



ADOLESCENT HEALTH SERVICE POLICY AND STRATEGY (2016-2020)



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GHANA HEALTH SERVICE

FOREWORD

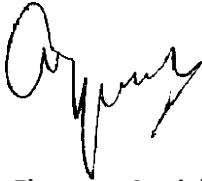
During the adolescent period, young people undergo physical and psychological changes which have implications for their social, economic and health development. The health and development of adolescents and young people are crucial for the development of the country. The health of young people living in Ghana is an integral part of the development agenda for the populace. They are the nation's most valuable resource. The health sector has the mandate to contribute to the promotion of the health and development of young people through the provision of quality adolescent health care using integration of services and programmes in health facilities and outreach sites including mobile services.

Young people (10-24 years) constitute 29.3% of Ghana's population according to the 2010 Population and Housing Census. They face challenges associated with sexual and reproductive health, HIV and STIs, nutrition, mental health, substance use, non-communicable diseases, intentional and unintentional injuries, various forms of violence, inequities and risks and vulnerabilities linked with child marriage, child labor, trafficking as well as disabilities.

There is the need to create a safe and supportive environment, ensure access to appropriate information, ensure that health facilities provide goods and services including counselling on mental health, nutrition, sexual and reproductive health, ensure the active participation of young people in programmes affecting them, and their protection from all forms of violence, harmful practices especially focusing on the more vulnerable such as pre-adolescents, younger adolescents, pregnant adolescents, adolescents practising prostitution directly or indirectly and adolescents living with HIV and AIDS.

Aware of the central role that adolescents and young people play in the development of the country, the WHO, UNICEF, UKAID, UNFPA, the Palladium Group and partners supported the Ghana Health Service to develop this service policy and strategy for Ghana's Adolescent Health and Development Programme. The aim of the service policy and the strategy is to provide the framework within which health service provision and other health related interventions for adolescents and young people would be coordinated and

implemented to ensure efficient use of resources towards achieving the overall health sector goals for adolescents and young people. It is expected that this document would be the reference source when planning for the health of adolescents and young people in the country for the next five years (2016-2020).



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ACRONYMS

·	ADHD	Adolescent Health and Development
·	ANC	Ante Natal Care
·	AYRHS	Adolescent and Youth Responsive Health Service
·	BMI	Body Mass Index
·	CHOs	Community Health Officers
·	CHPS	Community Health Planning & Services
·	CSE	Comprehensive Sexuality Education
·	CSO	Civil Society Organisation
·	DALYs	Disability- Adjusted Life Years
·	DCC	District Coordinating Council
·	DHMIS	District Health Management Information System
·	DHS	Demographic Health Survey
·	FHD	Family Health Division
·	FP	Family Planning
·	GBD	Global Burden of Disease
·	GES	Ghana Education Service
·	GHS	Ghana Health Service
·	HPV	Human Papilloma Virus
·	LI	Legislative Instrument
·	M&E	Monitoring & Evaluation
·	MOE	Ministry of Education
·	MoGCSP	Ministry of Gender Children & Social Protection
·	MOH	Ministry of Health
·	MoLGRD	Ministry of Local Government and Rural Development
·	NACP	National AIDS Control Programme
·	NCD	Non Communicable Diseases
·	NGO	Non- Governmental Organisation
·	NHIS	National Health Insurance Scheme
·	NPC	National Population Council
·	NYA	National Youth Authority
·	PNC	Post Natal Care
·	RCC	Regional Coordinating Council
·	RTA	Road Traffic Accident
·	SDP	Service Delivery Point
·	SHEP	School Health Education Programme
·	SRH	Sexual and Reproductive Health
·	STIs	Sexually Transmitted Infections
·	UNFPA	United Nations Population Fund
·	UNICEF	United Nation Children Fund
·	WASH	Water Sanitation and Hygiene
·	WHO	World Health Organisation

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INTRODUCTION

1.1 Background

The Republic of Ghana is centrally located on the West African coast and has an area of 238,537 square kilometers. It is bordered by Côte d'Ivoire on the west, Togo on the east, Burkina Faso on the north and northwest, and the Atlantic Ocean on the south across a coastline of 560 kilometers of the Gulf of Guinea. The country is administratively sub-divided into ten regions: Western, Central, Greater Accra, Volta, Eastern, Ashanti, Brong Ahafo, Northern, Upper East, and Upper West [GSS 2013]. The Ashanti, Eastern, and Greater Accra regions are densely populated together holding about half of the country's population of 27 million in 2014. The regions are subdivided into 216 districts to ensure equitable resource allocation and efficient, effective administration at the local level [GSS 2013].

According to the 2014 Ghana Demographic and Health Survey (GDS, 2014), the country is characterized by a young population with 14% and 13% in the 5-9 and 10-14 age groups, respectively. Adolescents aged 10-19 and young adults aged 20-24 together constitute 29.3% of Ghana's population (21.9% and 7.4%, respectively) and face particular challenges related to sexual and reproductive health, HIV and STIs, nutrition, mental health, substance use, non-communicable diseases, intentional and unintentional injuries, various forms of violence, inequities and risks and vulnerabilities linked with child marriage, child labor, trafficking as well as disabilities.

Ghana has a slightly higher female population with overall sex ratio of 92. Over 50 per cent of the population lives in urban areas. The Ghanaian population is made up of several ethnic groups: the Akans are the largest group (48%), followed by the Mole-Dagbani (17%), Ewe (14%), Ga-Dangme (7%) and others [GSS, 2013].

1.2 Context and Rationale

There are many reasons for the growing attention to the health of adolescents in Ghana. First, this group comprises a significant proportion of

the country's population. Second, as this cohort joins the workforce, the foundations laid in health will have profound implications for social, political, and economic development. This is particularly important given the declining fertility and mortality trends in Ghana. Third, healthy adolescents are a key asset and resource, with great potential to contribute to their families, communities and the nation both at present and in the future as actors in social change, not simply beneficiaries of social programs. The surge of interest in adolescent and youth health also responds to the improved global understanding of the developmental process that takes place during adolescence which guides designing and delivering tailored interventions for subgroups in this segment of the population taking into account their age and gender specific needs and interests.



Although the policy environment in the country is favourable for the promotion of the health and development of adolescents and young people, the health sector does not have an explicit Adolescent Health and Development Service Policy which prioritises and addresses the broad range of health issues aside sexual and reproductive health confronting contemporary adolescents and young people in Ghana. Issues on adolescent health are integrated into the National Reproductive Health Policy and Standards, the National Adolescent Sexual and Reproductive Health Policy

and the National Youth Policy. These policies focus mainly on Sexual and Reproductive Health (SRH) with emphasis on the prevention of HIV/AIDS and unintended adolescent pregnancies. Although the existence of a national health policy for young people may not necessarily guarantee improved health outcomes, empirical evidence has indicated that countries with strong adolescent health programmes benefit from supportive political environment as well as policies and strategies which promote the health and well-being of adolescents and young people.

A number of initiatives have been undertaken in Ghana since 1980 culminating in the launching of the National Adolescent Health and Development Programme (ADHD) in 2001. A seven year (2009-2015) National ADHD Strategic Plan was subsequently developed in 2009 which sought to provide a multi-sectoral support to every young person living in Ghana with education and information that will lead to the adoption of a healthy lifestyle physically, psychologically and socially. This was to be achieved through provision of age and sex appropriate information and counseling, comprehensive health services complemented by self-care, livelihood and leadership skills or competencies.

Many gains have been made over the past decades. The rate of new HIV infections among 15-19 year adolescents has decreased by 40% (from 0.5 to 0.3 percent), the proportion of females aged below 20 years who deliver with the assistance of a skilled provider increased to 72 per cent. On the other hand, birth rate among adolescents aged 15-19 remains high. Health services for adolescents are largely not integrated, are of poor and uneven quality and coverage, with inequity in access and utilization, are generally limited to Sexual and Reproductive Health (SRH), HIV and Sexually Transmitted Illness (STIs) and do not fully address the broader health and health-related problems faced by adolescents, especially adolescent girls.

Thus, it is imperative that a new Adolescent Health Service Policy and Strategy for the period 2016-2020 is developed to guide programs to mitigate the dual challenge that the country faces from the emerging health threats as well as those from the unfinished agenda of preventable death and infectious diseases among its large adolescent population. The formulation of this strategy is informed by the findings of the ADHD program evaluation

conducted from January to March 2016. It reflects some of Ghana's new health commitments and the newly agreed Sustainable Development Goals (SDGs) to provide the enabling environment for quality health service delivery for the adolescents. It also takes into account the Global Strategy for Women's, Children's and Adolescents' Health (2015-2030) which is aligned to the SDGs (WHO 2015).

The Global Strategy identifies nine “Action Areas” to update national policies, strategies, plans and budgets, namely: country leadership, financing for health, health system resilience, individual potential, community engagement, multi-sectoral action, humanitarian and fragile settings, research and innovation, and accountability [WHO 2015]. The new Health Service Policy and Strategy also takes cognizance of the Global Accelerated Action for the Health of Adolescents (AA-HA!): implementation guidance of 2016 [WHO 2016].

The Strategy therefore goes far and beyond SRH, HIV and STIs to provide broad strategic directions to promote, prevent, and manage the health and development of Ghanaian adolescents. It incorporates current recommendations on policies and programs that respond to priority health needs of the young, reflects the evidence base for action, captures new interventions and service delivery mechanisms, and guides on building a framework of focus to continually improve the health and development of adolescents through their participation and engagement, and on effective coordination with public, private, Non-governmental (NGO), local and international development partners.



SITUATION ANALYSIS

2. SITUATION ANALYSIS

Mortality and morbidity among adolescents and youth in Ghana are associated with a range of health and health-related behavioral problems as well as limited access to and utilization of quality health services. A detailed evaluation of the current situation of ADHD was done in March 2016 and readers are directed to the findings of the evaluation report for details **(GHS 2016)**.

A summary of the main conclusions are as follows:

- Access to appropriate health information by adolescents and young people has not improved significantly over the period of the review.
- Utilization of health services by adolescents and young people has remained poor even though there is improvement overall.
- The political and legal environment has enhanced considerably but the same cannot be said of the social and cultural environment.
- Community participation in ADHD has been weak; however, increasing numbers of adolescents and young people are getting more involved in health programme development and implementation.
- The management and coordination of ADHD programmes has improved considerably though more needs to be done at the decentralized levels. Funding for ADHD, especially from donor partners, has increased considerably.
- There is gradual improvement in most of the adolescent indicators over the period. However, at current rate of impact it will be impossible to achieve envisaged targets set for the new ADHD policy. **[GHS 2016]**

This section provides additional information on the current situation of adolescent health and development, and vulnerabilities they face due to age and gender, which are relevant to the Policy and Strategy but were not dealt in depth in the evaluation report.

2.1. Mortality Analysis

According to the WHO 2012 Global Mortality Data, the top five causes of mortality among adolescents were road injury, HIV, suicide, lower respiratory tract infections and interpersonal violence. Among of 15-19 year olds, however, deaths due to maternal causes are the second highest particularly in Africa where the late adolescent maternal mortality rate is about 34 per 100,000 people. Generally, unintentional injuries (road injuries, accidental drowning) take the lead in all continents, all age groups and all sexes as a cause of adolescents' mortality.

In Ghana, there is limited data on adolescent mortality due to unreliable age disaggregated death registration systems. In a study utilizing data from autopsies among Ghanaian adolescents 10 to 19 years in Accra, Ghana conducted in Korle Bu Teaching Hospital, out of the 14,034 autopsies carried out from 2001 to 2003 in Korle Bu Teaching Hospital (KBTH), 7% were among adolescents. Of the 882 deaths among adolescents analyzed, 402 (45.6%) were females. There were 365 (41.4%) deaths from communicable disease, pregnancy related conditions and nutritional disorders. Non-communicable diseases accounted for 362 (41%) cases and the rest were attributable to injuries and external causes of morbidity and mortality. Intestinal infectious diseases and lower respiratory tract infections were the most common communicable causes of death collectively accounting for 20.5% of total deaths.

Death from blood diseases was the largest (8.5%) among the non-communicable conditions followed by neoplasms (7%). Males were more susceptible to injuries than females. At least five out of ten specific causes of death were as a result of infections with pneumonia and typhoid being the most common. Sickle cell disease was among the top three specific causes of death. Among the females, 27 deaths (6.7%) were pregnancy related with most of them being as a result of abortion [Ohene, Sally-Ann, Yao Tettey, and Robert Kumoji 2016].

2.2. Morbidity Analysis

The priority disease and behavioral conditions that determine the morbidity status of adolescents and young adults in Ghana are sexual and reproductive

health, HIV and STIs, nutritional disorders, mental and substance use disorders, non-communicable diseases, intentional and unintentional injuries, various forms of violence, and risks and vulnerabilities linked with child marriage, child labor, trafficking as well as disabilities.

2.2.1. Sexual and Reproductive Health

Sexual experience

Sexual activity is high among Ghanaian adolescents and youth. Exposure to sexual activities begins at early ages and this trend has increased in proportion over the past decades. According to the 2014 GDHS, the proportion of adolescent girls 15-19 years having first sexual activity by 15 has increased by 61.6% in 15 years period; from 7.3 per cent in 1998 to 11.8 per cent in 2014. On the other hand, sexual debut by 18 has decreased from 56.7 per cent to 43.3 per cent for the 20-24 years age group for the same period.

The median age of first sexual activity for the 20-25 year age group has remained relatively unchanged from 1998 to 2014 at around 18 years for women and about 19.5 for men. Risky sexual practices are prevalent among adolescents. This is exemplified by persistence of multiple sexual partners, concurrent partners, and non-use of condoms by those sexually active **[DHS 2014]**.

Among youth aged 15-24, a substantially higher proportion of men (53 percent) than women (35 percent) have never had intercourse **[DHS 2014]**. Percentage of adolescent girls (15-19) never having sex has decreased from 62.2 per cent in 1998 to 57.3 per cent in 2014; percentage of adolescent boys (15-19) never having sex has moved from 80.7 per cent in 1998 to 73.4 per cent in 2014 **[DHS 2014]**.

Knowledge and Use of Contraceptives

Knowledge of contraceptives among young females and adolescents has been relatively high. Among married 15-19 year olds, knowledge of any form of contraceptive has improved from 85.6 per cent in 1993 to 96.5 per cent in 2014 **[DHS 2014]**. Correspondingly for 20-24 age group it was 90.9 per cent in 1993 to 99.1 per cent in 2014.

Although knowledge of contraceptives has been high among married young females, usage remains low. Only 16.7 per cent of married females 15-19 years were current users of modern family planning methods in 2014 from a low of 8.1 per cent in 1993.

Of those aged 20-24 years, 24.8 per cent were using contraceptives in 2014, an increase from 7.5 per cent in 1993 [DHS 2014]. By region, current use of any method is highest among women in Volta (32 percent) and lowest among women in Northern (11 percent). Use of contraceptive methods increases with education from 19 percent for currently married women with no education to 34 percent of women with a secondary or higher education [DHS 2014].

Exposure to Family Planning messages

There is low contact with family planning providers and missed opportunities. Data from the 2014 DHS showed that only six per cent of married females aged 15-19 years who were visited by a health care provider in the 12 months prior to the survey had any discussion on family planning (FP), while five per cent received family planning messages when they visited a health facility. Among females aged 20-24 years, 10 per cent and 17 per cent received messages on family planning when a health worker visited them and when they visited a health facility respectively [DHS 2014].

Accessibility, Attitudes and Availability of Information and ADHD Services

Reproductive health services such as contraceptives, safe abortion services and reproductive health counseling services are not always available to the entire population. In places where these services are available, young people are unable to access them because of factors such as provider bias, restriction by law, fear of being branded as a bad boy or girl, distance to services, unfavorable opening hours, or simply lack of knowledge about the availability of such services. Provider bias has its roots in the social values, norms and culture.

Thus, some service providers are reluctant to provide contraceptive services to young people for fear that they may promote promiscuity among them [WHO 2007].

HIV and other STIs

Worldwide, young people account for half of new HIV infections. In Ghana, the overall mean prevalence of HIV infection peaked at 3.6 per cent in 2003 and declined to 1.6 per cent in 2014. The mean prevalence has fluctuated over the period for youth aged 15-24 years, with a reported 1.2 per cent in 2013 and 1.8 per cent in 2014. In the 2014 DHS, nearly all the respondents had heard about HIV. However, only 20 per cent of females and 27 per cent of males had comprehensive knowledge of HIV. A comparison of HIV prevalence estimates for the 15-19 age group between the 2003 GDHS (0.3 percent) and the 2014 GDHS (0.3 percent) shows that HIV prevalence has remained stable for this age group **[DHS 2014]**.

Other STIs, such as gonorrhoea, syphilis, herpes, genital warts and chlamydia are important health concerns in Ghana. According to NACP 2014 annual report, Syphilis prevalence among 15-19 was 1.1 per cent and 0.9 per cent for 20-24 **[NACP 2014]**. Furthermore, eight per cent of females and nine per cent of males reported contracting a sexually transmitted infection in the 12 months prior to the DHS survey in 2014 **[DHS 2014]**.

Age at first marriage

Age at first marriage for adolescent women 15-19 by 15 years has decreased from 3.8 per cent in 1998 to 1.6 per cent in 2014. Age at first marriage for men 20-24 by 18 has also decreased from 35.5 per cent in 1998 to 20.7 per cent in 2014. Median age at first marriage for women (25-29) has rather increased from 19.3 in 1998 to 22.4 in 2014 **[DHS 2014]**.

In Ghana, 1 in 5 women are married before the age of 18 this amounts to approximately 260,000 affected girls in the country. The highest level of child marriage in Ghana is found in the Northern region, where a third of young women were married during childhood marriage before age 15 is relatively rare for girls in Ghana (5%) child marriage disproportionately affects girls over boys: among boys aged 20-24 years, 2% were married before the age of 18, compared to 21% of girls.

Child marriage is more common among rural populations, across regions of Ghana. Girls from rural areas are twice more likely to become child brides than those in urban areas households. In every region of Ghana, the poorest

women are more likely to have been married during childhood than their richer counterparts.

Across Ghana, uneducated young women are twice as likely to have married in childhood as those who attended secondary school or higher. Child marriage is becoming less common in Ghana; 1 in 5 young women today were married before 18, compared to 1 in 3 in the early 1990s. If observed trends continue, the prevalence of child marriage in Ghana could halve by 2050. However, As Ghana has a growing population, the prevalence will need to continue to decline in order to keep the number of child brides from growing. If the prevalence remains at the levels seen today (21%), there will be more child brides each year as the population grows (*Source: projection scenarios by UNICEF HQ Statistical division, 2016*)

Number of Sexual Partners

Results from the 2014 DHS show that among females aged 15-24 years who had ever had sex, two per cent reported two or more sexual partners in the 12 months before the survey. For the males, four per cent and 14 per cent respectively of those aged 15-19 years and 20-24 years had two or more sexual partners over the past year. These are practices which have implications for the sexual health of young people [**DHS 2014**].

Sexual Coercion

According to the 1998 GYRHS, 2 per cent of males and 12 per cent of females were forced into their first sexual experience, with 0.5 per cent of males and 0.6 per cent of females reporting that their first sexual intercourse was with a family member [**GSS 1998**]. A study of adolescent traders in Accra revealed that 2 per cent of males and 12 per cent of females reported that the first time they had sex they were forced; moreover, 8 per cent of males and 25 per cent of females who had ever had sex reported having been coerced to have sex at some point in time [**Nabila JS, Fayorsey C and Pappoe M 1997**].

Trend of Age Specific Fertility Rate

For 15-19 years the age specific fertility rate has decreased from 116 in 1993 to 76 per 1000 in 2014; for 20-24 the decrease is from 221 in 1993 to 161 in 2014 [DHS 2014]. The regional variation in terms of trends in adolescent pregnancy ranged between 16.4 per cent (Greater Accra Region) and 21.7 per cent (Upper East Region). Six (6) out of the ten Regions had adolescent

pregnancy more than the national target of 10. Greater Accra, Northern, Ashanti and Upper West regions recorded proportions below the national average.

Age at First birth

About one-fifth of Ghanaian women age 25-49 (22 percent) had given birth before reaching age 18, while nearly two-fifths (39 percent) have given birth by age 20. The median age at first birth has increased gradually from 20.3 years for older women 45-49 to 22.6 years for women age 25-29 – the youngest cohort for whom a median age can be computed – indicating an increase in age at first birth over the last 20 years. For 20-24-year group age at first birth was 16.9 per cent by 18 years, and 31.6 per cent by 20 years [DHS 2014]. Median age at first birth for 25-29 has ranged from 20.3 per cent in 1993 to 22.6 per cent in 2014.

Abortion

Among the ethnic groups in Ghana, there is a social stigma associated with abortion. According to the laws of Ghana, abortion is legally permissible if the pregnancy is a result of rape or incest or if the pregnancy is a threat to the health of the mother or the fetus. As a result, abortions are underreported. Data from a 1998 national survey (GYRHS) show that 11 per cent of males and 16 per cent of females aged 12–24 who ever had sex reported ever being involved in terminating a pregnancy. Proportion of adolescents 15-19 years having abortion has decreased slightly from 21.4 per cent in 2012 to 19.8 per cent in 2015 [GHS 2015].

Menstrual Hygiene Management (MHM)

In Ghana, 95% of girls sometimes miss school due to menstruation [House, S., Mahon, T. and Cavill, S 2012] . This can be attributed to girls' limited capacity to manage their periods resulting from a number of factors, including the lack of toilet facilities, limited access to affordable and hygienic sanitary materials and disposal options, leaving many to manage their periods in ineffective, uncomfortable and unhygienic ways, which negatively affect their health, well-being, dignity and education.

Cultural beliefs that menstruating girls are unclean or should be inactive and quiet contribute to many girls refraining from participating actively in class,

even if they attend school. Research found they are uncomfortable to go up to the chalkboard or stand up to answer questions for fear of staining their clothes and being teased [Nanbigne, E., et al 2016]. Education on menstruation and menstrual hygiene management for adolescent girls and boys in Ghana remains limited.

2.2.2. Substance use

With the release of its new policy recommendations in 2007, WHO signaled the urgent need for countries to make all indoor public places and workplaces 100 percent smoke-free to reduce population exposure to secondhand tobacco smoke. In Ghana, tobacco regulations are itemized in Articles 61 to 68 of the Public Health Act of 2012 (Act 851).

The Act, in Article 64, clearly prohibits the sale of tobacco without adequate labeling of its health hazards. Further legal provision for incorporating tobacco education on the hazards of smoking into school health programmes is given in Article 66 (4) of Act 851. The Act affirms Ghana's commitment to the WHO Framework Convention on tobacco control [WHO 2003].

In Ghana, though the prevalence of smoking is generally low among the general population (1.3%), its likelihood increases with increasing age and decreasing education and wealth. On average, 2% of 15-24 year adolescents and youth are smokers, ranging from 1.1% among 15-19 year olds to nearly threefold higher (3.1%) among the 20-24-year group [DHS 2014].

2.2.3. Non-communicable diseases

In Ghana, the high prevalence of lifestyle-related diseases and conditions creates a dual burden, given that the country already has a high number of infectious diseases that require significant human and financial resources to control. High blood pressure, or hypertension, is one major risk factor for cardiovascular diseases.

The overall prevalence of hypertension among adolescents and youth (15-24) in Ghana is 3.5%; higher in men (4.1%) than women (3.2%) and among the 20-24 years (5.1%) than the 15-19 (2.1%). Majority (98%) enter adulthood unaware of their condition. Health facility based records indicate that hypertension is the leading cause of disability among adults in Ghana [DHS 2014]. Diabetes Mellitus deaths in Ghana reached 4,832 (2.58%) of total

deaths. (WHO, 2014) and the age adjusted Death Rate is 36.81 per 100,000 of population, ranking Ghana at #60 in the world [WHO 2014].

2.2.4. Mental Health

Globally, mental illness is the leading cause of illness and disability and the largest DALYs lost among adolescents [WHO, 2014]. Mental illness is among the top public health problems in Ghana. Studies indicate that about 20% of children and adolescents in Ghana have some form of mental disorder with resultant compromise in the quality of their lives and productivity [Kleinjees S et al, 2010].

2.2.5. Adolescent nutrition

Iron-deficiency anemia was ranked as the greatest cause of global adolescent DALYS lost by the 2013 Global Burden of Disease (GBD) Study, and the third highest cause in 2012. In Ghana, the highest prevalence of anemia (47.7%) is among female adolescents aged 15-19. For all age groups, the rate is similar for pregnant and lactating women and doesn't differ by urban or rural status.

However, the lowest prevalence is among women in Upper West and Brong Ahafo regions (36%) and the highest in Volta Region (49%). Anemia is less prevalent among women with secondary level or more education, and among the wealthy (4th or 5th quintiles) compared with those with primary education [DHS 2014]. Anemia is the result of one of the most prevalent micronutrient deficiencies in women.

Risk factors associated with anemia in adolescence primarily relate to dietary inadequacies as in staple dieting with little meat intake, past malnutrition and low body nutrient stores, lifestyle factors such as early pregnancy, and health conditions mainly infections that cause blood loss, such as hookworms, malaria, and urinary schistosomiasis. About 15% of girls and 27% of boys 15-19 years have low BMI (<18.5) [DHS 2014]. Iodine deficiency and other related micronutrient deficiencies are of importance to adolescents in Ghana. They are often associated with adverse pregnancy outcomes such as abortion, fetal brain damage and congenital malformation, stillbirth, and perinatal death.

2.2.6. Injuries

Injuries are among the leading causes of mortality and morbidity among adolescents thus requiring monitoring measures of violence and injury. Physical fighting can lead to severe injuries and is associated with substance misuse and other problem behaviors. Fighting is common among younger adolescents, more so among boys than girls.

Serious injuries, such as those that require medical attention, also are common among younger adolescents as indicated in recent global level studies. Typically, injuries are more common among boys than girls and rates are highest in the Africa Region, but in over half of the countries in every region, it is common in at least 50% of young adolescent boys. In Ghana, prevalence of serious injuries reaches up to 80% among girls aged 13–15, higher than rates in most countries (30–40%) [WHO 2014].

Road traffic injuries

Age-disaggregated data on Road Traffic Accidents (RTAs) in Ghana is not generally available but data from Ghana Burden of Disease (GBD) and Trend Analysis survey, (Health Metrix Network et al, June 2006) showed that in 2004, death from RTA for all age groups was 1.7% of all deaths in Ghana, ranking ninth of all health conditions. When expressed over the population, the mortality rates of RTAs ranged from 5 per 100,000 in 1994 to 10 per 100,000 population in 2004. Over speeding, over loading and disregard for road signs or regulations are important human RTA causing factors in Ghana.

2.2.7. Violence

Intimate partner violence or violence in intimate relationships is common and not only can it result in physical injuries but also neurological and behavioral changes from traumatic experiences can lead to both immediate and later health problems and repeated victimization throughout life. Bullying is another indicator of involvement in violence. Being bullied is linked to a wide range of mental, psychosocial, cognitive/educational and health problems including depression and suicide, as well as other poor coping responses such as problems with alcohol and other drug use (WHO 2014). Violence is a common occurrence in Ghana and affects both women and men. Its age associated pattern makes it particularly important for adolescents in the 15-19 age group as they are the most affected.

Physical violence

Physical violence is experienced by more than 47 per cent of women 24 years and below, compared with 40.6 per cent of women aged 40-49 years and 37.5 per cent of women aged 50-60 years. Younger men aged 15-19 are also at particular risk of physical violence at 64.3 per cent. The lifetime incidence of physical violence among divorced, separated or widowed women is higher (46.3 per cent) compared with married women or living with a partner (41.8 per cent) [GSS 2016].

Sexual violence

The incidence of lifetime sexual violence is higher among younger Ghanaian women. More than 38 per cent of women aged 15-19 years and 40 per cent of women aged 20-24 have had at least one act of sexual violence compared with 18.8 per cent of those aged 50-60 years. On the other hand, sexual violence in men is commoner among the 30-39 years (29.7 per cent) compared with the 20-24 years group (29.2 per cent) (GSS, 2016).

While physical violence is more common for women and men in rural areas of Ghana, the incidence of sexual violence is higher among women and men living in urban areas (32.1 per cent of women and 28.5 per cent of men, compared with 27.8 and 18.1 per cent in rural areas, respectively) [GSS 2016].

2.2.8 Risks and vulnerabilities

Disability in Ghana

As at 2010, there were about 737,743 people with disability (PWD) in Ghana representing 3% disability rate of total population [GSS 2013]. Volta region has the highest disability rate of 4.3%, Upper East 3.8%, Upper West 3.7%, and lowest in Brong Ahafo 2.3%. Two-fifth of PWD has disability with sight (blindness or visual impairment), 25.4% have physical disability, 15% hearing and 13.7% speech, and 15.2% have intellectual disability.

Child Labor

In Ghana, 21.8% of 5-17 years are engaged in child labor; 22.7% among males, 20.8% in females; urban 12.4%, rural 30.2%. Among children 12-14 years, there is more likelihood of being engaged in child labor with a proportion of 26.9% [GSS 2014].

Trafficking

Children from Ghana are reportedly trafficked to neighboring countries to work on farms or in fishing villages and they are trafficked internally for similar purposes. Living in meager conditions and working long hours every day, these kids are exploited by fishermen desperate to feed their families and eke out a living along the banks of Lake Volta. The size of the problem is not very well known but it is estimated that more than 1,000 children are working as slave laborers on fishing boats across the country. [<http://gvnet.com/humantrafficking/Ghana.htm>]

2.2.9 Gender, Age, Region and Health

Gender, regional differences and age differences provide specific barriers which disproportionately affect adolescent girls and boys in relation to access to health services, information, or decision-making. About 45% of females aged 15-19 years do not make their own decision regarding their health care. Adolescent girls also face higher risks than boys in terms of exposure to violence, abuse and harmful cultural practices.

By region, current use of any method of FP is highest among women in Volta (32 percent) and lowest among women in Northern (11 percent). Use of contraceptive methods increases with education from 19 percent for currently married women with no education to 34 percent of women with a secondary or higher education.

Males were more susceptible to injuries than females, while the overall prevalence of hypertension among adolescents and youth (15-24) in Ghana is 3.5%; higher in men (4.1%) than women (3.2%) and among the 20-24 years (5.1%) than the 15-19 (2.1%). About 15% of girls and 27% of boys 15-19 years have low BMI (<18.5) [DHS 2014].

2.3. Health Systems Response

2.3.1. Service delivery

A wide variety of services and interventions are provided for ADHD in Ghana. These include FP, STI, comprehensive abortion care (including post abortion care), IEC, counseling and capacity building, HIV/AIDS-related information and services, and referrals. These services are provided mainly by GHS and a

number of NGOs scattered throughout the country. Although a variety of services exist, access to and usage of these services by the youth have remained poor even though improving. In Ghana, family planning services and supplies are available from a number of sources. The government sector remains the major source of contraceptives providing for 64 percent of current users, an increase from 39 percent in 2008.

The ADHD secretariat has developed guidelines for establishing Adolescent Friendly Health Facilities. A draft register for adolescent corners has recently been developed to be rolled out in 2016. A total of 291 ADH Corners were established in public (276) and private (15) health facilities **[RH report 2013]** but the functionality of most of them is questionable. Partnership between Marie Stopes International and the regional health directorate in ADHD services in the Western region has led to the establishment of 22 ADHD friendly corners in the Ghana Health Service facilities. Upper East Region, with thirteen districts, has seven ADHD corners with only four functional.

In Kumasi Metro, 88% of the 172 active health facilities are private owned and ADHS services are not strong and barely available. More recently in 2016, through the financial support of DFID and under the Palladium managed Ghana Adolescent Reproductive Health Project, 54 Youth Corners have been established within Ghana Health Service facilities in all 27 districts of Brong Ahafo. The corners have been designed and refurbished to provide space and a welcoming environment for the delivery of adolescent-friendly RH counseling and services. The absence of youth corners in the majority of the facilities throughout Ghana remains a concern.

Nevertheless, data from the recent DHS indicate that the coverage of maternity services for teenage girls (below 20 years of age) in Ghana is relatively high. According to the 2014 GDHS, 97 per cent of women below the age of 20 receive antenatal care from a skilled provider. Of these, only 17 per cent are attended by a doctor while 75 per cent are seen by a nurse or midwife. Sixty-six percent of mothers in the same age group are protected against neonatal tetanus, and 89 per cent of them receive iron tablets or syrup. Seventy-one per cent deliver in a health facility; four-fifth or 63.7% of these in public sector facilities and 7.6 per cent in the private sector. The

coverage of maternal postnatal care within the critical first two days after birth is 79.4 per cent; 71.7 per cent within the more critical first four hours followed by 15.2 per cent within 4-23 hours [DHS 2014].

Comprehensive sexuality education (CSE) and related programs are delivered piece meal and do not embrace majority of adolescents particularly those out of school and in rural and remote locations. School health education program (SHEP) is run by the Ghana Education Service (GES) in collaboration with GHS through the support of UNICEF, UNFPA and again more recently Palladium. Numerous manuals and technical guidelines have been developed which need further cascading to the lower levels.

Youth centers are recognized as important platforms for delivering health information and services to adolescents. It requires that they are adequate in number and fairly distributed in a country to serve their purpose. Currently, there are extremely few youth centers (4 overall) in the whole of Ghana and all are urban located. Besides concerns over the wide gap in geographic equity, the existing youth centers are constrained by lack of resources including finance, staffing, equipment and furniture and maintain service quality problems. Though the policy of one youth center per region has been revisited to one per district, this is yet to be ratified.

Moreover, in the existing network of the public and private health system, the existence and functioning of youth friendly services are not sufficient to address the growing health demand of large number of adolescents and youth in the country. The few available general services are also branded by the majority of youth as not being youth friendly. The socio-cultural and religious norms and practices are also found to be constraints to the promotion and provision of adolescent friendly services, including the use of condoms and other contraceptive methods while on the other hand promotion of culturally appropriate sexuality interventions such as upholding virginity didn't get enough attention.

A review of the mental health service in 2014 showed that its main strength was the presence of a long established service with staff working across the country in outpatient departments and hospitals. The main weakness was that government spending on mental health was very low and the bulk of

services, albeit very sparse, were centred at the capital city leaving much of the rest of the country with almost no provision [Mark Roberts, Caroline Mogan and Joseph B Asare 2014].

2.3.2. Human Resources for Adolescent Health

Number and distribution

In Ghana, different categories of staffs are involved directly or indirectly in the provision of health care services for adolescents. At present, Ghana has attained approximately half of the international standard required for key health workforce categories. The WHO benchmark for doctors stands at 0.20 physicians per 1000 population and that for nurses stands at 2.20 per 1000 population. The number of midwives has increased by 86.67 per cent from 120 in 2007 to 224 in 2010. However, the distribution of medical officers, midwives and other health staff is skewed in favor of urban areas. At the National Secretariat, there is a fairly adequate staffing with a good mix of qualifications and backgrounds from clinical, public health, demography and social sciences professions.

Training and development

A number of capacity building activities have been undertaken before and after the development of the National ADHD Strategy 2009-2015. About 604 frontline service providers were trained in ADHD programming. In the 2013 DHMIS, it is reported that 764 service providers were trained on the ADHD programme. Compared with the target of training 90 per cent service providers, this is an underachievement.

Adolescent friendly health services standards and targets, including monitoring tools, have been developed for all levels, as well as draft guidelines for the institutionalization of adolescent friendly health services. ADHD has been incorporated in pre-service for diploma and certificate Community Health Nurse (CHN) standalone courses, in collaboration with Nurses and Midwifery Council. Also, e-learning training platform for in-service and pre-service on ADHD has been developed.

Despite these achievements however, low competence and undesired attitudes of health care providers towards adolescents, attrition and shortage of staff trained in AYFHS, limitations of knowledge on legal and

regulatory issues on ADHD among staff are prevailing key challenges. Moreover, there is apparent limitation in scope of existing tools, curricula and training approaches in terms of addressing the broader aspect of health and health related behavioral conditions of adolescents beyond SRH.

2.3.3. Data Management, Supervision, Monitoring and Evaluation

Data on ADHD have been integrated into DHMIS after development of specific indicators for ADHD. However, the DHMIS is still not user-friendly in terms of complete disaggregation for measuring the relevant adolescent health indicators. International survey data such as DHS do not cover 10-14 age-group hence data on this age group is incomplete.

Also, the use of wide age bands limits the ready availability of data and information on ADHD related to some important variables in these surveys. Little or no data are available on adolescent services delivered in almost all the facilities and districts in some regions such as the Western Region. The process for putting in place a data bank on ADHD at ADHD secretariat has started but data capture is still incomplete with a number of gaps remaining including its disaggregation by age and gender.

Existing supervisory, monitoring and evaluation tools on ADHD have been reviewed and the Standards and Tools for monitoring Adolescent and Youth Friendly Health Services in Ghana have been developed. National dissemination was done in 2012 but regional/district level dissemination is pending and the tools are yet to be operationalized countrywide.

Supervision has been inadequate and irregular even though attempts have been made to integrate ADHD supervision as part of the larger Reproductive Health supervision. At regional level, regular supervision to districts either is not conducted or is very poor and feedback is not given to the districts after supervisory visits. There are no district focal persons to facilitate adequate regional supervision in all the districts and sub-districts as is the case in Western Region. In other regions where supervision and monitoring is mostly integrated, it had little or no emphasis on ADHD, and districts fail to prepare periodic performance data or annual reports on both ADHD.

2.3.4. Financing for Adolescent Health and Development

In Ghana, nearly six in ten female adolescents aged 15-19 (59.3%) and young women aged 20-24 (57.7%) are covered by the National/District Health Insurance Scheme (N/DHIS). The corresponding/respective proportions for males in the same age groups are 54.4% and 42.2%. None in both groups are covered by health insurance through employer or private commercial schemes. About 14% to 21% in both groups are registered but not covered probably because of failure to pay for premiums, and in more than 91% of those covered in both groups the premiums were paid by relatives or friends.

Residence, education and wealth do not have significant impact on insurance coverage for adolescents and young adults except for the wide regional variation for all age groups, which ranges from the lowest N/DHIS coverage (37.4%) in Western to the highest in Upper West (73.6%) regions. In terms of paying for services, about 27% and 35% and 19% and 31% of adolescent aged 15-19 and young adults aged 20-24 in the female and male categories, respectively make out-of-pocket payments for services [DHS 2014].

Most Ghanaian adolescents and youth have very weak purchasing power due to their poor socio-economic status and this has impact on their ability to access health services. Particularly, this may be more so among those who lack parental or other form of support. Scaling up insurance schemes and prioritization of services for fee exemption (cost reduction) to protect all adolescents and youth is a continuing challenge. The MOH and GHS operate an integrated health delivery system and financial information is not disaggregated up to programme level. However, evidence shows that GoG funding for ADHD is minimal and infrequent making the programme largely dependent on partner support. Summary of ADHD stakeholder analysis in Ghana is provided in Annex 2.

2.3.5. Governance and Partnership

The complex interplay of factors which affect ADHD shows clearly that no single ministry, agency or department will have all the resources, time and authority to implement programmes aimed at improving ADHD. There has been marked improvement in coordination and collaboration among partners of ADHD at national level but the same cannot be said at lower levels. Currently, there exists a National Steering Committee under the

auspices of National Population Council (NPC) but the regularity and effectiveness of coordination remain a concern. There is an ADHD technical steering committee in place under the Family Health Division (FHD) and ADHD secretariat with two sub-committees on media and capacity building, and with resource teams in some regions.

2.3.6. Legal and Policy Framework

Generally, there is a favorable legal and policy framework in support of ADHD in Ghana, but a few gaps and challenges remain. The Government of Ghana is committed to and signatory of several international and national initiatives that recognize the right to health, and entitle all persons, in particular adolescents and youth, to available, accessible, acceptable and quality health-care facilities and services. Despite the existence policies, strategies, guidelines and plans, there is a general lack of awareness among health service providers, teachers, parents, adolescents and youth, and the community at large about the existing policies and strategies and the health needs of adolescents and youth.

The following are some of national policy and legal documents mostly from **[Awusabo-Asare K et al. 2004]**:

- Article 37(4) of the 1992 Constitution
- Revised National Population Policy, 1994; Act 485
- National Population Council Act, 485, 1994
- Ghana Adolescent Reproductive Health Policy (2000)
- 2nd Edition Reproductive Health Policy and Standards (2003)
- Ghana Youth Policy 1999
- Ghana Health Sector Policy (2008)
- Health Sector Medium Term Development Plan, 2014-2017
- Road Map for Repositioning Family Planning in Ghana (2006-2010)
- Reproductive Health Strategic Plan (2007-2011)
- 1960 Criminal Codes
- Education Act 778, 2008
- Inclusive Education Policy, Ministry of Education, 2013
- 1998 Children's Act, Act 560
- Ghana: Legislation Enacted to Criminalize the Trokosi Tradition of Enslavement (1998)

- Legislation against Female Genital Mutilation (FGM)
- Child and Family Welfare Policy 2015

2.3.7. Socio-Cultural Issues and Community Participation

The rich cultural diversity among the various ethnic groups in Ghana provides both advantages/opportunities and challenges to the promotion of ADHD in the country. Ethnic background has implications for some aspects of adolescent reproductive health, since practices such as initiation rites and marriage systems vary by ethnic affiliation. People continue to define themselves along these ethnic lines, although interethnic marriages are breaking down some of the affiliations [Awusabo-Asare K et al. 2004].

According to A.A et al, among the various ethnic groups, 'adolescence' is the prepubertal stage after childhood within which the individual attains physical, sexual and social maturity. Historically, this stage began for women with menarche or initiation and ended with marriage or childbearing. For males, the period was marked by initiation or marriage. For instance, among the Krobo of the Ga-Adangbe and the Akan, puberty rites were performed for girls after menarche to signify their maturity. Known as 'Dipo' among the Krobo and 'Bragro' among the Akan, the initiation ceremony was a community affair and was held under the auspices of the queen mother. A girl who became pregnant before an initiation ceremony committed an offense and the maximum punishment was banishment from the community [Awusabo-Asare K et al 2004].

In the past, as now, the process of socialization and preparation for adult life included informal training and apprenticeship. While girls were trained in personal hygiene, domestic activities, child care, vocational skills and the art of trading, boys were taught to be farmers, hunters, fishermen and craftsmen. These are positive initiatives which promote ADHD [Awusabo-Asare K et al 2004]. Unfortunately, the diverse socio-cultural factors also pose major challenges for promotion of ADHD.



HEALTH SERVICE POLICY AND STRATEGY FOR AYRHS

3. HEALTH SERVICE POLICY AND STRATEGY FOR AYRHS

3.1 Definitions

Adolescent: A person aged 10 to 19 years; “Child” is 0-17 years; “Youth” is from 15-24 years; “Young Adult” is from 18-24 years, while “Young Person” is from 10-24 years. [Source: United Nations Youth. 2016. Definition of youth. Accessed on 15 December 2015 at <http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf>.]

3.2 Component Areas

The Policy and Strategy shall take into consideration the health and health-related needs of adolescents and young people in the area of:

- Sexual and Reproductive Health
- All forms of malnutrition, including iron-deficiency anaemia, under-nutrition (e.g. other micronutrient deficiencies), overweight, and obesity;
- HIV/STI
- Other communicable diseases, particularly diarrheal diseases, intestinal infections, meningitis, malaria, tuberculosis, and lower respiratory infections;
- Non-Communicable Conditions, such as haemoglobinopathies, congenital anomalies, leukaemia and other neoplasms, ischaemic heart disease, cerebrovascular disease, asthma, and sense organ diseases;
- Mental Health conditions, such as depressive disorders, conduct disorder, anxiety disorders, self-harm, substance abuse and suicide.
- Interpersonal violence, including child maltreatment, youth violence, gender-based violence, intimate partner violence, sexual assault, and violence against lesbian, gay, bisexual, or transgender (LGBT) individuals;
- Intentional and Unintentional Injuries, especially Road Traffic Accidents

- (RTAs), falls, drowning and fire
- School health service
 - Gender-related issues which affect the health of adolescents and young people
 - Adolescents with disability
 - Risks and Vulnerabilities including child marriage, child labour, trafficking

3.3 Guiding Principles and Statements

The development and implementation of the Policy and Strategy are guided by the following principles.

1. **Respect for human rights and fundamental freedoms** including the right to life, human dignity, development and participation rights, equality and freedom from discrimination on the basis of race, ethnicity, gender, sex, sexual orientation, age, disability, health status, geographical location or social, cultural and religious beliefs and practices.
2. **Strategic partnerships** for provision of holistic and integrated Adolescent Health information and services through multi-pronged, multi-faceted and multi-sectoral approaches that are effective and efficient in reaching adolescents. Adolescent Health and Development is a cross cutting issue for several stakeholders, with the health sector playing a pivotal role. Synergistic action with other sectors and stakeholders including education, gender, social welfare and the media is crucial for improving the access to information and achieving behaviour change.
3. **Diversity.** Recognition that adolescents have different needs for health information, education and services including counselling. Adolescents are heterogeneous and diverse in terms of age, gender, urban/rural, class, religion, region, cultural beliefs, disability, and sexual orientation and so on. Adolescents have specific needs for boys and girls within and between the different levels of maturation. Adolescent health programmes shall have in-built flexibility, respect diversity and ensure there is no discrimination in access to essential quality health services.

4. **Gender sensitivity and Gender equity.** Adolescent health programmes shall recognize and address the needs of adolescents of different genders in an equitable, non-discriminatory manner because deep-rooted gender stereotyping and differentials result in health risks. Needs based programme planning with gender equity as a central theme shall be ensured. Services and programmes shall take into account adolescents' felt needs, issues and rights; help build self-esteem; and develop abilities to take on responsibility for self, relationships and society around them.
5. **Equity in Service Delivery:** The Policy and Strategy focuses on ensuring that the health system responds effectively and appropriately to the specific needs of adolescents and youth, in comparison with other groups in the population and that they are reached with evidence-based interventions. It guides health programs to recognize and address the needs of adolescents and youth of both genders in an equitable, non-discriminatory manner that is free from stereotyping.
6. **Adolescent Involvement.** Involvement of adolescents in the planning, implementation, monitoring and evaluation of Adolescent and Youth programs for effective program implementation, promotion of partnerships and creation of open channels of communication for achievement of mutual goals shall be promoted. Health services and programmes shall be participatory, with increasing scope for active engagement and expression by adolescents in related decision-making. Recognition of the critical role parents, guardians and communities play in the promotion of the health of the adolescents shall be recognised.
7. **Life cycle approach.** Use of the life cycle approach in youth programming shall be promoted.
8. **Disability and vulnerability responsiveness.** Special attention shall be given in provision of adolescent and youth health education and services to ensure that the peculiar needs of those with disabilities and vulnerable groups are recognized and taken care of and their interests advanced.

9. **Evidence-based interventions and programming.** Utilization of evidence-based interventions and programming is key; hence research shall be promoted to inform adolescent and youth programming.
10. **Quality Driven.** Adolescent and youth services shall be based on Accessibility, Convenience, Privacy and Confidentiality, Appropriateness, Safety, Comprehensiveness, Affordability, Decentralisation, and Partnerships, Acceptability and Responsiveness.



VISION, GOAL AND STRATEGIC OBJECTIVES

4. VISION, GOAL AND STRATEGIC OBJECTIVES

4.1 Vision

Improved health status of adolescents and young people through equitable access to appropriate, comprehensive, gender-sensitive, quality and cost-effective adolescent and youth responsive health information, education and services.

4.2 Goal

The goal of the Policy is to enhance the health status and quality of life of adolescents and young people in Ghana, to contribute towards realization of their full potential in national development through mainstreaming information and gender-sensitive and responsive health services.

4.3 Strategic Objectives

The Strategic Objectives for the Policy and Strategy are:

1. Improve access to information on health and health services relevant to the age and gender specific needs of adolescents and young people to enable them make informed decisions
2. Build capacity of health service providers and support staff to enable them have the required knowledge, skills and a positive attitude towards the provision of effective adolescent and youth responsive services at all levels.
3. Improve access to specified package of health services that are of high quality, gender sensitive, disability-responsive in an appropriate environment at all levels.
4. Develop and advocate for relevant enabling environment including protective health policies, and legislative framework to support the provision of AYHS at all service delivery and management points.
5. Promote partnership and inter-sectoral collaboration among adolescent and youth groups, relevant institutions and communities in the provision

- and utilization of Adolescent and Youth Responsive Health Service.
6. Develop innovative strategies to address financial barriers for AYRHS.
 7. Strengthen Research for evidence-informed policies and interventions in AYRHS.
 8. Strengthen management, leadership and support systems for AYRHS

4.4 Adolescent Health Service Delivery Standards and Desired Outcomes

The following health service delivery standards and outcomes are expected out of the Health Service Policy and Strategy:

- a. Adolescents and young people are able to obtain health information and services including counselling relevant to their needs, circumstances and stage of development when seeking healthcare at various levels of health service delivery.
- b. Health service providers and support staff have the required knowledge, skills and a positive attitude to provide adolescent and youth responsive services relevant to the age and gender-specific needs of adolescents and young people at all health service delivery points.
- c. Adolescents have access to specified package of health services that are of high quality, gender sensitive, disability-responsive in an appropriate environment at all levels.
- d. Partnership and inter-sectoral collaboration are promoted and strengthened among adolescent and youth groups, health institutions, schools and communities in the provision and utilization of AYRHS.
- e. Health policies, management systems, financial and other conducive legal environment are in place at all levels to support the provision of AYRHS at all service delivery points.
- f. Adolescents are free from unwanted/unplanned sex, pregnancy and childbearing
- g. Adolescents have positive parents/guardian/sibling/peer/teacher-adolescent relationship
- h. Adolescents have adequate height and weight for age
- i. Adolescents adopt healthy lifestyles and self-care skills and are empowered to avoid use/misuse of substance
- j. Adolescents, especially adolescent girls, should be empowered to take decisions regarding their health

- k. Adolescents have up to date immunizations which are available for young people.
- l. Adolescents' gender and age specific views, needs and interests are identified and embedded in health policies targeting them.

4.5 Targets

The key Impact and Outcome targets to be achieved by 2020 will include the following.

1. Reduction of adolescent mortality rate
2. 90% of adolescents and young people reached with information on health and health services
3. 90% of adolescents and young people with knowledge on SRH services and rights
4. Adolescent girls and young people with comprehensive knowledge on HIV by 2020 from 20% to 60%
5. Adolescents accessing adolescent health service by 2020 to at least 60%
6. Increase proportion of female adolescents age 15-19 with valid National Health Insurance cards from 52.7% in 2014 to at least 70% by 2020
7. From 8% in 2016 to 70% by 2020 of targeted service providers and support staff trained in AYRHS
8. Increase the proportion of females aged 15-19 years using modern contraceptive methods from 6 per cent in 2014 to 20 per cent by 2020; and among those aged 20-24 years from 21 per cent in 2014 to 40 per cent by 2020
9. Increase the proportion of sexually active unmarried females aged 15-19 years using modern contraceptive methods from (6) per cent in 2014 to (25) per cent by 2020; and among those aged 20-24 years from 21 per cent in 2014 to 40 per cent by 2020
10. Decrease the Unmet need for family planning among sexually active females aged 15-19 years from 50.7 per cent in 2014 to 30 per cent in 2020, and among those aged 20-24 years from 34 per cent to **20** per cent by 2020
11. Increase the proportion of young males aged 15-24 years with 2 or more partners who used condoms in the last 12 months from 34 per cent in 2014 to 40 per cent by 2020

12. Increase proportion of pregnant adolescent attending the recommended number of ANC visits from 80 per cent in 2014 to at least 90 percent by 2020
13. Increase the proportion of females aged below 20 years who deliver with the assistance of a skilled provider from 72 per cent in 2014 to at least **90** per cent by 2020
14. Reduce induced abortion rate among 15-19 year-old females form 17 per cent in 2007 to **10** per cent in 2020 and among those aged 20-24 years from 25 per cent to **15** per cent by 2020
15. Incorporation of HPV vaccine into EPI policies
16. Reduction of prevalence of depression by age and sex
17. Reduction of prevalence of anaemia in women ages aged 15-19 from 47.7% in 2014 To 35% by 2020
18. Age-standardized prevalence of current tobacco use among persons 15 years and older [by age and sex]
19. Reduce the prevalence among adolescent smokers among 15-19 years from 1.1% to less than 1% and 20-24-year youth smokers from (3.1%) to less than 2% by 2020
20. Reduce prevalence of BMI among females undernourished (15-19) from 14.4% in 2014 to 10% by 2020
21. Reduce prevalence of BMI among females Overweight/Obesity (15-19) from 8.7% in 2014 to 5% by 2020



BROAD STRATEGIES AND KEY ACTIVITIES

5. BROAD STRATEGIES AND KEY ACTIVITIES

5.1 Strategic Objective 1: Improve access to information on health and health services relevant to the gender specific needs of adolescents and young people to enable them make informed decisions.

Broad Strategies

There is high level of misconception and misinformation about sex, fertility and contraception in Ghana. Young people often lack knowledge of their rights and services available to them. They also lack the knowledge and skills to live life enhancing lifestyles for promotion of health, including mental health. A significant number of parents lack the knowledge and/or confidence to talk to their children about sex and relationships.

Effort will therefore be made through Social and Behavioural Change Communication (SBCC) strategies (including comprehensive school-based sexuality education and mass media messaging) to change the underlying norms and attitudes that perpetuate poor health outcomes for young people. Comprehensive SBCC Strategies will be developed to inform, educate and promote healthy lifestyles and responsible behaviours, including sexual health in line with the National Health Promotion Policy and Strategy.

Specific to sexual health, comprehensive sexuality education programs will focus on providing accurate information about human sexuality; providing an opportunity for young people to develop and understand their values, attitudes, and beliefs about sexuality; helping young people develop relationships and interpersonal skills; and exercising responsibility regarding sexual relationships, including addressing abstinence, pressures to become prematurely involved in sexual intercourse, and the use of contraception and other sexual health measures [Suzanne P 2016].

Multi-media approaches will be used including inter-personal, mass media and social/new media platforms, and both public and private sources will be supported to reach in and out-of-school youth. Mass media messaging will include using print, radio, and television to convey messages intended to ensuring positive healthy lifestyles in youth; informing adolescents about their rights, especially the right to have access to health-care services, and responsibilities towards each other and others in society. The special SBCC needs of people with disability and the vulnerable will be addressed.

5.1.1 Strategy 1.1: Developing comprehensive SBCC strategy to inform, educate and promote healthy lifestyles and responsible behaviours, including sexual health in line with the National Health Promotion Policy and Strategy.

The process for developing such a comprehensive SBCC strategy will include compiling and gathering evidence to inform the strategy development, reviewing existing SBCC materials to identify gaps, designing evidenced based SBCC programmes and interventions in collaboration with relevant stakeholders, printing of relevant existing and new materials and making them available for implementation. All component areas of AYRHS will be addressed under this strategy as required.

5.1.2 Strategy 1. 2: Promoting SBCC targeting adolescents in school

Age-appropriate and gender sensitive SBCC interventions (per component areas) will be designed and implemented through school-based programmes in collaboration with GES. If required, advocacy for the revision of school curriculum in line with the Policy and Strategy will be undertaken.

5.1.3 Strategy 1.3: Promoting SBCC targeting adolescents out of school

Age-appropriate and gender sensitive SBCC interventions (per component areas) will be designed and implemented through community-based channels targeting adolescents out of school. Appropriate community-based groups such as youth advocate networks and peer educators will be involved in design and implementation of such SBCC interventions. Multi-channel approaches will be used including building on existing platforms for pregnant women, adolescents and parents. Other social media channels that will reach

our core audiences such as Twitter, Facebook, Pinterest and WhatsApp will be used and enhanced. The impact and reach of the campaigns will be monitored through on-going collection of real-time data using available service platforms such as the Adolescent health Mobile Application.

5.1.4 Strategy 1.4: Promoting SBCC targeting adolescents with disability

The scale and scope adolescents with disability will be assessed. Age-appropriate and gender sensitive SBCC interventions (per component areas) will be designed for people with disability and implemented through relevant institutions and organized groups. Appropriate materials and channels (voice format, braille etc) will be utilized depending on type of disability. The interventions will be monitored and outcomes evaluated for re-designing.

5.1.5 Strategy 1.5: Promoting SBCC among vulnerable adolescent including the underserved.

The scale and scope of the problem will be assessed. Age-appropriate and gender sensitive SBCC interventions (per component areas) will be designed and implemented targeting vulnerable and underserved adolescents and implemented through relevant institutions and organized groups.

5.1.6 Strategy 1.6: Promoting SBCC among general population in communities

A significant number of parents lack the knowledge and/or confidence to talk to their children about their transforming bodies, sex and relationships, as well as about healthy lifestyles. Parents and the general public will be targeted with relevant SBCC messages using multiple channels (such as interactive theatre, information vans, panel discussions etc.) to empower them to support the adolescent and young people taking into account their gender specific experiences such as menstruation.

In addition, a community mobilization plan will be developed and implemented with the objective of getting the public on the side of adolescents and transforming negative perceptions or taboos specifically associated with the age and gender of adolescents.

5.2 Strategic Objective 2: Build capacity of health service providers and support staff to enable them have the required knowledge, skills and a positive attitude for the provision of adolescent and youth gender responsive services effectively at all health service delivery points.

Broad Strategies

A number of strategies will be adopted to ensure that health service providers and support staff have the required knowledge, skills and positive attitude for the provision of adolescent and youth and gender responsive services at all health service delivery points. A needs assessment will be conducted in all the component intervention areas to be followed by preparation of a capacity building plan and execution of the plan covering pre-service and in-service aspects.

5.2.1 Strategy 2.1: Conducting needs assessment and preparation of capacity building plan for AYRHS in the health service

Training needs assessment on the human resource capacities for the provision of a comprehensive AYRHS will be conducted and a 5-year training plan developed accordingly.

5.2.2 Strategy 2.2: Ensuring adequate production and equitable distribution of health workers with appropriate skills in AYRHS

Capacity of pre-service training institutions will be assessed and existing curricula will be reviewed to cover all aspects of the AYRHS Policy and strategy and integrated into all health pre-service programmes. Support will be provided to institutions which will be found to be deficient in essential aspects after the assessment. Equitable distribution of staff will be promoted at all levels of service delivery.

5.2.3 Strategy 2.3: Improving knowledge, attitude and skills of service providers and support staff in AYRHS

A continuous professional training package will be designed and implemented for relevant service providers and support staff which will include post-training monitoring. The needed training manuals will be developed for various training programmes on ARYHS.

5.3 Strategic Objective 3: Improve access to specified package of health services that are of high quality, gender sensitive, disability-responsive in an appropriate environment at all levels.

Broad Strategies

Access to comprehensive health services for AYRHS will be enhanced through a range of channels and delivered in ways that reach marginalized, hard-to-reach and vulnerable adolescents as well as the general population of young people. Combined interventions will be encouraged to address needs and AYRHS will be integrated into health delivery system. Access to all the relevant package of comprehensive intervention areas will be improved.

Guidelines, protocols and tools for Supervised Delivery will be developed to ensure compliance at all levels. Wherever possible, advocacy actions will be undertaken to effectively tackle the underlying factors that increase the risk of poor health outcomes including teenage pregnancy – such as poverty, low educational attainment, poor attendance at school, lack of self-esteem. Offering appropriate support to young people who are experiencing these underlying risk factors will help to build their resilience and raise their aspirations and so reduce the likelihood that they experience a range of poor outcomes, including teenage pregnancy.

5.3.1 Strategy 3.1: Improving access to FP services among sexually active Adolescents and married adolescents

In partnership with relevant stakeholders, access to and use of effective FP services among sexually active adolescents and married adolescents will be enhanced, and ensure that commodities are available at all service delivery points. All channels for provision of FP services will be used.

5.3.2 Strategy 3.2: Improving adolescent pregnant girls (married and unmarried) access to timely and quality Ante Natal Care (ANC), Skilled Delivery and Post Natal Care (PNC).

Existing channels and new ones will be adopted to improve access to adolescent responsive ANC, skilled delivery, and ANC services at all levels of care. Maternity services will be tailored to meet the needs of teenage mothers and young fathers. Where appropriate, pregnancy schools will be

organised for pregnant adolescents and adolescent corners will be established in health facilities and in communities or schools with private sector involvement. Integration of adolescent health services into the home visit/outreach package of CHPS will be promoted and CHOs will be equipped with adequate information, materials and commodities to enable them perform their duties.

5.3.3 Strategy 3.3: Improving adolescent access to safe abortion services using the CAC approach as per the laws of Ghana

Comprehensive Abortion Care services will be integrated into all adolescent sexual and reproductive health services as permitted by law.

5.3.4 Strategy 3.4: Reducing adolescent health-related school dropout rate.

Traditionally, pregnant school girls have been forced to leave school. Enabling pregnant and parenting girls to continue their schooling allow them to acquire education and develop skills that enhance their ability to care for themselves and their families and to increase their long-term employment opportunities. Advocate for improvement of pre-enrolment screening of adolescents to include other common conditions (such as sickle cell, disease diabetes, epilepsy, buruli ulcer, substance use etc.) that may lead to school dropout and prompt appropriate interventions will be provided. Appropriate guidelines for the screening exercise will be developed in collaboration with Ghana Education Service. Other childhood conditions, not pregnancy-related, are known also to force adolescents out of school.

5.3.5 Strategy 3.5: Strengthening school health services for adolescent

In collaboration with GES/MOE, integrated package of school health services will be provided in all schools. Advocacy will be undertaken to promote healthy diet and physical activity in schools and menstrual hygiene management. Standards and guidelines will be provided for rendering adolescent health service in schools. The package of services will include HPV vaccination (females 9 to 13 years), tetanus toxoid and other vaccinations among target population in schools.

5.3.6 Strategy 3.6: Integration of Mental Health into all adolescent health service

As much as possible, basic mental health care, including prevention of suicide, will be provided at all adolescent health service delivery points. Early identification of mental health conditions will be promoted by training non-medical personnel who work with adolescents.

5.3.7 Strategy 3.7: Improving the Nutritional status of adolescents

The nutritional status of adolescents and young people will be enhanced through a number of interventions. Adolescents girls will be specifically targeted to tackle the high prevalence of anaemia among them. Adolescents and young people will be sensitized on their nutritional needs.

Optimal nutritional composition and safety of all school meals that fall under government –sponsored school feeding programs will be advocated for. In addition to nutritional interventions mentioned under Strategy 3.5 and 3.8, intermittent Iron-Folic Acid (IFA) supplementation will be promoted among adolescents. Adolescent nutrition interventions will be monitored and evaluated including the compliance to IFA supplementation.

5.3.8 Strategy 3.8: Integration of Non-communicable disease (NCD) prevention into all adolescent health services

To reduce NCDs among adolescents and young people, healthy lifestyles will be promoted and early screening, diagnosis and management services will be provided among adolescents and young people. Basic equipment (such as weighing scales, height measures, sphygmomanometers, peak flow meters, glucometers, etc.) will be provided to all service delivery points. Enforcement of tobacco and alcohol controls in schools will be advocated for.

5.3.9 Strategy 3.9: Integration of specific health needs of adolescents with disabilities into adolescent health service delivery

Responsive comprehensive services will be provided for adolescents with disability and the services mainstreamed into adolescent health services at all levels. This is to mitigate the challenges adolescents with disabilities face in accessing health care services.

5.3.10 Strategy 3.10: Provision of health services for vulnerable groups and key populations including those in hard-to-reach areas

Specific vulnerable groups, key populations and adolescents in hard to reach areas will be identified and targeted for provision of AYRHS. CSOs / NGOs will be supported to offer adolescent health outreach services to vulnerable and key population including those in hard-to-reach areas.

5.3.11 Strategy 3.11: Prevention and response to harmful practices such as early and forced marriages and FGM and sexual violence against adolescents.

Specific at-risk adolescents such as those in early and forced marriages, child labour and those with Female Genital Mutilation (FGM) will be identified and targeted for provision of AYRHS. CSOs / NGOs will be supported to offer adolescent health outreach services to these groups of adolescents.

5.3.12 Strategy 3.12: Prevention and response to violence and injuries against adolescents

Disaster risk reduction initiatives will be promoted among adolescents (example road injuries, violence, self-harm). Services to identify, refer and prevent domestic violence will be integrated in primary health or reproductive health-care programmes for adolescents. Advocacy activities will be undertaken to promote risk reduction (e.g. from road injuries, self-harm and violence) among adolescents and appropriate health care services will be provided.

5.3.13 Strategy 3.13: Improving adolescent access to STIs/HIV and Tuberculosis services, including treatment, care and support for all people with STIs and people with HIV.

Treatment, care and support services for STIs/HIV and TB will be provided at all Service Delivery points, as well as post exposure prophylactic (PEP) as per national guidelines without discrimination.

5.4 Strategic Objective 4. Develop and advocate for relevant enabling environment including protective health policies and legal frameworks to support the provision of AYRHS at all service delivery and management points

Broad Strategies

The necessary enabling policy and legal environment conducive for implementing AYRHS will be developed and advocated for. Enforcement of existing policies conducive for AYRHS will be promoted through advocacy activities, such as advocating for enforcement of tobacco and alcohol controls in schools, control of exposure of adolescents in general to unhealthy products including tobacco, alcohol, illegal substances and unhealthy foods and beverages. At the same time new policies/LIs will be supported for enactment to address policy issues inimical for AYRHS. Important areas that will be addressed include early and forced marriage, Female Genital Mutilation, child labor and violence against adolescents. The response to adolescent health will be used as an indicator of equity to create an appropriate climate for policies and laws necessary for meeting adolescent health needs.

5.4.1 Strategy 4.1: Ensuring the implementation of existing policies for AYRHS

Existing policies supportive of AYRHS will be identified and advocated for implementation by relevant agencies.

5.4.2 Strategy 4.2: Ensuring the review and enactment of new policies/LIs to address policy issues inimical for AYRHS

Existing policies and LIs will be reviewed and where necessary advocacy activities will be undertaken for the enactment of new ones to address policy issues inimical for AYRHS.

5.4.3 Strategy 4.3: Ensuring the enforcement of laws for control of exposure, marketing, importation and access to unhealthy products including tobacco, alcohol, illegal substances and unhealthy foods and beverages high in salt, sugar and unhealthy fats

5.5 Strategic Objective 5: Promote partnership and inter-sectoral collaboration among adolescents and youth groups, relevant institutions and communities in the provision and utilization of AYRHS

Broad Strategies

The Government of Ghana will collaborate with bilateral and multilateral organizations in the implementation of the AYRHS. All partners will be encouraged to spell out clearly mutually agreed duties and responsibilities in relation to outlined strategies and activities, backed by appropriate Memorandum of Understanding (MOU) to enable all collaborators play their role to their fullest potential and to facilitate all activities consistent with the AYRHS within its area of jurisdiction. Appropriate governance structures will be established at all levels to promote joint planning and transparency, with active involvement of adolescents and young people.

5.5.1 Strategy 5.1: Ensuring better planning and coordination of projects involving Regional Coordination Council/District Coordination Council (RCC/DCC) to avoid conflicts and improve accountability

The composition of the National adolescent technical committee will be broadened and supported to include adolescent and youth groups among others while multi-sectorial ARYHS will be established at both regional and district levels to include representatives from RCC/DCC. Joint monitoring and evaluation (M&E) activities will be promoted at all levels.

5.5.2 Strategy 5.2: Enhancing involvement of adolescents and young people in planning, implementation and monitoring AYRHS at all levels

An Adolescent and Youth Advisory Panel will be established as a sub-committee of the National Technical Committee with representatives from in-school and out of school adolescents and young people, including those living with disability /vulnerable, at all levels.

Appropriate TOR will be developed to guide their advisory role and used for monitoring their outputs. Adolescent participation and leadership in AYRHS planning and programming at all levels will be promoted and supported and equal participation of adolescent boys and girls will be ensured.

5.5.4 Strategy 5.4: Strengthening collaboration among GHS, GES, MoGCSP, CSOs, development partners, communities and other relevant stakeholders at all levels.

Collaboration among GHS, GES, MoGCSP, CSOs, development partners, communities and other relevant stakeholders at all levels will be strengthened and adolescent champions (e.g. queen mothers etc.) will be identified and supported to promote adolescent health programmes at the community level.

5.6 Strategic Objective 6: Develop innovative strategies to address financial barrier to AYRHS.

Broad Strategies

Innovative resource mobilization strategies will be developed and implemented to mobilize adequate, stable and predictable financial and in-kind resources to support the ARYHS. Resource support may be in form of financing, transfer of technology and expertise and leveraging strategic partnerships with major development partners. Funds will be mobilized from domestic and international public and private financial sources.

5.6.1 Strategy 6.1: Mobilizing resources from internal and external sources

Costed implementation plan for ARYHS will be developed and a resource mobilization plan will be developed and implemented. Utilization of funds will be monitored. Public Private Partnership (PPP) arrangements will be employed as appropriate. Inclusion of adolescents with disabilities and vulnerabilities will be advocated for in the National Health Insurance Scheme (NHIS).

5.6.2 Strategy 6.2: Ensuring efficient utilization and accountability of available funds

Adolescent health will be promoted for inclusion in the national health account and other existing accounting schemes of MOH/GHS; auditing of ARYHS funding will be done annually to ensure efficient utilization and accountability.

5.7 Strategic Objective 7: Strengthen research for evidence-informed policies and interventions in AYRHS

AYRHS policies and interventions will be based on evidence, gender and age analysis, hence operational research in relevant areas will be encouraged.

5.7.1 Strategy 7.1: Developing and implementing a comprehensive research agenda on AYRHS

A research advisory team on AYRHS will be constituted to develop a comprehensive research plan in collaboration with Health Research and Development Division of GHS and supported to implement the research plan.

5.7.2 Strategy 7.2: Ensuring that research findings inform AYRHS policies, interventions and programmes

Use of research findings will be promoted. Consequently, a database of AYRHS will be established and updated regularly and research findings will be disseminated to stakeholders through available media/fora to facilitate their use in programming.

5.8 Strategic Objective 8: Strengthen management, leadership and other support systems for AYRHS.

Broad Strategies

Leadership and governance for AYRHS will be strengthened to attain highest levels of transparency and accountability, and effective implementation of the programme. Timely availability and use of appropriate gender and age-disaggregated data on AYRHS will be promoted for evidence-based decision making, as well as improving supply chain systems to meet regular logistics and commodity needs at health facilities and other service delivery points (SDPs) to facilitate efficient and effective delivery of AYRHS across the country.

5.8.1 Strategy 8.1: Strengthening leadership and governance for AYRHS to attain highest levels of transparency and accountability.

Existing leadership and governance structures will be reviewed and approaches to address gaps identified will be supported.

5.8.2 Strategy 8.2: Ensuring timely availability and use of appropriate gender and age- disaggregated data on AYRHS for evidence-based decision making.

To facilitate evidenced-based decision making, timely availability and use of appropriate gender and age- disaggregated data on AYRHS will be ensured. Current sources of data on gender and age disaggregated data and their frequency of release will be identified and DHIMS will be revised to incorporate data from these other sources and missing key indicators.

5.8.3 Strategy 8.3: Improving supply chain systems to meet regular logistics and commodity needs at health facilities and other Service Delivery Points (SDPs).

Availability of essential commodities and logistics for AYRHS is critical for programme implementation. Advocacy activities will be undertaken to ensure commodity security to facilitate efficient and effective delivery of AYRHS across the country. National, Regional and District coordinators will be trained in proper supply chain management, and supply chain officers will be trained in warehousing and logistics in partnership with Stores, Supply and Drug Management Division of GHS.



MANAGEMENT ARRANGEMENT AND ROLES AND RESPONSIBILITIES

6. MANAGEMENT ARRANGEMENT AND ROLES AND RESPONSIBILITIES

6.1 Management Arrangement

Towards achieving the objectives of this policy, the following governance structures shall be established and/or strengthened:

6.1.1 A National Technical Committee on Adolescent Health to co-ordinate the implementation of the Service Policy and Strategy. The composition of this committee shall be multi-disciplinary and multi-sectoral in nature with adequate representation of adolescent groups. Nomination to serve on the committee will be done by each agency or partner to be guided by an appropriate TOR which will spell out the mandate, specific objectives and skills required.

6.1.2 The ADHD programme of FHD of Ghana Health Service shall serve as secretariat of the National Technical Committee. Similar structures shall be established at the regional and district levels.

6.1.3 The Governments of Ghana may collaborate with bilateral and multilateral organizations in the implementation of the Adolescent Health Service Policy and Strategy.

6.2 Roles and Responsibilities of Partners

Full description of the roles and responsibilities of all partners engaging in the ADHD national program is provided in Annex 2.

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Annex 1: Ghana ADHD program stakeholder analysis

Partner Category	Partner Name	Areas of Focus and Operation	Source(s) of fund(s)
Governmental	National Population Council (NPC)	Primarily provides policy direction to ADHD in Ghana, oversees ADHD implementation Policy, resource mobilization, and M&E of population activities	DFID (2014-2016), USAID, UNFPA, and UNICEF (TA)
	National Youth Authority (NYA)	Provides relevant and conducive environment that defines and supports the implementation of effective frontline youth empowerment practices, focusing on young people's participation in socio-economic and political development whilst facilitating private and third sector provider investments in youth empowerment	UNFPA, UNESCO, Palladium, GoG (Coordination), GAC, and PPAG
	GES/MOE	primarily responsible for implementing ADHD activities in school-based settings through the SHEP	UNICEF, Palladium, Global Fund/NAC, UNESCO, GoG
	Women and Juvenile Unit within the Ghana Police Service	Deals with domestic and sexual violence; barometer for assessing violence against young people in Ghana	Government of Ghana
	Ministry of Gender Children and social Protection	Coordinate and ensure gender equality and equity, promote the survival, social protection development of children, vulnerable and excluded and persons with disability and integrate fulfilment of their rights, empowerment and full participation into national development	Government of Ghana UNICEF, DFID, UNFPA
Non-Governmental Implementing Partners	Planned Parenthood Association of Ghana (PPAG)	To assist national efforts aimed at improving the socio-economic and political life of the population Promotes the physical and mental health of families, especially the youth through positive sexual behaviors Promotes better health and nutrition of families, especially children and women Initiates and promote educational and other programmes aimed at responsible family life for the youth	DANIDA A+, DFID, GAC, UNFPA, KOICA, the Global Fund, GCACI, MOFA-JAPAN, JOICFP, JICA
	Palladium	Policy development and advocacy Strategic information, data analytics and informatics Project management	DFID

Partner Category	Partner Name	Areas of Focus and Operation	Source(s) of fund(s)
		<p>Research, monitoring, evaluation and learning</p> <p>Financing, modeling and economic analysis</p> <p>Project design and strategic planning</p> <p>Specialist technical assistance</p> <p>Procurement and logistics</p> <p>Human capital, training and systems strengthening</p>	
	Ghana Social Marketing Foundation	Social marketing, SBCC on RH, HIV, STIs for young people	USAID
	The African Youth Alliance (AYA)	HIV/AIDS-related information and services that specifically target young people	UNFPA, Pathfinder and Program for Appropriate Technologies in Health (PATH)
	Marie Stopes International Ghana (MSIG)	Bring quality family planning and reproductive healthcare to the world's poorest and most vulnerable people	BMGF, DFID, Embassy of the Kingdom of the Netherlands, USAID, Anonymous
	Hope for Future Generation	Improve access to SRH, Information, Advocacy, Collaboration with service providers, STI, HIV counseling and testing, and drop-in centers	MSIG
	UNFPA	Support to ADHD on prevention of adolescent pregnancy and child marriage, FP and RH commodity security	
	WHO	TA for ADHD in IEC, job aids, guidelines and training manual, indicator and M&E tools development; research and technical review	The UN system
	USAID Systems for Health Ghana	Support to FHD in implementation of FP and RH services in 5 regions, ADH Training Manual, e-learning material, AYF corners, School clubs, and newsletter	USAID
	UNICEF	HIV Alert Model with UNFPA and UNESCO, TA and financial support for GHS Adolescent Health Service Policy and Strategy, member of ADHD TWG	The UN system, USAID, DFID, philanthropy

Annex 2: Roles and Responsibilities of Partners

Partner	Roles and Responsibilities
Training institutions	<ul style="list-style-type: none"> • Curriculum development and review for both pre-service and post service • Develop training materials for pre-service use • Undertake and support research • Capacity building of trainees • Support the development of innovative strategies
Religious groups	<ul style="list-style-type: none"> • Dissemination of appropriate information on adolescent health • Improve utilization of AYRHS • Support advocacy for policy / law / Legislative Instrument (LI) development and review • Funding and resource support • Providing supportive services
National Commission for People with Disabilities	<ul style="list-style-type: none"> • Advocacy for people with disability • Curriculum adaptation and implementation for people with disability • Resource mobilization • Policy and law development • Play the watchdog role for the implementation of policy for people with disability • Source of information on people with disability and platform for mobilization
MOH/GHS	<ul style="list-style-type: none"> • Policy and strategy development • Advocacy for the enactment and review of laws • Curriculum development and implementation both for pre and in- service • Resource mobilisation and distribution (human, finance, infrastructure, commodities etc.) • Capacity building • Monitoring, supervision and evaluation • Service delivery including Health promotion • Linkages, partnerships and coordination of activities • Development of research agenda and operational research • Licensing and regulation of health facilities
Ghana AIDS Commission	<ul style="list-style-type: none"> • Advocacy role for HIV programmes • Role in enactment of Laws and policies on HIV issues • Financial resource mobilization • Partnership, linkages and Coordination of HIV prevention control activities • Training • Monitoring of HIV activities

Partner	Roles and Responsibilities
Kayaye Association of Ghana	<ul style="list-style-type: none"> • Information dissemination to members on AYRHS • Advocacy and mobilization of members for service delivery • Support in research
Media	<ul style="list-style-type: none"> • Advocacy Information Dissemination, Sensitization and SBCC • Source of information • Mobilization of funds and people
DOVVSU: Domestic Violence and Victim Support Unit	<ul style="list-style-type: none"> • Investigating • prosecution and enforcement of laws • Referring • Dissemination of information on rights and responsibilities • Source of data / information
CSOs/NGOs	<ul style="list-style-type: none"> • Advocacy/ lobbying, (sometimes form pressure groups) • Create awareness • Training • Support (funding, technical) • Mobilization of funds and people • Provision of health services • Operation research
Ministry of Chieftaincy / House of Chiefs / Queen Mothers Association	<ul style="list-style-type: none"> • Advocacy and champions • Ensure cultural values are observed • Community Mobilization • Information dissemination • Source of information • Enact by-laws
Development Partners	<ul style="list-style-type: none"> • Funding support • Technical support • Advocacy • Provision of global standards and guidelines • Collaboration (planning, implementation, monitoring and evaluation)
Mental Health Authority	<ul style="list-style-type: none"> • Support in policy formulation • Support in capacity building for both pre-and in-service • Advocacy • Collaboration in service provision
Academia	<ul style="list-style-type: none"> • Research • Training • Collaborating in clinical trials
Ministry of Education / Ghana Education Service (MOE/GES)	<ul style="list-style-type: none"> • Mobilization of schools/students for health education and services

Partner	Roles and Responsibilities
	<ul style="list-style-type: none"> • Support adolescent health programme implementation in schools (e.g. De-worming and WASH) • Review/ revise and implement policies to promote health for in-school adolescents • Review curricula to strengthen integration of adolescent health information and services in schools • Advocate for budgetary support for the school health programme • Support research in schools
Ministry of Youth and Sports / National Youth Authority (MoYS/NYA)	<ul style="list-style-type: none"> • Mobilization of out-of-school adolescents for health information and services • Support implementation of out-of-school adolescent health programmes • Review/Revise and implement policies to promote health for out-of-school adolescents • Support resource mobilization including advocating for budgetary support for out-of-school health programmes • Support monitoring and supervision of community-based adolescent health interventions • Support research
National Population Council (NPC)	<ul style="list-style-type: none"> • Develop and coordinate the implementation of policies for the promotion of Adolescent Sexual and Reproductive health • Generate evidence for programming and improving Adolescent Sexual and Reproductive Health • Monitor and evaluate the implementation of Adolescent Sexual and Reproductive Health Programmes • Mobilize resources for promotion of Adolescent Sexual and Reproductive Health Programmes • Advocate for increased budgetary support for Adolescent Sexual and Reproductive Health Programmes
Ministry of Gender, Children and Social Protection (MoGCSP)	<ul style="list-style-type: none"> • Develop and coordinate the implementation of policies for social protection of adolescents and young people • Ensure the enforcement of laws protecting the rights of adolescents and young people including the vulnerable and key populations to health information and services • Advocate for social protection of vulnerable groups and key populations • Mobilize resources to promote the health of vulnerable adolescents and young people including people with disabilities

Partner	Roles and Responsibilities
Ministry of Local Government and Rural Development	<ul style="list-style-type: none"> • Provide budgetary support for Adolescent Health activities at the district level • Ensure and provide platform for the involvement of young people in local governance • Support policies for retention of pregnant girls and vulnerable groups in schools • Support the provision of social protection for the vulnerable adolescent in communities • Monitor the implementation of adolescent health interventions

