of their strategies in order to address the needs of young people.

The respondents for the study were young people 10-24 years and SRH service providers selected from 10 communities located in the 7 districts in which the ASK partners work. The data was collected using focus group discussions (FGDs) and in-depth interviews. In all 39 FGDS were held with different categories of young people. Additionally 34 and 124 service provider and young people in-depth interviews respectively were held. The data was collected by young people who received a 5 days trainings on how to conduct research and the study tools. Ethical approval for the study was obtained from the Navrongo Health Research Centre’s Ethical Review Board.

The data collected was transcribed and re-organized manually based on the themes in the study and the research questions. It was then summarized according to themes and common themes summarized together, the distinct views were also highlighted. Some verbatim quotes were highlighted to better show the individuals’ experiences.

The findings of the study indicated that high number of unwanted/unplanned pregnancy and unsafe abortion were the main SRH challenges of young people. Other challenges included high prevalence of STIs stemming from improper condom use, multiple sex partners, unprotected sex and substance abuse (alcohol and aphrodisiac abuse for sexual performance enhancement) especially in young men. A prominent underlining sub theme identified was the role of misconceptions surrounding sex and SRH services in exacerbating the extent of the challenges faced at community level. Participants mentioned that these misconceptions were usually fuelled by ignorance (low literacy rate), shyness, religious bias, ethno-social sex related taboos and barriers.
In discussing the factors driving the young people to access specific services, the participants indicated that males turn to do so because of fear of STIs and females because of fear of unwanted pregnancies. These differences are highlighted in the quotes from participants indicated below;

“Boy’s only buy condoms because they fear STIs through unprotected sex”. “Girls buy secure and other emergency contraceptives because of fear of unwanted/unplanned pregnancy”. “When we have STI screening program more males attended than females?”

Across discussions, young females mention that SRH services that help them to deal with post pregnancy and post abortion stress and stigmatization were unavailable. They further indicated that even for the SRH services available in formal facilities younger unmarried females cannot access these services because they lack the necessary funds. The young females further indicated that services such as abortion and long lasting reversible contraceptives were unavailable in the health facilities in their communities. As already explained, formal providers in Ghana are hesitant to provide abortion services because of the medico-legal issues and this explains why abortion services are not available.

Across all the FGDs the young males (both unmarried and married) were of the notion that whilst there are a lot of SRH service designed for young women very little attention was paid to specialists’ services for young men.

“My wife and I have had all the children we want, but I don’t know what my options are aside condom which is not 100% secure and my wife complains about the side effects of oral contraceptive pill.”

A number of barriers to young people access to existing SRH services and information were identified. The main barrier for unmarried young people was the fear of being stigmatized as “spoilt” or promiscuous if people get to know they have accessed SRH service. This is linked to issues of inadequate confidentiality and privacy. One unmarried female noted that

“we feel shy to do it. Because adults insult us and they see us as bad young people if we try to access SRH information and services”.

Almost all the young people interviewed indicated that at least once in their life they have been discouraged from accessing SRH service or information by a religious leader.

In some communities, formal service providers mentioned that accessing SRH service when one is unmarried is considered distasteful and unmarried young people especially women who do so greatly reduce their prospect of obtaining decent suitor and/or a good marriage. For the married young people the main limiting factor was the need for children or more children by their spouse and in-laws. As one service provider puts it

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1Long lasting reversible contraceptives are birth control methods that provide effective contraceptive for long periods usually a year or more with requiring users’ actions. Examples include intrauterine devices and subdermal implants.
“Most young couples who live in close proximity to in-laws are given so much pressure to give heirs early in their marriage. So most married young people do not access preventive service such as F.P, contraceptives and condoms.” (Formal service providers)

The study identified the following the main enabling factors for young people access to SRH information and services are availability of the service in the community; quality of SRH services; and the perception of the confidentiality and privacy of the provider. Closely linked to the availability of services is the increased in number of informal service providers like peer educators at community level.

Whilst these factors are the same for all the young people, support from husbands and more importantly when they (husbands) decide to accompany their wives to the service provider was one key enabling factor for married females (10-24 year old). For 10 – 19 year olds parental support and the provision of free contraceptives were identified as enabling factors when it comes to services. In terms of information, the young people (10 – 19 years) are more likely to access SRH when the services are more interactive and playful such as quizzes, games, video plays and dramas.

It was found that 43% of young males use some form social media as compared to about 13% of the females, with the main social media applications used being WhatsApp and Facebook. Among those using social media, a high proportion about 9 in 10 for both sexes reported ever accessing SRH information on social media. The main SRH information accessed on social media was related to issues on family planning, STI/HIV and pregnancy. For those who did not use social media the main reason was that their phones did not have internet access. In looking into the future the young people thought Facebook, WhatsApp and text messaging were potential ways to getting SRH information to young people.

Among the service providers, majority indicated that they did not use social media platforms for providing SRH information. The main reason given for not using these platforms to share information was because a large number of the clients were illiterate hence do not use these platforms as means of communication. One provider indicated that

“the young people in my area don’t have smart phones and if they do most of them are not literate so these platforms don’t help me in providing information.”

The young people indicated that the ASK project has contributed to increasing awareness on SRH issues in their communities; improving skill and knowledge of local service providers and to increasing access to SRH services such as condoms.

The under listed recommendations have been put forward to help address the barriers and enhance young people access to SRH services and information;

- Health facility should consider establishing youth corners or putting in strategies such as seeing young people first when they visit them to access services. In facilities that do not have enough space to establish youth corners, they can dedicate specific rooms or days to deal with health issues of youth in general in addition to SRH issues.
- The concept of self-dispensing machines for SRH commodities such as condoms and pregnancy test kits should be explored further and where possible deployed to enable adolescents access services without any interference.
• The whole concept of provider confidentiality, judgmental attitude needs to be re-examined. In addition to providing training for service providers, it is critical to provide supportive supervisions, in other to support them build their skills in young friendly services very well.

• Community level opinion leaders and religious leaders and community leaders should be targeted and engaged in addressing SRH issues of young people. They can play a critical role in address SRH issues of married young people.

• Special SRH programs and interventions for young males should be developed. These interventions can cover issues on male facility; use of aphrodisiacs and sexual enhancement drugs and their general sex life.
Table of Contents

ACKNOWLEDGEMENT ........................................................................................................................................... i
LIST OF ACRONYMS ............................................................................................................................................ ii
EXECUTIVE SAMMARY ........................................................................................................................................ iii

1. Background and Introduction ......................................................................................................................... 1
   1.1. Background ................................................................................................................................................ 1
   1.2. Introduction ................................................................................................................................................ 1
       1.2.1. Problem statement .......................................................................................................................... 2
       1.2.2. Research questions .......................................................................................................................... 3
       1.2.3. Research objectives .......................................................................................................................... 4

2. Methodology ....................................................................................................................................................... 5
   2.1. Study design ................................................................................................................................................ 5
   2.2. Data collection tools and methods ............................................................................................................. 5
       2.2.1. Data collection teams ....................................................................................................................... 5
   2.3. Role of implementing partners .................................................................................................................. 6
   2.4. Study area and population ........................................................................................................................ 6
   2.5. Sample size determination, sampling and data collection techniques ....................................................... 7
   2.6. Ethical considerations ............................................................................................................................... 7
   2.7. Quality control in data collection ............................................................................................................ 8
   2.8. Data analysis ............................................................................................................................................. 8
   2.9. Limitations and challenges ....................................................................................................................... 9

3. Results and discussions ................................................................................................................................... 10
   3.1. SRH Challenges of young people ........................................................................................................... 10
       3.1.1. SRH problems: Who presents what? ................................................................................................. 10
   3.2. SRH and contraception services: What service is accessed and who accesses it most? ....................... 11
       3.2.1. Inaccessible SRH and Contraception Services ............................................................................. 12
   3.3. SRH and contraception information and service for young people - where to go, who to see .......... 13
       3.3.1. Access to Contraception/Family Planning Services ..................................................................... 15
       3.3.2. Access to STI information and services ....................................................................................... 16
   3.4. Strategies to improve young people access to SRH services and contraception: what providers do and young people perspectives ................................................................. 17
       3.4.1. Perspectives of service providers ................................................................................................... 17
       3.4.2. Perspectives of young people ......................................................................................................... 18
3.5. Role of informal service providers in facilitating access to SRH services and contraception..... 19

3.5.1. Traditional healers/ Herbalists........................................................................................................... 19

3.5.2. Peer Educators .................................................................................................................................. 19

3.5.3. Relationship between formal and informal sectors .............................................................................. 20

3.6. Barriers and enabling factors.................................................................................................................. 21

3.6.1. Barriers to accessing SRH and contraception services ................................................................. 21

3.6.2. Bridges - Enabling factors for accessing contraception and SRH services and information .. 25

3.6.2.1. Individuals that support young people to access to SRH and contraception services .... 26

3.6.3. Comparing barriers and enabling factors for access to contraceptives and SRH services . 26

3.7. Social media - a plausible tool for sharing SRH information or not? .............................................. 27

3.8. Role of ASK Project in improving access to SRH information and services ............................... 28

4. Conclusions and recommendation ......................................................................................................... 30

4.1. Conclusions........................................................................................................................................ 30

4.1.1. SRH Challenges, services accessed by young people and inaccessible services ................ 30

4.1.2. Barriers to young people’s access to SRH and contraception information and services ... 30

4.1.3. Bridges - Enabling factors for accessing SRH and contraception services and information 31

4.1.4. Strategies to improve young people access to SRH and contraception services: What providers do and perspectives of young people ................................................................. 31

4.1.5. Role of informal service providers in facilitating access to SRH services ................................. 31

4.1.6. Relationship between formal and informal sectors ............................................................................ 32

4.1.7. Social media ..................................................................................................................................... 32

4.1.8. ASK Project...................................................................................................................................... 32

4.2. Recommendations ................................................................................................................................. 32

References .................................................................................................................................................. 34

Annexes ..................................................................................................................................................... 36

Annex A: List of communities selected for data collection........................................................................ 36
1. Background and Introduction

1.1. Background
The Access, Services and Knowledge (ASK) programme is a 3 year (2013-2015) program funded by the Dutch Ministry of Foreign Affairs with the aim of enhancing uptake of Sexual Reproductive Health (SRH) services among young people aged between 10-24 years, including underserved groups. The programme which is a joint effort of 8 Dutch organizations and their southern partner is implemented in 7 countries namely Kenya, Uganda, Ethiopia, Ghana, Senegal, Pakistan and Indonesia.

The central objective of the programme is to improve the SRHR of young people (10-24) by increasing young people’s uptake of SRH services. To achieve this, the Alliance uses a theory of change which includes three complementing and integrated domains. In order to realise SRHR, a programme needs to address the capacity of the individual (through gender-sensitive SRHR education, information and skills building), create an enabling environment (through working with communities and advocacy), and improve the availability, accessibility and quality of SRH services for young women and young men. M-health and e-health project interventions will be integrated in these three domains.

In Ghana, the program is implemented by 7 partners comprising of SimliAid, Northern Presbyterian Health Services (NPHS), Planned Parenthood Association of Ghana (PPAG), Northern Sector Action on Awareness Centre (NORSAAC), Hope for Future Generations (HFFG), Savana Signatures and Curious Minds. These organizations are supported by their Dutch partners to work in demand and awareness creation and advocacy.

The ASK program in Ghana is implemented in the Northern, Central, Brong Ahafo and Upper East Regions of Ghana. The programme in Ghana targets young people in the age group 10-24, mostly in rural and hard to reach areas. Special focus will be placed on young people aged 10 to 16, young girls and young mothers and young people living with HIV.

1.2. Introduction
According to the 2010 Ghana Population and Housing Census (PHC), young people (aged 10-24 years) make up 31.8% of the total population, with majority (50.5%) being females. Among the young people, the 10-14 year olds make up 37.1%, 15-19 year olds form 33.3% and 20-24 year olds represent 29.6%. About 52.4% of these young people reside in urban areas (communities with population more than 5000) whilst 47.6% reside in rural areas (GSS, 2013a). By 2020, it is projected that the percentage of young people in the Ghanaian population would drop slightly to 30.3% with the proportion of males (50.7%) surpassing that of females (49.3%) (GSS 2013b). This projection indicates that young people will continue to be a large part of the Ghanaian population and there will need some support to deal with their sexual and reproductive issues.

Ghanaian young people, like their counterparts in other African countries, face a lot of challenges when it comes to their SRHR; key among which are issues on teenage pregnancy, human immunodeficiency virus
(HIV) and other Sexually Transmitted Infections (STIs), access to Sexual and Reproductive Health (SRH) services, etc.

One way to assist young people to avoid unwanted pregnancy and STIs is to make contraceptives available to them for use. In an analysis of the 2003 and 2008 Ghana Demographic and Health Survey (GDHS) data, Abdul-Rahman et al (2011) concluded that unmet need for modern contraceptives was increasing among 15-19 year olds. The unmet need for family planning seems to be more prevalent among adolescents living in rural areas and those married (Maronne et al, 2014). In 2010, it was observed that 62% of young people in Ghana had unmet need for contraceptives as compared to 33% for 30-34 year olds (ICF Macro, 2010).

According to the 2008 GDHS report, about 14% of female adolescents (15-19 years) had started child bearing (GSS et al, 2009). For young girls who have started child bearing, access to antenatal service can help in identifying danger signs and hence the provision of appropriate support and treatment by health professionals. Unfortunately, these pregnant young girls have poor antenatal attendance because of the bad and judgmental attitude of some health workers towards them (Kudolo et al, 2008). Certain cultural practices and beliefs such as “pag pregibu²” among Dagbomba and other ethnic groups in the Northern region can also affect Antenatal Care (ANC) attendance and general health seeking behaviour of young people.

The prevalence of HIV among Ghanaian young people (15-24 years) has been quite unstable. Between 2008 and 2010, the prevalence of HIV among young people increased from 1.9% to 2.1%. In 2013, the HIV prevalence decreased to 0.8% (NACP 2014). Sexual transmission is the main factor accounting for most HIV infections in Ghana (ibid). Condoms provide dual protection against pregnancies and HIV infections. Unfortunately condom use among young people (15-24 years) is very low and had been decreasing. Between 2003 and 2008 the current use of male condoms decreased from 5.2% to 3.6% among 15-19 years old females and from 7.7% to 5.5% among 20-24 years old females.

1.2.1. Problem statement

Within the last one and half decade, agencies of Ghana’s Ministry of Health and both local and International Non-Governmental Organizations have developed and implemented strategies to help address the SRH challenges of young people. Although some progress has been made in certain areas such as improving SRH knowledge, a lot more needs to be done to get young people to use SRH services.

Adolescents in Ghana also been reported to have a generally poor knowledge on SRH issues. In 2008 only 34.2% of males and 28.3% of females between 15 and 24 years were found to have comprehensive knowledge of HIV (GSS et al, 2009). GSS et al 2009 further observed that the 15 -24 year olds had the lowest knowledge on contraceptives as compared to older age groups. This poor knowledge might have contributed to the high contraceptive failure rates reported among adolescents in some other studies (Glei, 1999; Rasch, 2002).

² This is a ritual perform for a primigravida before they are allowed to disclose their pregnancy status. Before this ritual is performed the women cannot go for ANC
The effect of all these SRH challenges faced by the young people is high teenage pregnancies, HIV infections and maternal mortality. According to the Ghana Statistical Service (GSS), young people between the ages of 12 and 14 years have the highest Maternal Mortality Ratio (MMR) as compared to other age groups. The MMR of 5671 deaths per 100,000 live births recorded among 12-14 year olds is about ten times the national average (GSS 2013c). In 2015 the GSS and other organisations further noted that, the total demand for family planning (FP) among 15-19 year olds was about 70%, this is higher than the national average of 57% (GSS et al 2015). Although this is an indication that sexually active young people want to use FP, the health systems is unable to meet this demand. As compared to other age groups the 15-19year olds has the lowest percentage of their FP demand being met. It is therefore not surprising that about 1 in every 2 Ghanaian young person (15 -19 years) has an unmet need for FP with teenage pregnancy rate of about 14% in 2008 and 2015 (ibid). Additionally, young people (<20 years) have been reported have the least (4+) antenatal clinic (ANC) attendance before delivery (ibid).

To help address these challenges by the young people, ASK - Ghana partners have adopted both old strategies (such as the use of peer educators and counsellors and building the capacity of health workers) and new strategies (such as the use of new media- social media, text messages, help lines, etc.) to get the young people to improve their knowledge on and to use SRH services. The ASK partners are still in need of information that would help them sharpen the innovations/strategies they are using in order to better reach the young people and to improve their access and use of SRH services.

This operations research was therefore conducted to get information and insight that would help ASK partners to better enhance the effectiveness of their strategies in order to address the SRH needs of young people.

1.2.2. Research questions

Main question
What are the enabling factors and barriers in accessing SRH and contraception services and information\(^3\) from formal and informal providers\(^4\) and has the ASK project strategies addressed these barriers and promoted enabling factors?

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\(^3\) For the purpose of this research SRH services and information will be limited to Information and counselling; pregnancy and related services and STIs including HIV. Contraception refers to access to and use of contraceptives/family planning.

\(^4\) For the purpose of this study formal providers refer to providers within the orthodox health system such as health facilities and drug/pharmacy stops. Informal providers refer to peer educators/community-based distributors, drug peddlers, traditional & alternate medicine providers etc. Providers are generally people who render/supply SRH services indicated in footnote 3 to both adolescents and adults. They can either be formal (trainer health professional) or informal (peer educators, drug peddlers and others who have not health professional),
Specific questions

- What enables young people to access and use contraceptives and SRH services?
- What barriers do young people who succeed in accessing SRH services face and how did they overcome this?
- What was the role of the project in overcoming barriers young people had to face in accessing SRH services?
- How can the ASK project support young people to access and utilize SRH services and information more?
- Where do young people who are unable to visit formal SRH providers go for their SRH services?
- What are the differences between males and females in the following categories: 10-19 year olds and 19-24 year olds; married and unmarried young people in accessing SRH services including contraceptives?
- What is the role of informal SRH providers (peer educators, community based distributors etc) in facilitating access to contraception and services?
- What is the role of social media and other technology-based strategies used by ASK partners in improving young people’s access to SRHR information?

1.2.3. Research objectives

Main objective

To identify the enabling factors and barriers in accessing SRH services from formal and informal providers and how the ASK project has influence these factors

Specific objectives

- To understand the factors that enable young people to access and use contraceptives and other SRH services
- To identify the barriers young people who succeed in accessing SRH services face and how they overcome this
- To understand the role of the project in assisting young people overcome barriers in accessing SRH services
- To identify where young people who are unable to visit formal SRH providers go for SRH services
- To understand the differences between males and females in the following categories: 12-17 year olds and 18-24 year olds; rural and urban; married and unmarried young people when it comes to access to SRH services.
- To understand the role of the informal SRH providers (peer educators, community based distributors etc) in facilitating access to contraception and other SRH services
- To understand the role of social media and other technology-based strategies used by ASK partners in improving young people’s access to SRH information
- To propose ways in which the ASK project can support young people to access and utilize SRH services and information more
2. Methodology

2.1. Study design

The study was a qualitative study which focused on young people (10-24 years) living in the intervention areas of the ASK partners.

The study design was based on the assumption that even in challenging circumstances; some young people still find ways of overcoming barriers to accessing their SRHR. The experiences of these young people and their peers who have not been able to overcome the barriers can be used to improve programming and the delivery of SRH services to young people.

The design also allowed for the collection of data from service providers. This helped in understanding the enabling factors and barriers from the perspective of the service provider. Community level information was also collected through focus group discussions in order to understand how SRH issues are addressed at that level.

2.2. Data collection tools and methods

The data was collected using three tools; Focus Group Discussion (FGD) guide, an in-depth interview guide for individual young person and in-depth interview guide for service providers. The FGDs were largely a participatory mapping exercise and the young people were made to jointly draw a map of the village, mapping out the locations where they (can or do) access SRHR information and SRH services (formal and informal). This helped in identifying services available in their communities. It also explored issues on barriers and enabling factors to young people access to SRH information and services; their preference in terms of how information and services are delivered among others.

The in-depth interview with service providers explored who they see, who come to them (and who do not) and why (not)? What do the providers do to actively reach out to young people to encourage them to access their services (or perhaps discourage)? What helps them in their job, how do the ASK partners support these processes?

Issues on how young people overcome barriers in accessing SRH services; their decision making processes; the key factors that motivated them to seek SRH information and services among others were covered in the individual in-depth interview guide for the young people.

2.2.1. Data collection teams

A team of four data collectors/young researchers (interviewers) and a supervisor (OR team member) visited each community selected to collect the data for the study. The interviewers were divided into two sub-teams of two for them to conduct the FGDs. Each sub-team conducted two FGDs in a day. During the FGD discussion one person was the facilitator and the other the recorder. All four of them then conducted the individual level in-depth interviews the next day.

The supervisor helped to guide the whole process and conducted the service provider interviews.
2.3. Role of implementing partners

Research and monitoring and evaluation activities of the ASK-Ghana are coordinated by the Operations Research (OR) Team. This team is made up of Monitoring and Evaluation Officers of the partner organizations. The OR team represented the partners in the implementation of the operations research.

The team reviewed and approved the research proposal and tools. They also helped in recruiting the young people who supported with the data collection. They also participated in and supported the training of young people as researchers using the explore manual. The training was conducted to equip the young people with the knowledge and skills to support the OR data collection. In addition to coordinating the community entry by getting their field officers to inform communities and health facilities about the schedule of the data collection, the OR team members also served as supervisors during the data collection. In the validation of the draft report the team members represented their various organizations and played a very critical role in providing feedback for the finalization of the report.

2.4. Study area and population

The study was conducted in the ASK intervention districts and communities. The districts are Karaga, Gushegu, Central Gonja and Sagnerigu districts in the Northern region and Asikuma Odoben Brakwa in the Central region. The rest include Talensi and Garu-Tempani districts and Bolgatanga Municipal in the Upper East region and Sunyani West Municipal in the Brong Ahafo region.

The interventions activities of the partners do not cover the whole districts. In each district there is one partner who works in selected number of communities. Generally the number of communities per districts ranges from a 5 to 15.

District level statistics are generally unavailable or very difficult to come by in Ghana. Therefore to provide some bit of background information on the study area some regional level information is use. Table 1 below shows regional level information for selected indications. All the regions had about 3 in every 10 persons living there being between ages 10-24 years. The Brong Ahafo and Central regions had the highest proportion (21%) of 15-19 year olds who had start child bearing. This figure is higher than the national average of 14%. In terms of current use of modern contraception the Northern had the lowest percentage with the lowest level of demand for family planning (table 1).

Table 1: Selected regional level indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Northern</th>
<th>Upper East</th>
<th>Brong Ahafo</th>
<th>Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of young people (10-24years)(^1)</td>
<td>32.0</td>
<td>32.0</td>
<td>33.0</td>
<td>32.0</td>
</tr>
<tr>
<td>Percentage of 15-19 year olds who have begun child bearing(^2)</td>
<td>10.1</td>
<td>9.7</td>
<td>21.3</td>
<td>21.3</td>
</tr>
<tr>
<td>Current use of any modern contraception (women 15-49 years)(^2)</td>
<td>10.8</td>
<td>23.3</td>
<td>26.2</td>
<td>27.5</td>
</tr>
<tr>
<td>Total demand for Family planning(^2)</td>
<td>39.0</td>
<td>50.2</td>
<td>56.7</td>
<td>60.4</td>
</tr>
<tr>
<td>Unmet need for family planning(^2)</td>
<td>27.8</td>
<td>26.5</td>
<td>26.5</td>
<td>29.4</td>
</tr>
</tbody>
</table>

\(^1\)GSS (2013) 2010 Population and Housing Census: Demographic, Social, Economic and Housing Characteristics
\(^2\)GSS et el (2015) Ghana Demographic and Health Survey Report
The study population was young people (10-24 years) living in the communities ASK partners work in. The assistance of the ASK partners was sought to identify the health facilities and peer educators/village volunteers and other people who provide SRH services to young people within the communities. The young people, health facilities and peer educators/village volunteers in the selected communities were also interviewed as part of the study.

2.5. Sample size determination, sampling and data collection techniques

Data was collected at three different levels; service provider level, community level (FGD with young people) and individual level.

The list of all communities in which the ASK partners work was obtained and the communities grouped into urban and rural based on the 2010 Ghana Population and Housing Census. Based on the fact that the study is a qualitative studies and that most of the communities are clustered in the Northern and Upper East regions where there might not be large variations between communities, and the purposive nature of the study it was decided by the principal investigator and the Operations Research Team that a sample size of 10 communities was enough to provide the needed information. Other factors such as the time available (because of the life span of the project); financial and logistical challenges were considered in arriving at the sample size of 10 communities.

Based on the rural urban grouping, 30% of the communities were classified as urban with the 70% being rural. Using proportional to size sampling 3 urban and 7 rural communities were selected for the study. Simple random sampling technique was then employed to select the communities in each class (that is urban and rural) (see Annex for list of selected communities).

During the FGDs some selected young people who have succeeded in accessing SRH services were identified for individual level in-depth interviews. The peer educators/volunteers and other SRH service providers were also asked to recommend young people who have accessed services for the in-depth interviews.

The FGDs and service providers’ interviews took place on one day. Whilst the in-depth interview with the individual young people was scheduled to the next day after the FGDs. On the whole 39 FGDs, 124 in-depth interviews and 34 service provider interviews were conducted.

2.6. Ethical considerations

Ethical clearance for the study was obtained from the Navrongo Health Research Centre Ethical Review Board, based in the Upper East Region of Ghana.

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5 Young people who indicate they accessed SRH services within the three months preceding the data date of data collection will be considered as having been able to overcome the barriers.
In every selected community the consent of the community elders (chief, assemblyman/woman, etc) was sought as part of the community entry process. Similarly, at the health facility level the consent of the In-charge was sought. In seeking the consent of the community leaders and health staff the team also discussed the fact that some of the interviewee will be under 18 years and asked them for consent to interview young people from 10 to 18 years. In all the communities and health facilities the needed consent was granted for interviews to be conducted with young people below 18 year.

During the FGDs the consent of the entire group was sought. Additionally, the rights of the participants not to answer any question they feel uncomfortable about and also to stop the interview at any point if they do not want to continue was explained to them before the start of all interviews. The potential benefits of the research were explained to the participants. The only foreseen risk related to the study was the time respondents spent responding to the questions. The estimate time needed to complete the interview was explained to the participants before the start of the interview. Oral consent was sought from the whole team and one person made to sign on behalf of the group.

Similar consent processes were repeated in situations an individual was being interviewed, whether the individual was below or above 18 years. At the individual level the teams did not indicate to them whether consent was granted by the community leaders and health workers or not unless they specifically asked. This was done to ensure that the individual decision to participate or not to participate was not influenced by that of the community leaders and health workers. The three layers of consent process ensured that all individuals are adequately protected.

The consent for recording of interviewees was sought before interviews are recorded. In recording interviews, identification information such as names were not recorded.

2.7. Quality control in data collection

Twenty five (25) young people were taken through 5 days training on how to conduct research and the research tools. The best 20 were selected to take part in conducting the interviews. During the trainings, the young people discussed the research tools and translated it into the local language. This ensured that they understood the questions and the kind of information each question is meant to collect. The tools were also pretested and the feedback discussed.

All interview notes and recordings were reviewed after each day’s work by the supervisors. Through this review, the interviewers were assisted to identify and ask all follow-up questions that would help in obtaining in-depth understanding of the issues under study. As part of the data quality control process each team met every day to discuss the process and challenges.

2.8. Data analysis

The data collected was transcribed and re-organized manually based on the themes in the study and the research questions. It was then summarized according to themes and common themes summarized together, the distinct views were also highlighted. Some verbatim quotes were highlighted to better show the individuals’ experiences.
2.9. Limitations and challenges

The OR team members were tasked with the recruiting of young people who will help with the data collection based on criteria which were agreed on at that inception meeting. One of the key requirements was that the young person should be able to read in English and translated it into one of the local languages. He/she should also be able to translate responses from the respondent into English and write it out clearly. However some of the young people recruited by the OR team members had difficulty reading. However, this was only known when they came for the training. The resulting effect was that those who had difficulty reading did not understand all the issues covered in the training. To address this most of them were not selected in the final teams but a few were given the opportunity because their team would have had limited numbers. Supervisors were then directed to give them minimal role and to provide more support to them during the actual data collection. Generally the young people were not experienced in the collection of research data. However, the research was a very good opportunity for them to be introduced to research and the training helped in getting them to know the basics with the hope that implementing partners will continue to use them in their future research activities. Their involvement in the data collection also contributed to one of the key objectives of the project, which is to promote meaningful youth participation.

The data collection teams also had challenges identifying young people who successfully accessed SRH and contraception. This made is difficult for the research to achieve the objective of learning from their experience.

There was limited probing and follow up on response, this made is difficult to provide clear explanations and reasons for some of the findings.

There is always a tendency for project implementers to see operations research as an evaluation. This situation also came us during the implementation of the operations research and could have influenced some of the results considering the level of involvement of the partners. This notion could have influenced them to select young people who will make their implementation look good as FGD participants. The partner involvement could also have affected the objectivity of the responses given by the young people. To address these issues, the partners were always reminded to see the research as a way of trying getting information to improve the implementation of the project and not an evaluation. The OR team members were also made to work in communities their organizations were not working it. These actions helped to minimise these limitations.

The study also wanted to find information for various categories of young people unfortunately respondents were not found for all the categories. For example married 12-17 year olds were not found in the communities. Therefore information for this age group was only limited to those who were not married.
3. Results and discussions

3.1. SRH Challenges of young people

“Our main challenge here is ignorance, people don’t know and so they don’t practice healthy sexual habits” (formal health sector service provider).

Service providers in the formal and informal sector identified high number of unwanted/unplanned pregnancy and unsafe abortion as the main SRH challenges of young people. Other challenges mentioned included high prevalence of STIs stemming from improper condom use, multiple sex partners and unprotected sex. Some added substance abuse (alcohol and aphrodisiac abuse for sexual performance enhancement) especially in young men.

A prominent underlining sub theme identified was the role of misconceptions surrounding sex and SRH services in exacerbating the extent of the challenges faced at community level. Participants mentioned that these misconceptions were usually fuelled by ignorance (low literacy rate), shyness, religious bias, ethno-social sex related taboos and barriers. The participants also alluded to the fact that in their native communities, there exist a genuine desire for SRH information and services but these desires are quickly diminished by religious/moral taboos and ethno-social sex related myths and rules. These factors heavily dictated the space and manner in which SRH issues and services are perceived and accessed. One respondent mentioned that

“A lot people have questions about sex and SRH especially young girls but in my community, accessing information means you are promiscuous or ‘spoilt’” (A formal health sector service provider).

This comment resonates with a comment by another participant who said:

“Most people in my community have the preconceived idea that SRH services are for prostitutes and promiscuous people. Women are afraid to access SRH services in the community because the community regards such women as women who have intentions to cheat on their husbands and boyfriends, their in-laws will call them names and they will get a bad reputation” (A formal health sector service provider).

Most participants were convinced that all above mentioned factors (religious/moral taboos and ethno-social sex related myths and rules) have contributed to create an ambience of mistrust for SRH services as well as the SRH service providers among the community members.

3.1.1. SRH problems: Who presents what?

In terms of the SRH problems presented by clients, there were variations between that of the clients of informal and formal providers. Whilst the main problems presented by clients of informal providers included unwanted pregnancy; STIs; heavy bleeding during menstruation and menstrual pain and problems of infertility /impotency, the clients of the formal providers presented problems of incomplete/unsafe /illegal abortions, family planning complications and infertility. The kinds of problem presented by the clients to the service provider reflect the client views and perception about the services provided by the service provider. As the findings indicated, client went to informal providers for abortion
services and visited formal providers if they develop complications. In Ghana, abortion is considered illegal unless it is to save the life of the mother, so most formal providers do not provide abortion services, but they are allowed to help clients who visit them with incomplete abortions and to address abortion related complications. Clients also visit formal providers for FP services and for help with FP complications because the informal providers do not provide FP services with the exception of sale of condoms.

Clear differences were observed in terms of the problems presented by young males and young females. According to the service providers most of the young males sought treatment/help on issues related to STIs and periodically a few reports of sexual dysfunction or weakness, their female counterpart however sought help for treatment for vaginal discharges and bleeding usually due to STI infection or pain during sex, unsafe/illegal abortion, FP and FP complications and infertility.

These challenges are similar to those identified and analysed in the Ghana Strategic Plan for the Health and Development of Adolescents and Young People (2009-2015) (MoH 2009). Although the strategic plan was developed to help address these issues not much has changed as we come to the end of the strategic plan period. The findings of the 2014 GHDS indicated that about 14% of all Ghanaian adolescents (15-19 years) had started child bearing with the percentage (21.3% each) in the Central and Brong Ahafo regions. This is a clear indication that the challenges still persist.

3.2. SRH and contraception services: What service is accessed and who accesses it most?

As indicated in the objectives section, the SRH services covered within this research included pregnancy, STI and related services, whilst contraception mainly referred to family planning. Discussions with the service providers (both formal and informal) indicated that females turn to access SRH and contraception services more than males. They indicated that this trend was due to the fact that female of all ages and status were much assertive when it comes to talking about their SRH problems than their male counterparts who usually feel intimidated about talking about SRH issues with providers. Among married young people, the informal providers reported that females access their services more than males. This finding is similar to other studies which have observed that females are more likely to use health services than males. One reason that can also account for why the females accessed SRH and contraception services more than males might be because the SRH services consider under the study were related more to pregnant and that there are more female contraceptives and SRH interventions targeted at females than males.

Females were reported to patronize services and information that are tailored towards family planning, abortion, antenatal whilst more males access services pertaining to condom used, impotency, infertility, and STI treatment. One service provider noted that

“males access condoms more, it is considered normal for males to buy condoms than female, other services like the “secure” (contraceptive pill) and emergency contraceptives are accessed more by females. It’s considered normal for females to access such services”. (Formal service provider)

The kind of FP/contraception service accessed reflected the sex of the individual who uses that specific contraceptive method.
In discussing the factors driving the young people to access specific services, the participants indicated that males turn to do so because of fear of STIs and females because of fear of unwanted pregnancies. These differences are highlighted in the quotes from participants indicated below;

“Boy’s only buy condoms because they fear STIs through unprotected sex”. “Girls buy secure and other emergency contraceptives because of fear of unwanted/unplanned pregnancy”. “When we have STI screening program more males attended than females?"

In general the Ghanaian society stigmatizes young people who get pregnant before marriage with very little action paid to the males that impregnates them (Abdul-Rahman et al 2011). So it is not surprising that the young girls are more concern about pregnancy than STI. However their choice of non-barrier contraceptive methods is an issue of concern and will put them at risk of STIs. This choice and fear of pregnancy also reflects their perception of their risk of getting infected with STIs

3.2.1. Inaccessible SRH and Contraception Services

In exploring the availability of SRH services the study also focused on services that were not accessible to young people. Across FGDs, young females mention that SRH services that help them to deal with post pregnancy and post abortion stress and stigmatization were unavailable. They further indicated that even for the SRH services available in formal facilities younger unmarried females cannot access these services because they lack the necessary funds. The young females further indicated that services such as abortion and long lasting reversible contraceptives were unavailable in the health facilities in their communities. As already explained, formal providers in Ghana are hesitant to provide abortion services because of the medico-legal issues and this explains why abortion services are not available. In terms of the long lasting contraceptives, these are usually provided by midwives and some medical doctors, however most of the communities from which the data was collected had only Community Based Health Planning and Services (CHPS) compounds which are usually manned by Community Health Nurses who cannot provide these type of contraceptives.

In communities with facilities in which these services were available, the young females indicated that, the service was not accessible if they are not accompanied by their husband/partners or a male family member. Similar observation was made by Ngom et al (2003) in a study in the Upper East Region of Ghana.

Across all the FGDs the young males (both unmarried and married) were of the notion that whilst there are a lot of SRH service designed for young women very little attention was paid to special services for young men. The married young men mainly complained about little sensitizing on various family planning/contraception methods for men. They explained that these methods are usually not available in the local formal service providers’ facility and even in cases where they are available they are usually reserved for older married couple. The quote below from one male participant summarizes the challenges they face.

6Long lasting reversible contraceptives are birth control methods that provide effective contraceptive for long periods usually a year or more with requiring users’ actions. Examples include intrauterine devices and subdermal implants.
"My wife and I have had all the children we want, but I don't know what my options are aside from condom which is not 100% secure and my wife complains about the side effects of oral contraceptive pill." (Male FGD participant)

The unmarried young people especially those aged 10-19, complained of not being able to access stigma free services from formal SRH service providers. In that there were few formal service provider operating youth friendly services. Also some unmarried young men complained about their inability to access stigma free comprehensive abortion care for their partners or breach of trust by formal service providers in the local communities. For instance an unmarried participant age between 20-24 years explained that:

"My girlfriend and I cannot walk into the health centre and ask for an abortion without getting dirty looks from the nurse like we are committing a crime. If we were married that will be a different story." (Unmarried male, 20-24 years)

Others mentioned lack of educational material in local languages, inadequate professional counsellors in their communities as well as the lack of appropriate equipment and facilities such as specialized HIV counselling and testing units as some of the SRH related service that are inaccessible to them.

3.3. SRH and contraception information and service for young people - where to go, who to see

The participants hinted that although their communities faced enormous SRH related challenges, there were various actors providing different levels of SRH and contraception information and services within their communities. The findings indicated that both the formal and in-formal actors were playing a critical role in addressing the SRH needs of young people. Table 2 shows the sources of SRH and contraception information and services. As shown in the table there were more contraceptive related information and service providers than the other SRH issues. Each group of provider focused on a very specific services that they were generally known to provide with the formal sectors health facilities being the only ones that provided almost all the services.
Table 2: Sources of SRH and contraception information and services

<table>
<thead>
<tr>
<th>Sources</th>
<th>Kind of service/information</th>
</tr>
</thead>
</table>
| Hospital, Clinics, Health Center, CHPS | • Family planning for married couples  
• Testing and treatment for STIs  
• Antenatal for all pregnant women  
• Treatment of infertility and barreness  
• Abortions |
| TBA                      | • Pregnancy counseling and delivery service                                                  |
| Drug store/chemical sellers | • Sale of condom; pills  
• Information on condom use and dosage for oral contraceptives  
• Sale of emergency contraceptives |
| Herbalist                | • Herbal remedies and advice on STI, Barrenness, infertility  
• Abortions |
| Peer educator/ NGO       | • Distribution of free condoms and contraceptives  
• Counselling during community outreaches  
• Provision of free STI screening  
• Provision of reference SRH material  
• Continuous advocacy for SRH health in communities |
| MEDIA - Radio, discussions, Television, SOCIAL drama | • Forums for discussing SRH issues with Key Speakers  
• Call in SRH help-lines and talk shows  
• Films and drama shows on STIs especially HIV/AIDS |

It worth noting that although the participants recognized each of the formal and informal service providers as mentioned in Table 2, each group of females reported that they only access certain services from the provider. For married young females, accessing SRH services was usually restricted to the formal service providers such as CHPS, clinic etc. A slightly different view was reported by the unmarried female participants, who explained that they only go to formal providers outside their native communities in extreme cases such as HIV testing or when they are in need of an abortion. Some unmarried young females especially those between 10 to 19 years indicated that they travel a minimum of 3-7 miles to other towns to access formal services to avoid stigmatization by formal health provider personnel in their native towns. Most unmarried females reported that they preferred peer educators and NGO based service providers because these providers always ensure secrecy and confidentiality in service provision. In addition, informal services are cheaper and the personnel don’t stigmatize unmarried females.

Across focus groups, the male participant’s mentioned that they accessed mainly SRH services and information that were tailored to STI treatment and prevention especially proper condom use and STI screening. Among the married males it was common place to access such information from the formal service providers such as CHPS and drug store because they were likely to obtained accurate information and experience a higher quality of service. In the words of one participant...
“the staff in the hospital are the best source of information and they have all the instruments for testing for STI, that’s why more married people go to the community clinic for SRH services and information”. (Married male participant)

The opposite was reported for the unmarried male participants, whether they were aged 20-24 or 10-19, they indicated that they usually access information and services from informal providers especially peer educators and local NGOs.

As to distance travelled to access SRH services, response across the male focus groups showed disparities across marital status with little difference across age groups. In that, married young people of all ages are likely to access service in their own native communities if there are adequate facilities than go nearby villages or towns. Unmarried young males of all ages indicated that they usually prefer to access SRH services outside their towns and villages and are likely to travel an average of 5km from their native communities to access SRH services. It was further explained that unmarried young people usually travel these distance in order to ensure anonymity and to prevent stigmatization. This was especially true for the young people within the age group 10-19 years as most communities consider that age too young to be having sex. One participant aged 10-19 year noted that

“in my community, my age mates and I are considered to be too young to be having sex so we normally buy our condoms when we go to the big town, at least no one knows us there”. (Male 10-19 years old)

3.3.1. Access to Contraception/Family Planning Services

Majority of married young people (10-24 years) interviewed indicated that they mainly patronize FP service from providers within their communities.

The common trend reported among the unmarried young people was either to access FP information from SRH informal service providers within their communities such as peer educators, NGOs or from formal service providers outside their communities. The latter is true for most young unmarried 10-19 year olds who usually have to hide their sexual habits from their parents and other community members in their towns. A 10-19 year old stated that;

“most of us don’t go to the clinics in our town, we can’t dare if we don’t want all people to know our SRH issues in our town”. (Unmarried female, 10-19 years old)

The 10-19 year old males further indicated that they patronize free services like the distribution of condoms.

For the unmarried females it was observed that it is only those between 20-24 years who normally access services outside the communities they live in. They further indicated that in cases where they need services like abortion they prefer to travel an average of 5km to formal facilities outside their communities for the services, to help deal with issues related to stigmatization and confidentiality. They explained that they face a lot of stigmatization from service personnel in their local formal SRH facilities hence they don’t have confidence in the services provided in these formal facilities. A 10-19 year old unmarried female stated that
“If you are young, some of the health workers are not friendly” (10-19 year old unmarried female).

Another interviewee observed that

“If you go to the clinic for family planning the nurse tell your parents when they meet them at church”. (10-19 year old unmarried female)

### 3.3.2. Access to STI information and services

In general, the participants of all ages and marital status mentioned that they usually hear about the services available in their communities from community sensitization campaigns and outreaches organized by some formal providers or NGOs and from peer educators during door to door outreaches. For the unmarried females, they reported that they hear about the availability of services from friends and family members who have prior experience with such services.

Married females reported that they prefer to use STI services provided in formal SRH facilities because these facilities have experienced doctors and personnel plus quality equipment which make diagnosing STI and testing for pregnancy easier. Also the doctors and other health personal are able to provide and explain information about STI and pregnancy prevention, symptoms and treatment. In the discussions with the unmarried female (20-24 years), they explained that they preferred to contact local informal providers such as drug stores, peer educator and herbalist for services and information pertaining to STI. Their preference is mainly guided by the fact that these providers are readily available at all time in their local environments and provide rapid response when contacted. A participant said;

“their physical presences in the community make us hear about the service and it is easy to contact them.” (20-24 year old unmarried female)

A similar trend was observed in the responses given by younger unmarried females (10-19 year olds), however, their decision to utilize the services from peer educators and NGOs is purely based on the fact that these providers offer free or cheaper STI screening and pregnancy testing services.

The response from the discussions with the married males gave an indication that for most married males 10-19 and 20-24, usually, access to STI services were not priority as compared to pregnancy prevention services. Varied reasons were given by for this trend; some were of the opinion that accessing STI prevention when you are married gives an indication of promiscuity. A married 10-19 stated that

“I think most married men in my town don’t use STI related SRH services ... because their wives will automatically assume that they are cheating on them.”

The following quotes sums up the views of married 20-24.

“In my religion, once you married you supposed to have sex with only with your wife hence condom use or use of any other STI prevention procedure becomes unnecessary”. “Marriage in our community is for procreation hence pregnancy prevention is frowned upon by most families so most of us don’t find it necessary to utilize this type of SRH services”.
The few married males who patronize STI and pregnancy prevention related information and services, indicated that they did so in order to enjoy sex without worrying about their partner getting pregnant as well as to space out their children.

The discussion among the unmarried young males showed that the main SRH needs of this group were usually related to STI prevention and treatment as well as pregnancy prevention hence they patronize these services more than any other SRH service. During the interviews one unmarried participant pointed

“*As men we are concern about STI prevention than any other SRH issue*.“ (Unmarried male young person)

They indicated that this was because they

“*… don’t usually have a fixed sex partners, we usually utilize STI services and inputs to ensure that we don’t contract and/or spread STI across partners.*”(Unmarried male)

Although most unmarried males seem to be generally more concerned with STI prevention service primarily, 10 to 19 year olds were much more concerned about pregnancy prevention. This was because the large number of them were not financially independent or still in school hence were ill prepared to bear the financial responsibilities and constraints attached to pregnancy. A 10-19 old participant mentioned that

“I am too young to have children so I go the CHPS outreaches for free condoms to protect myself from getting someone pregnant.”(10-19 years old unmarried)

Most of the unmarried males reported that they preferred to utilize service from informal service providers such as peer educators, herbalists and drug stores because accessibility was easier and these providers were in close proximity and can be contacted at any time of the day. Also the services provided by the informal sector are relatively cheaper than those of the formal sector.

3.4. Strategies to improve young people access to SRH services and contraception: what providers do and young people perspectives

3.4.1. Perspectives of service providers

Previous studies on the young people access to SRH services and information have found that most services providers are usually aware of the fact that some extra effort and strategies are need to enable young people access the services and information (Kudolo et al 2009). With this in mind, the study sought to identify the strategies that were being used by the SRH providers to enhance young people access to their services.

For the informal provider the main strategy was to ensuring confidentiality. They indicated that assurance of confidentiality in all discussion and interactions was pivotal when it comes to encouraging the young people to access SRH and contraception services. Young people usually need to feel that SRH services are tailored to meet their needs and that their SRH problems will be heard in an environment that ensures
confidentiality and by people who are not judgmental. Aside building confidence and trust in young people, formal providers also noted that the prospect of being given cheap or free incentives such as condoms and contraceptives attracts young people to access certain SRH services.

3.4.2. Perspectives of young people

Whilst the in-depth interviews with the service providers was focus on understanding what they were doing to encourage young people to access services, discussions with young people focused on what they will like to be done – looking into the future.

On the whole, there were no variations in the suggestions that came from males and females and between married and unmarried. In terms of age groups the only difference observed was that the 10 -19 year old suggested an increase in free services. The key suggestions are discussed below;

- Supporting intensive peer education

There is a need to train additional community based SRH peer educator and incentivize the already existing peer education system through continuous professional skill improvement trainings. The peer educators should be provided with more and free contraceptive for young people who cannot afford formal services. They added that NGOs should increase school based campaigns by increasing availability of education and learning material on SRH in schools. Also there was a need to translate educational material into local languages and into audio-visual forms for those who can read or write.

- Public Education and announcement

The young people also suggested an increase in the SRH outreach activities in their communities as another way to increasing accessible. They explained that as the organization of more open fora and discussions on SRH issues will help to sensitize indigenes by demystifying some of the sex related taboos and myths, in addition to the stigma attached to people who use SRH and contraceptive services.

- Making SRH and contraceptive services accessible

A section of participants recommended that SRH providers should consider the provision and the use of self -services units like “ATMs” that dispenses pregnancy and STI home test kits and contraceptives that can easily be used by young people. The notion was that such services cuts out the stigmatization by health personnel and ensures access to SRH services at all times.

- Use of social media (Facebook, WhatsApp)

Many were of the view that, social media could serve as an indispensable tool in increasing access to information. The use of social platforms such as Facebook and WhatsApp were mentioned as fast and safe way peer educators and other SRH providers can use for the dissemination of SRH news, articles and information.
Establish youth corners in health facilities

The young people suggested that health facilities should have designated areas for young people. In the words of one young female, “… hospitals should have special or separate places for young people alone. So that young people will feel free to ask about sex life issues and also request for treatment.

3.5. Role of informal service providers in facilitating access to SRH services and contraception

Informal SRH and contraception service providers perform a critical role to making some SRH information and services accessible to young people. Throughout the study and from literature two informal sector actors have been found to be very common, that is traditional healers/herbalists and peer educators. The study further sought to get an understanding of the SRH services provided by the herbalist and peer educators and how young people get to know about these services.

3.5.1. Traditional healers/ Herbalists

Generally the participants in the FGDs and interviews pointed out that, the traditional healers/herbalists usually provide indigenous and traditional information on STIs, causes and symptoms. Specifically, they provided the community with traditional/folk information on the causes, symptoms and treatment for many sexual related health problems such as impotency and infertility in married men and women, sexual weakness in young males, irregular menstruation, heavy bleeding and mistral pain among females and STI (genital warts, gonorrhoea and syphilis in both sexes). One participant mentioned that;

“the herbalist in our town, is considered a master for the cure for infertility and barrenness, there are so many testimonies of the potency of his medicines”. (Male participant)

Among the young females it was noted that for STIs such as HIV and hepatitis B, which the formal service providers find difficult to treat, some community members revert to traditional healers for spiritual healing. The findings further indicated that the traditional healers/herbalist were not providing information and services to help prevent contraception.

In terms of the mode of healing and medicine, the participants and respondents across all ages and sex indicated that the traditional healers normally use herbal preparations and concoctions. Across the various groups of participants and interviewees there was a general view that the herbal medicine was very potent – cured a lot of STIs and help dealt with issues of infertility among males and females.

The study identified recommendations from friends who had benefited from the services of traditional healers; face to face discussions with healers who move from home to home marketing their services and in recent times radio adverts as the mechanism through which young people get to hear about the services of traditional healers.

3.5.2. Peer Educators

Peer education has been identified as an efficient way to making contraception information and some services available to young people. It can also be used to provide information on other SRH services but with limited opportunity to provide the services. Peer education is able to address barriers of mistrust.
between young people and health workers. The study found that young people had a lot of trust in peer educators and identified them as one group of providers who were very confidential in the provisions of services. In the words of one participant,

“I sometimes go to peer educators for advice and emergency contraceptives because they can keep secrets”. (Female paricipants)

The participants indicated that the peer educators provided information on usage of contraceptives and STI symptoms. More specifically the young people indicated that they go to see peer educators when they have questions on menstruation, vaginal discharges, pain during sex and general sex health, emergency contraceptives and free condoms. A 20-24 year old unmarried mentioned that

“I go to the peer educator in my town because they are also reliable and confidential plus they also distribute condoms freely.”

All these benefits notwithstanding, the young people indicated that they still have challenges in accessing information and services from peer educators. The main challenges are inadequate supplies and the wrong timing of meetings. The females still think issues on confidentiality needs to be strengthen.

3.5.3. Relationship between formal and informal sectors

All the service providers (formal and informal) interviewed indicated that there was a cordial relationship between the formal and informal service providers. They collaborate largely in terms of referral of clients. The informal sector usually refers clients to the formal sector. As noted by one TBA

“I usually accompany my clients especially the teenage mothers to the health centre when they have a problem, it makes them feel safe and helps to build their confidence in me. Eventually they are able to trust me with all their SRH needs”.

The formal providers also provide training and information, education and communication materials (IE&C) for some of the informal providers.

The informal services providers however indicated that there was a need to properly define referral system between the two sectors to ensure consistency in SRH service and information provision. They further suggested that to improve the relationship, the formal sector needs to do more in recognizing their role in provision of SRH services and information. In the words of one informal service provider;

“they need to recognize us as valid service providers and give us the necessary training and assistance needed so we can help them in providing the necessary SRH information, they can’t do it all alone.”

The formal service providers put forward the under listed suggestions as a way of improving their collaboration with the informal providers;

• Proper training of informal providers in youth friendly service
• Meeting on regular basis with informal service providers for discussions
• Provision of regular refreshers for both informal and formal provider to update their skills
• Institute awards scheme to reward SRH providers (formal and informal) in the communities
• Recognition of their contribution of informal providers
• Collaboration with informal provider to provide education at community level.

3.6. Barriers and enabling factors

3.6.1. Barriers to accessing SRH and contraception services
Among all respondents it was generally noted that SRH at community level was mediated through a very strong religious/moral and cultural filter hence most often than not provision of SRH and contraceptive services and information have to be done with some degree of secrecy or caution because their clients fear stigmatization. This situation tend to affect the provision of contraceptive more than the other SRH services. One formal service provider noted that:

“There are several platforms for disseminating SRH and contraception information and services on a large scale but in most of our communities, sex is regarded as a private issue hence everything has to be done with some level of secrecy”.

Some opinion and religious leaders propagate notions that issues that happen in marriage like sex are sanctified and hence should not be discuss with other people including health personnel. In addition to the issues of religious and moral norms service providers and the young people themselves noted that the main barrier for unmarried young people was the fear of being stigmatized as “spoilt” or promiscuous if people get to know they have accessed contraceptive services. This is linked to issues of inadequate confidentiality and privacy. One unmarried female noted that

“we feel shy to do it. Because adults insult us and they see us as bad young people if we try to access contraceptive information and services”.

Almost all the young people interviewed indicated that at least once in their life they have been discouragement from accessing SRH service or information by a religious leader.

In some communities, formal service providers mentioned that accessing SRH and contraceptive services when one is unmarried is considered distasteful and unmarried young people especially women who do so greatly reduce their prospect of obtaining decent suitor and/or a good marriage. For the married young people the main limiting factor was the need for children or more children by their spouse and in-laws. As one service provider puts it

“Most young couples who live in close proximity to in-laws are given so much pressure to give heirs early in their marriage. So most married young people do not access preventive service such as F.P, contraceptives and condoms.” (Formal service providers)

Whilst this finding is similar to that of Abdul-Rahman et al (2011) who noted that married young people (15-19 years) had a less chance of using contraceptives as compared to their peers, it is contrary to that of Achana et al (2015) who found that married people (15-49 years) had about two time more chance of using contraceptives as compared to their unmarried peers. The study population of current study and Abdul-Rahman et al (2011) was mainly young people and those married might have been in their early years of their marriage and would like to have children. The population for Achana et al however included
a larger sample of women older than 24 year, who might have been years into their marriage, had children already and were interested in spacing their birth or even stopping child bearing.

The service providers noted that married young people were concerned about how other community members will see them if they realize they are assessing family planning services. One of them noted that

“married people fear about the comments people would pass when they see them seeking services. Gossip and mockery on married people.” (Formal service providers)

Responses from the married and unmarried young female did not indicate much difference in the barriers they face. Among the young males age 20 -24 years, it was observed that whilst the stigmatization based on ethno-social rules and myths about marriage, sex in marriage and birth control made it difficult for married males to access SRH and contraceptive services readily without confrontations from older community members, religious restrictions on sex and sex before marriage were the factors among their unmarried male counterparts.

For the discussions and interviews with younger females within the 10-19 years, the parental restriction made it difficult for young females to access SRH services. In most communities, a young female’s chastity is used as a measure of a family’s virtue hence there is a lot of pressure on females to remain virgins until marriage. Restricting the females from accessing services and even information is a way of preventing them from being perceived as promiscuous by the rest of the community.

The study further found that 10-19 year olds access to SRH and contraceptive services is also limited by financial constraints and the general view that they were too young to talk about sex or get involve in sex made it difficult for them to access services and information. In the words of one married male (10-19 years)

“I just got married and started a family I don’t have enough money to be going to the clinic for family planning, it’s too expensive for me”.

Some formal service providers also held the view that 10-19 years old are too young to even discuss SRH and contraception issues. Among young females 10 -19 years the participants indicated that in additional to financial constraints parental restrictions was one other factor which made it difficult for them to access services.

Unlike the 10 -19 year olds, 20 -24year olds across all categories were seen as old enough to discuss SRH issues, the participants however indicated that their access to information and services was limited by ignorance and stigmatization and if they are unmarried they will face the barriers already enumerated for unmarried young people.

In the discussions and interviews, young females further listed poor quality of service, lack of confidentiality and attitude of SRH service providers as the main things that discourages them from accessing services. They indicated that some providers discuss client’s medical problems with other community members and sometimes their parents especially in cases they attend the same church. This however was more a problem for the unmarried adolescent as compared to the married ones. One unmarried female interviewee indicated that
“Judgmental attitude of some service providers makes it difficult for us to access service. Also lack of confidence in them is another fear.”

The young people further indicated that the limited SRH facilities and service providers in their communities was also a barrier. This finding is similar to Achana et al 2015 who observed that women who live in close proximity (within 2kms) from a health facility had a higher chance of contraceptive use as compared to their peers who live far away (more than 2km).

The young people further observed that the ratio of young people to facilities and facility personnel was too large so the personnel were over stretched and overloaded. The overstretched services result in long queues and long waiting time for clients and this makes it unattractive to access the services. They however commended NGOs for the good services they provide. They observed that the most significant SRH related impact programs are run by NGOs.

3.6.1.1. **Individuals impeding young people access to their SRH and conception services**

Apart from the general issues at the community level which affected young people’s access to SRH information and services, the study also explored the role specific individual in the community played in inhibiting young people’s access to SRH information and services and the specific actions they took in this regards. The table 3 below summarizes the findings by age and marital status.

With the exception of the ways/actions taken to discourage the use of contraception services by partners of 20-24 year old married and religious leaders for unmarried 10-19 year olds, no sex related difference was observed in the findings. For the partners of the 20-24 year old married respondents the females discourage their spouses by accusing them of infidelity when they want to use condoms, whilst the males discouraged their wives when they insist on use of condoms by indicating the condom was uncomfortable. This finding is in line with several other researches which reported that some condom users have indicated it is uncomfortable and reduces pleasure. The association of condom use with unfaithfulness has also been reported by in other studies. Generally these findings indicate the lack of proper understanding and benefits of the use of condoms with respect to pregnancy and STI preventions.
In terms of the actions taken by religious leaders to discourage unmarried 10-19 year olds from the using contraception services. The findings indicate that the religious leaders discourage the young boys by preaching and telling them that sex is restricted for only adults so they should not get involved although in the case of the young girls they also preach about chastity, the girls specifically indicated that they ostracize them and describe them as evil when they suspect they are using SRH services.

Stigmatization by health workers and their judgmental attitude has been reported to be a major barrier to young people access to SRH services in a number of studies (RamaRao, et al 2003; Pullum, 1991). It is a very worrying issue since the health workers are supposed to know better and help the young people to make informed SRH decisions.
3.6.2. Bridges - Enabling factors for accessing contraception and SRH services and information

The enabling factors varied based on the category of young people. For the married young people, service providers were of the view that, the most enabling factor is the quality of the service and information being provided. According to the services providers, in deciding to visit a facility to access service or not married young people take into account the kind of facilities available, the friendliness of the staff, reviews from other couples and the level of confidentiality.

This view was also shared by all the different groups of young people who were interviewed. The role of quality service in improving access to FP services has been critically examined by RamaRoa et al 2003. In their study they concluded that contraceptive use increases with increasing quality. With predictive probabilities of contraceptive use being 55%, 62% and 67% respectively for low, medium and high quality care.

For unmarried young people the study found that, their access to SRH and contraception services and information is influenced positively by their perception of service quality and the qualification of the staff, in addition to friendliness of service providers and respect for client.

“Many unmarried young will only access SRH services in facilities that they consider as receptive and youth friendly” (A formal service provider).

Support from husbands and more importantly when they (husbands) decide to accompany them to the service provider was one key enabling factor married females (10-24 year old) indicated in the interviews and in the FGDs. They further added that service providers treat them better when they are accompanied by their partners. Older males (20-24) whether married or unmarried were usually encouraged to access service and information purely based on testimonies and recommendations from friends, family and colleagues. For the younger males aged 10-19 especially the unmarried ones, trust in service provider and level of confidentiality assured by the provider. They were of the opinion that services that provide some level of confidentiality are more trustworthy than those who don’t hence they will prefer to travel long distance to other towns and communities to access services from trustworthy service provider.

Parental support and the provision of free contraceptives were identified as enabling factors that helps 10-19 years to access contraceptives and SRH services.

“Young people (10-19 years) are encouraged by the promise of free condoms and other contraceptives. When these facilities organize SRH services that are free, a lot more young people within this age group will attend” (formal service provider).

A 10-19 year old participant explained that

“we like the services from the NGO, the condoms are either free or cheaper but good quality.”

In terms of information, the study found that young people (10 – 19 years) were more likely to access SRH and contraception information when it more interactive and playful such as quizzes, games, video plays and dramas.
Across all participants and respondents the main enabling factors identified were the availability of the service in the community, quality of SRH services, and the perception of the confidentiality and privacy of the provider. The increased number of informal service providers like peer educators at community level was named as one of the most significant factors that has enabled young people to access to SRH and contraception information and services.

### 3.6.2.1. Individuals that support young people to access to SRH and contraception services

During interviews with selected young people they were asked to list individuals who supported them to access SRH and contraception services and the kind of support they provided. The table (4) below show the results. Generally no gender differences were observed when it comes to the individuals who encourage males and females. With the exception of teachers, the young people were generally supported by their peers (friends and peer educators). This explains the strong emphasis young people place on recommendations from peers when it comes to deciding on whether to visit a service provider or not.

<table>
<thead>
<tr>
<th>Individual supporting access to SRH services</th>
<th>Individuals supported</th>
<th>Kind of Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>Young married females</td>
<td>Recommend SRH service providers</td>
</tr>
<tr>
<td></td>
<td>Young unmarried females</td>
<td>encouragement to access SRH service such as STI screening and abortion</td>
</tr>
<tr>
<td></td>
<td>Young males (married and unmarried)</td>
<td>Condom provision</td>
</tr>
<tr>
<td>Peer educators</td>
<td>Both married and unmarried</td>
<td>Peer educators provide reference SRH educational material</td>
</tr>
<tr>
<td></td>
<td>Unmarried young people especially 10-19 year olds</td>
<td>Peer educators provide free or subsidized SRH incentives</td>
</tr>
<tr>
<td></td>
<td>Both married and unmarried</td>
<td>TBAs provide prenatal and antenatal advice</td>
</tr>
<tr>
<td>School teacher</td>
<td>Young females and males between 10-19</td>
<td>Sensitization of sex and the need to access SRH service in school</td>
</tr>
</tbody>
</table>

### 3.6.3. Comparing barriers and enabling factors for access to contraceptives and SRH services

As already indicated, for the purpose of this research SRH services and information was limited to Information and counselling; pregnancy and related services and STIs including HIV. Contraception refers to access to and use of contraceptives/family planning. Analysis of the findings indicates that there were not much differences in the barriers and enabling factors for contraception and SRH services. The few differences observed were in the areas of access to voluntary counselling and testing for HIV (VCT); proximity of services provider/facility and parental support.
HIV VCT is a key part of routine services provided for all pregnant young women, whether young or old. All women who visit antenatal clinic are counselled on the need to know their HIV status and on the benefits it will bring to them and their unborn babies. Apart from the pregnant young people all other young people will have to make a decision on their own to go for VCT or are advice to do some when they visit a hospital with signs and systems that the clinician thinks is STI related. In such situations they will be referred to go for testing. With the exception of HIV where the facility might have a rapid test kit, all other STI testing might have to occur in another facility, most likely the district hospital.

This then raises the issue of proximity of services providers/facilities. The proximity of service provider/facility, affects access to SRH services more than contraceptive services. Generally health workers at the lower level (CHPS) are able to provide most commonly used contraceptives (condoms, injectable and implants), however these staff are unable to provide testing for most STIs with the exception of HIV. Young people who will need to be tested for other STIs will therefore have to be referred to the facilities especially district hospitals, which are far away from where they live. Unless they are really sick they might end up not going.

Married young females experience less barriers in accessing SRH services as compared to all the other categories of young people. This is largely because the SRH services turn to be more female focussed and these married young people do not experience the barriers their unmarried colleagues face. Additionally, young married females turn to enjoy more parental support when it coming to accessing SRH services than their unmarried peers who are even afraid to let their parents know they might be accessing services. Parents support the married young people because they see access to services as a way of improving the health of the married young female. However, unmarried young people who want to access SRH like HIV and STI testing are seen as being promiscuous.

3.7. Social media - a plausible tool for sharing SRH information or not?
Social media has a great potential when it comes to sharing information and it provides opportunity for two way communication. The study explored it potential used in sharing SRH information with young people.

It was found that 43% of young males use some form social media as compared to about 13% of the females, with the main social media applications used being WhatsApp and Facebook. Among the males a larger proportion turn to use Facebook as compared with WhatsApp. However, for the females the proportion that use WhatsApp and Facebook was the same. Among those using social media, a high proportion about 9 in 10 for both sexes reported ever accessing SRH information on social media. The main SRH information accessed on social media was related to issues on family planning, STI/HIV and pregnancy. For those who did not use social media the main reason was that their phones did not have internet access. In looking into the future the young people thought Facebook, WhatsApp and text messaging were potential ways to getting SRH information to young people.

Among the service providers, majority indicated that they did not use social media platforms for providing SRH information. The main reason given for not using these platforms to share information was because a large number of the clients were illiterate hence do not use these platforms as means of communication. One provider indicated that
the young people in my area don’t have smart phones and if they do most of them are not literate so these platforms don’t help me in providing information.”

On the other hand, a couple of providers indicated that they regularly used social media platforms such as WhatsApp, Facebook to disseminate SRH information to their clients.

“My facility sends weekly SMS on adolescent health problems to young clients and other community members”.

In response to questions asked about the appropriateness of social media as a platform for sending out information, the regular users responded that social media provides a medium to reach large number people in a shorter time frame. Others were of the view that social media especially WhatsApp and helplines are less expensive and help to cut down cost of transportation and communication during community based sensitization. A few others mentioned that some of these platforms come with some level of anonymity so SRH clients’ especially young people feel confident to discuss their SRH problems without fear of being identified and stigmatized.

3.8. Role of ASK Project in improving access to SRH information and services

The ASK partners in Ghana work largely in the area of awareness creation, service provision and advocacy. The partners employed various strategies to help address the SRH and contraception needs of young people through providing information, building capacity of service providers to provide services and even providing the services themselves.

A review of the project documents from the various partners indicates that all the partners involved in awareness creation used some form of peer education as a way of providing information/creating awareness. Some used the peer educators to distribute condoms. Other strategies include community entry and sensitization and the one-on-one engagement with selected community leaders. For the partners involved in the service provision, their main strategy was to build the capacity of staff to provide youth friendly services and to set up/make their facilities more youth friendly, but not many of these trainings had taken place at the time of the OR data collection. Although there were other strategies being planned, these that not been started at the time of OR data collection.

The use of the peer educators, community entry and sensitization activities were however limited in terms of engagement with religious and community leaders in additions to dealing with health workers. Community leaders were only informed about the project as part of the community entry but were not targeted in the sensitization activities. The religious leaders were not even targeted at all. Additionally, since there is a critical need for the community and religious leaders to change their attitude towards contraceptive and SRH services use by young people, the one of engagements might not yield the desired results, so there will be a need for more long term engagement.

Although the OR is not an evaluation, it tried to get a snap shot of the role ASK project had played so far in terms of improving access to SRH and contraceptive information and services for young people. The respondents noted that the project has contributed to;

- Increasing awareness on SRH issues in their communities
- Improving skill and knowledge of local service providers
• Improving access to contraceptives such as condoms
• Decreasing stigma attached to SRH issues such as STIs

Among all the groups it was indicated that the project partners were able to influence young people’s access to SRH information through sensitization campaigns using seminars, drama and games and the provision of information, education and communication materials on SRH. Findings further indicate the project partners had improved young people access to contraception by using peer educators to distribute (free) and sale condoms at a subsidized price. It was further indicated that peer educators as part of their work also provided education to address some of the misconceptions on contraception.

Although the respondents indicated that the peer educators trained by the project partners usually educate and encourage them to visit health facilities when they have SRH problems, the study did not find any increase in their access to SRH services.

Although ASK partners have contributed and continue to contribute enormously to enhancing the SRH information and services at community level, the respondents thought they can do more. They therefore put forward the under listed suggestions to help improve the benefits they can drive from the project.

• Establishment of youth specific SRH information centres in the various communities.
• Organizing annual refresher courses on SRH topics for service providers such as TBAs and drug/chemical sellers
• Recognizing and appropriately appreciating the efforts of the informal service providers as part of the SRH providers
• Intensifying services provision in schools and other institution like churches.
4. Conclusions and recommendation
Based on the findings of the study following conclusions are drawn.

4.1. Conclusions

4.1.1. SRH Challenges, services accessed by young people and inaccessible services
Main SRH challenges faced by young people include unwanted/unplanned pregnancy, unsafe abortion and STI infections. One emerging issue that came up was the use of aphrodisiac and sexual enhancing drugs especially in young men. The females also face challenges related to heavy bleeding during menstruation and menstrual pain.

The main problems presented by client of informal providers included unwanted pregnancy; STIs; and problems of infertility /impotency, the client of the formal providers presented problems of incomplete/unsafe /illegal abortions, family planning complications and infertility. In terms of sex differences young males sought for treatment/ help on issues related to STIs and periodically a few cases of sexual dysfunction or weakness, their female counterpart however sought help for treatment for vaginal discharges and bleeding usually due to STI infection or pain during sex, unsafe /illegal abortion, FP and infertility.

Generally the females’ patronized services and information related to family planning, abortion, antenatal whilst more males access services pertaining to condom use, impotency, infertility, and STI treatment.

Although some SRH services was available in the communities, service related to how to deal with post pregnancy and post abortion stress and stigmatization were unavailable for young females. Among the males there is a general concern that not much attention has been paid to their SRH needs and that they cannot access abortion access for their girlfriends.

4.1.2. Barriers to young people’s access to SRH and contraception information and services
A number of barriers to young people access to SRH and contraception services and information have been identified in the study. Most of these barriers could have been overcome to some extend but for the issues of poor quality of service, lack of confidentiality and judgmental attitude of SRH service providers especially in the formal sector. Issues related to the provider judgmental attitude, lack of privacy and confidentially are barriers for all the categories of respondents. The young females are particularly concern about formal providers informing their parents that they access SRH services.

At community level, SRH issues are mediated through a very strong religious/ moral and cultural filter hence most often than not provision of SRH and contraception services and information is done with some degree of secrecy or caution because of fear of stigmatization. The issue of stigmatization affects unmarried young people most. For married young people, the main barrier is the demand for kids from their spouses, parents and in-laws. Young people (10-19 year) access to SRH and contraception services and information is limited by financial constraints and the general view that they were too young to talk about sex or get involve in sex. In general these barriers tend to affect access to contraceptives than other SRH services.
4.1.3. Bridges - Enabling factors for accessing SRH and contraception services and information

The main enabling factors for young people access to SRH and contraceptive information and services are availability of the service in the community; quality of SRH services; and the perception of the confidentiality and privacy of the provider. Closely linked to the availability of services is the increased in number of informal service providers like peer educators at community level. Whilst peer educators support the provision of condoms they have limit capacity to provide other SRH services.

Whilst these factors are the same for all the young people, support from husbands and more importantly when they (husbands) decide to accompany their wives to the service provider was one key enabling factor for married females (10-24 year old). For 10 – 19 year olds parental support and the provision of free contraceptives were identified as enabling factors when it comes to services. In terms of information, the young people (10 – 19 years) are more likely to access SRH when the services are more interactive and playful such as quizzes, games, video plays and dramas.

4.1.4. Strategies to improve young people access to SRH and contraception services: What providers do and perspectives of young people

The main strategy of informal service providers is to ensure confidentiality. Assurance of confidentiality in all discussion and interactions is pivotal when it comes to encouraging the young people to access SRH services. For formal providers, the main strategy is building confidence and trust in young people and providing cheap or free contraceptives such as condoms.

From the young people’s perspective the strategies that can be used to improve their access to SRH information and services include intensive peer education; public education on SRH to help deal with community level barriers and increasing access to services through the use of self-service units like “ATMs” that dispenses pregnancy and STI home test kits and contraceptives. The establishment of youth corners and adoption of youth friendly attitude by providers are also some of the strategies.

4.1.5. Role of informal service providers in facilitating access to SRH services

Peer educators and traditional healers have been identified as the key informal providers who play a critical role in the provisions of SRH services to young people. Traditional healers/herbalist usually provide treatment for many sexual related health problems such as impotency and infertility in married men and women, sexual weakness in young males, irregular menstruation, heavy bleeding and mistral pain among females and STI (genital warts, gonorrhoea and syphilis in both sexes).

Young people have a lot of trust in peer educators and see them as one group of providers who were very confidential in the provisions of services. Young people go to see peer educators when they have questions on menstruation, vaginal discharges, pain during sex and general sex health, emergency contraceptives and free condoms. Peer educators provide information on usage of contraceptives and STI symptoms.
4.1.6. Relationship between formal and informal sectors

There is generally a cordial relationship between the formal and informal service providers. They collaborate largely in terms of referral of clients. Whilst the some informal providers refer clients to formal providers, the formal providers also provide training and information, education and communication materials (IE&C) for some of the informal providers. This collaboration is however largely between peer educators and TBAs on the informal side and health workers on the formal. The collaboration when it comes to traditional healers is very limited. To improve on the collaboration there is a need to;

- Properly defined referral system between the two sectors to ensure consistency in SRH service and information provision.
- Hold regular meetings between both sectors
- Recognize the contribution of informal providers
- Jointly organize education campaigns at community level.

4.1.7. Social media

Social media has a great potential when it comes to sharing information on SRH and it provides opportunity for two way communication. However considering that young people in most of the communities the study was conducted in do not have access to internet and phones (smart and normal), it will not be an effect medium for information provision in these communities. It can however be use in the more urban communities where access to internet is better.

4.1.8. ASK Project

Through sensitization campaigns, the project has contributed to improving young people’s knowledge on SRH and contraception and decreasing stigma attached to SRH issues such as STIs. The training of the peer educators have contributed to improving their skill and knowledge and distribution of free condoms has also helped to improve access and use of contraceptives.

As at the time of the OR data collection the project was not adequately targeting and addressing misconceptions of community level leaders, in order to get them to support the young people to access their SRH rights. There was also no clear activities or strategies targeted at religious leaders who tend to have a lot of influence on how people view SRH and contraceptive information and services.

The one-on-one engagement some partner started with the community leaders has the potential to influence their attitude towards young people SRH, but the engagement will have to be over a period of time to bring the desire attitudinal and behaviour change.

4.2. Recommendations

The following recommendations are put forward to help improve young people’s access to SRH information and services;

- Health facility should consider establishing youth corners or putting in strategies such as seeing young people first when they visit them to access services. In facilities that do not have enough space to establish youth corners, they can dedicate specific rooms or days to deal with health issues of youth in general in addition to SRH issues.
- The concept of self-dispensing machines for SRH commodities such as condoms and pregnancy test kits should be explored further and where possible deployed to enable adolescents access services without any interference.
- The whole concept of provider confidentially, judgmental attitude needs to be re-examined. In addition to providing training for service providers, it is critical to provide supportive supervisions, in order to support them build their skills in young friendly services very well.
- Efforts should be made to improve the collaboration between the formal and informal providers. This can be done through:
  - Properly defined referral system between the two sectors to ensure consistency in SRH service and information provision.
  - Hold regular meetings between both sectors
  - Recognize the contribution of informal providers
  - Jointly organize education campaigns at community level.
- Community level awareness to SRH challenges of young people and its consequences in later life need to be intensified. This will help deal with issues of community level barriers that limit young people access to SRH information and services. In organizing this awareness programs it is critical that the formal providers collaborate with the informal providers especially the traditional healers.
- Community level opinion leaders and religious leaders and community leaders should be targeted and engaged in addressing SRH issues of young people. They can play a critical role in address SRH issues of married young people.
- Special SRH programs and interventions for young males should be developed. These interventions can cover issues on male facility; use of aphrodisiacs and sexual enhancement drugs and their general sex life.
- To better enhance the impact of the ASK project, partners should consider strengthening school based interventions and the use of other channels such as churches.
- Providers should take advantage of occasions such us market days and youth gathering within the community to increase access to services. This can be done my moving the service point to venue of the gathering.
- For married young people it is critical for the project to explore strategies that will encourage them to visit service providers as a couple and for them to make joint decisions on which contraceptive to use.
References


GSS (2013a) 2010 Population and Housing Census: Demography, Social, Economic and Housing Characteristics. GSS Accra

GSS (2013b) 2010 Population and Housing Census Report: Children, Adolescents and Young People in Ghana. GSS, Accra


GSS, GHS, ICF Macro (2015) Ghana Demographic and Health Survey 2014 – Key indicators


Annexes

Annex A: List of communities selected for data collection

<table>
<thead>
<tr>
<th>Name of ASK partner</th>
<th>Region</th>
<th>Community</th>
<th>District/Municipal</th>
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<tr>
<td>NORSAAC</td>
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<td>Gushegu</td>
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<td>Simli Aid</td>
<td>Northern</td>
<td>Zanzugu</td>
<td>Central Gonja</td>
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<tr>
<td>Curious Minds</td>
<td>Northern</td>
<td>Jisonaayili</td>
<td>Sagnerigu</td>
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<td>NORSAAC</td>
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<td>Tamalgu</td>
<td>Karaga</td>
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<td>Talensi</td>
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<td>Central</td>
<td>Breman Ayipey</td>
<td>Asikuma Odoben Brakwa</td>
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