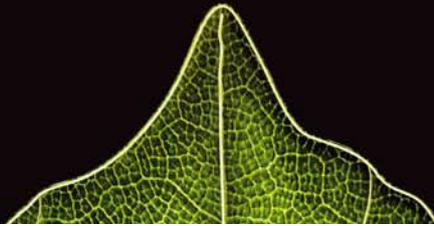


Delivering Reproductive Health Services to Young People in Ghana's Brong Ahafo Region: A Situational Analysis of Adolescent Health Corners

November 2016



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To request copies of the report or for more information on the report, please contact Meghan Bishop at meghan.bishop@thepalladiumgroup.com.

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EXECUTIVE SUMMARY

Background

The DFID-funded Ghana Adolescent Reproductive Health Project (GHARH), implemented by Palladium in collaboration with the Government of Ghana and other NGO partners, was launched in 2014 with the long-term aim of improving adolescents' sexual and reproductive health (ASRH). Specifically, the project aims to design and implement interventions to reduce adolescent birth rates and maternal mortality rates in Ghana's Brong Ahafo Region. It also aims to strengthen the capacity of the Government of Ghana (GoG) and other partners to manage ASRH programs.

GHARH aims to improve knowledge and behaviour around sexual and reproductive health (SRH) for adolescents, resulting in fewer and safer pregnancies, fewer sexually transmitted infections (STIs), and fewer girls dropping out of school due to pregnancy. As part of the initiative to achieve these aims, the Brong Ahafo Regional Health Directorate and the District Health Management Teams have partnered with GHARH to refurbish and operationalise Adolescent Health Corners in 54 health facilities. These Corners are designed to deliver adolescent-friendly reproductive health counselling and services, as well as to provide a space for youth to socialise. As of March 2016, 10 Corners had been refurbished and were open for business; from July 2016, all 54 Corners were functional.

Objective

This analysis aims to 1) understand the factors that influence use and non-use of Adolescent Health Corners; 2) ascertain the client profile of the Adolescent Health Corners and examine which services are most in demand; and 3) document the services offered and the barriers to their use.

Methodology

Analysis of routinely collected monitoring data from the corners provided an overview of services offered and client demographics. Qualitative data collection included focus group discussions (FGDs) with users and non-users of two Corners with high client volume and two Corners with low client volume to compare their activities and challenges. In-depth interviews (IDIs) were carried out with clients, providers, and teachers. In addition, a checklist was used to take an inventory of the operations and facilities at the 10 sites. A brief literature review was also conducted, which is attached for context in Annex 4.

Key Findings & Recommendations

The analysis found that the Adolescent Health Corner initiative comprises an effective, original and dynamic way to improve ASRH in the Brong Ahafo Region. The Corners provide an innovative approach to service provision; both the games and the community outreach are key to attracting and retaining young clients.

Analysis of the routinely collected data from the 10 Corners showed that the majority of clients were girls, although in the 10-14 age group, almost three times as many boys came

for services. Ghana Demographic and Health Survey (GDHS) data indicates that girls start to be sexually active from age 15 onwards and begin childbearing in their late teens or early 20s. Their demand for both family planning and ante-natal and post-natal care thus explains the increase in numbers in the two older age groups. There are substantially fewer male clients aged 20-24 when compared with women of a similar age. The analyses also indicated that the majority of boys came to the Corners for nutrition information, general information, education and psychosocial support often related to bodily changes at puberty, as well as to procure condoms. Young women also came for general counselling (sometimes related to how to avoid intimate partner violence) as well as for family planning and ante-natal care.

The Adolescent Health Corners have had a positive effect on both SRH knowledge acquisition and on the uptake of services because they have a leisure dimension which encourages young people to frequently come with the primary aim of socialising. This serves to both de-medicalise and defeminise the setting, which makes it less stigmatising for boys.

Community involvement and accountability is key to the Corners' success and sustainability. The Corners acknowledge the socio-cultural context of ASRH (such as the high prevalence of transactional sex), and share priorities with the community such as reducing teenage pregnancies. To date, many schools are actively engaged with the Corners. Parents also tended to view the Corners favourably, with mothers often bringing their daughters in for services as they are aware of how teenage pregnancy can negatively affect girls' lives. As the Corners become better established, more partnerships can be built with religious and traditional leaders for a truly holistic approach. In particular, engagement with local chiefs through Durbars (traditional ceremonies) and within Churches to aid sensitisation was seen by interviewees as a useful way forward.

Young people view the Corners in a positive light, particularly as they are known for good client confidentiality. The few respondents who had negative opinions perceived family planning methods to cause side-effects which rendered young women infertile. This phenomenon is found in many other developing country settings and underscores the need for high quality counselling with regard to contraceptive choices.

In general, young people have not been engaged in the running of the Corners and had not been asked their opinions on the nature and quality of services. The creation of a youth steering committee may be useful to recommend activities (including sporting activities which were frequently requested by youth), identify underserved groups (such youth with disabilities), and help with sensitisation. The Corners did not seem to have a close or formalised relationship with the peer educators recruited by the Ghana Youth Authority and local associations. Young people using the Corners were keen to be involved in sensitization and outreach. As they can positively recommend services from their own experience it seems crucial to capitalise on their enthusiasm. Interviewees noted that use of social media (Whatsapp, Facebook) is likely to enhance awareness about the Corners and can provide an important way of providing feedback. Additionally, the GHARH-funded TV soap opera YOLO had quite an influence on young clients. It may be worth adding the YOLO logo to branding and signage for additional impact and recognition.

Turning to service provision, the more successful Corners had younger providers who were often available out-of-hours to furnish condoms or to manage problems of menstrual

disruption, for example. Providers with negative attitudes, who ‘blamed’ youth for not coming to the Corner or who did little or no outreach tended to have low client volume. It was noted that a significant proportion of providers had not been specifically trained in ASRH issues and approaches, which should be rectified. It is also recommended that a gender balance of providers be available in each corner as girls often want to see a female health provider and boys a male health provider. Provider knowledge was generally good although a minority had incorrect beliefs about family planning methods. One provider conveyed stigmatising and incorrect information about homosexuality. Thus, sensitization and non-discrimination training is needed.

Some Corners experienced stockouts and equipment shortages which need to be rectified. Formal systems should be established to monitor stock supplies and usage at Corners as well as referrals to nearby facilities. Currently, referrals and relations with other facilities are ad hoc.

Although the services are advertised as being free, in reality, because of the complexities of Ghana’s health insurance system, most clients end up paying a small fee, especially for family planning commodities. It is recommended that GHARH and the Ghana Health Service (GHS) work together to clarify if it is possible to amend the insurance system so that young Corner clients can be covered.

With regard to the routine data collected, the GHARH Corner register which is used for monitoring purposes should be better harmonised with the GHS registers as the numerous forms are onerous for providers to fill in each month. In particular, the GHARH register should collect data on method mix and on clients’ marital status to better monitor FP services—and their impact in terms of CYPs—as well as client profiles.

The Corners have shown an extremely promising start. Close supervision and monitoring as well as improved provider training and enhanced community engagement can ensure that quality services are delivered at all Corners, and that the Corners become a flagship initiative for both GHARH and GHS.

ACRONYMS

ANC	Antenatal care
ASRH	Adolescent sexual and reproductive health
AYFHS	Adolescent and Youth Friendly Health Services
BAR	Brong Ahafo Region
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
DFID	Department for International Development (UK Aid)
FP	Family planning
GBV	Gender-Based Violence
GHARH	Ghana Adolescent Reproductive Health
GoG	Government of Ghana
HIV	Human Immuno-Deficiency Virus
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
IUD	Inter-uterine device
JHS	Junior High School
LARC	Long-Acting and Reversible Contraception
mCPR	Modern contraceptive prevalence rate
NGOs	Non-Governmental Organisations
NHIS	National Health Insurance System
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
WHO	World Health Organisation
WRA	Women of reproductive age
YOLO	You Only Live Once (TV Soap opera)

INTRODUCTION

Evidence suggests that many Ghanaian adolescents do not use SRH services, particularly due to stigma around premarital sex. Awusabo-Asare and Ananim (2008) found that two out of three young women and four out of five young men with STI symptoms did not seek treatment, while approximately half of unmarried sexually-active female adolescents and over one-third of sexually-active male adolescents did not use contraceptives. Research around youth-friendly services highlights the need for tailored services responding to different market segments, such as married and unmarried young women and boys.

In response to these challenges, the DFID-funded Ghana Adolescent Reproductive Health (GHARH) project, in collaboration with the Ghana Health Service (GHS), supported the refurbishment of 54 Adolescent Health Corners in the Brong Ahafo region. Working with the Regional Health Directorate and the District Health Management Teams as well as the Brong Ahafo Regional Administration and Municipal/District Assemblies, these Corners provide youth-friendly services, which include family planning, ante-natal and post-natal care, HIV and STI testing, and psychosocial counselling. In addition, the Corners are avenues for preventive care and education about sexual and reproductive health (SRH).

As of March 2016, 10 Adolescent Health Corners had been refurbished and opened for business; from July 2016, the other 44 Corners were also functional. The primary client group for the Corners is men and women under 24 years of age. Those over 24 are referred to a regular health facility. Annex 1 shows a map of all the Corners and highlights the 10 Corners involved in the study in the Brong Ahafo region. Annex 2 lists more specific characteristics of each Corner. Some Corners are stand-alone structures and others are integrated into a nearby hospital or health centre. Corner staff are certified GHS nurses, midwives, and community health nurses trained on ASRH issues. If a client's needs cannot be met in the Corner, the young person is referred to specialist health services in the adjacent facility.

Because these corners are newly opened, little is known about demand and supply side issues affecting their function, efficiency, and potential impact. This situational analysis—a joint undertaking by GHARH, the University of Cape Coast (UCC) and the Ghana Health Service (GHS)—fills this gap. The 10 Corners that have been operational since March 2016 were chosen for data collection in order to explore their services, challenges, and potential impact, as well as how they are viewed by staff, young people, and other community stakeholders. Routinely collected data from the Corners is analysed and additional quantitative data, from the 2104 Ghana Demographic and Health Survey (GDHS), is presented to contextualise the qualitative findings against regional and national trends. Together, this information can be used by GHARH and GHS to understand how to increase the Corners' impact and performance and, if necessary, to modify service delivery methods to improve health outcomes among young people.

STUDY OBJECTIVES

This study had three main objectives:

- 1) To understand the socio-cultural, economic, attitudinal and operational factors that influence use and non-use of the adolescent health corners;
- 2) To ascertain the client profile of the adolescent health corners and examine which services are most in demand; and
- 3) To document the services offered and the barriers to their use.

The information provided by this analysis fills these information gaps, providing critical and timely feedback to the GHS to enable improvements in the youth-friendly services offered at the Corners.

METHODOLOGY

The study methodology included analysis of routine data from the Corners, application of a checklist, and qualitative data collection and analysis. Two complementary qualitative techniques were used: focus group discussions (FGDs) to ascertain normative attitudes and the social context of SRH decision-making and behaviours, and individual in-depth interviews (IDIs) to capture experiences and opinions.

To compare Corners with different characteristics, the qualitative research focussed on two sets of Corners: those which, according to routine data collected between January and March 2016, had a high volume of clients (Acherensua and Fiapre Corners) and those which had low client flow (Kwapong Corner and Bomaa Polyclinic¹).

Male and female clients and non-clients aged 15-19 and 20-24 were involved in the FGDs. Amongst users, open-ended questions addressed whether the Corners deliver quality services (using young people's own definition of quality as well as standard definitions), their perceptions of the friendliness and availability of clinic staff, the availability of commodities, satisfaction with referrals and follow up, and the barriers to young people using and recommending the service. The questions elicited suggestions for how the Corners be improved to better create and meet demand. Questions for non-users addressed why they do not use the services, the barriers associated with their non-use, and how these can be overcome. The FGDs were carried out by a moderator and note-taker.

In-depth exit interviews with clients were conducted at the two high and two low volume Corners. The questions addressed reasons for the clients' visit, satisfaction with their consultation, willingness to recommend or return, and suggestions for improvement. Further IDIs were conducted with community leaders/stakeholders in the four high and low volume corner communities, to get their perspectives on the role and impact of the services. Due to availability, all four interviewees were teachers.

In all 10 Corners, individual health care provider interviews discussed training and job satisfaction, commodity availability, effectiveness of the referral system and outreach, the perceived impact on ASRH, and additional support needs. Subsequently, a checklist to assess service quality and the minimum package of services was administered. The checklist is derived from selected elements of the tools contained in the "Standards and

¹ Although Kwapong was one of the poorest performing Corners (in terms of client volume) between January and March 2016, its client volume had increased by the time the fieldwork was carried out. However, the routine data was not available at this point and so it was included as a low-volume corner. In fact, Nsoatre Corner and Bomaa Corner had the lowest client volumes for July-September 2016.

Tools for Monitoring Adolescent & Youth-friendly Health Services (AYFHS) in Ghana” (GHS 2010). Annex 3 provides a summary analysis of the checklist findings.

A brief literature review on youth/adolescent corners was also conducted and is provided in Annex 4.

Table 1 shows the distribution of research activities by Corner.

TABLE 1: DISTRIBUTION OF FIELD RESEARCH ACTIVITIES BY CORNER

		Focus Group Discussions (FGDs)						In Depth Interviews (IDIs)			Checklist	
		A	B	C	D	E	F	Client Exit Interviews		Teachers		
								Male	Female			Providers
High volume GHARH Corner												
1	Acherensua Corner	1	1	1	1	1	1	1	3	1	1	1
2	Fiapre Corner	1	1	1	1	1	1	2	2	1	1	1
Low Volume GHARH Corner												
3	Kwapong Corner	1	1	1	1	0	0	0	1	1	1	1
4	Bomaa Polyclinic	0	0	1	1	0	0	0	2	1	1	1
Other GHARH Corners												
5	Bronsankro Corner									1		1
6	Fiaso Health Centre									1		1
7	Nsoatre Corner									1		1
8	Dormaa RCH									1		1
9	Sunyani Municipal Centre									1		1
10	Atronie Health Centre									1		1
Total		18						11		10	4	10

FGD Key: A: Male users age 15-19, B: Female users age 15-19, C: Male nonusers age 15-19, D: Female nonusers age 15-19, E: Male users 20-24

Sampling

In the two high-volume and two low-volume corners, GHARH staff alerted the provider and GHS staff in advance and asked them to contact potential study participants (except exit interviewees, who were contacted on site). Interviewers had a detailed screening sheet to check each individual’s eligibility for the study. The screening sheet also ascertained participants’ socio-economic details such as age, marital status, and education level. All participants provided informed consent to participate in the study.

Limitations

Male and female clients of the four Corners and non-clients aged 15-19 and 20-24 were intended to participate in the FGDs. However, despite arranging in advance for eligible participants to be to present, no male or female users were available at either Kwapong or Bomaa clinic. Similarly, no 15 to 19-year-old users were available in Bomaa, which had seen no clients from July–September 2016.

Individual exit interviews were to be conducted with two male clients and two female clients at each of the four Corners. No male clients were present at either Kwapong or Bomaa, and only one female client (instead of two) could be found at Bomaa. To make up for this deficit, an extra female client was interviewed at the high-volume clinic of Acherensua.

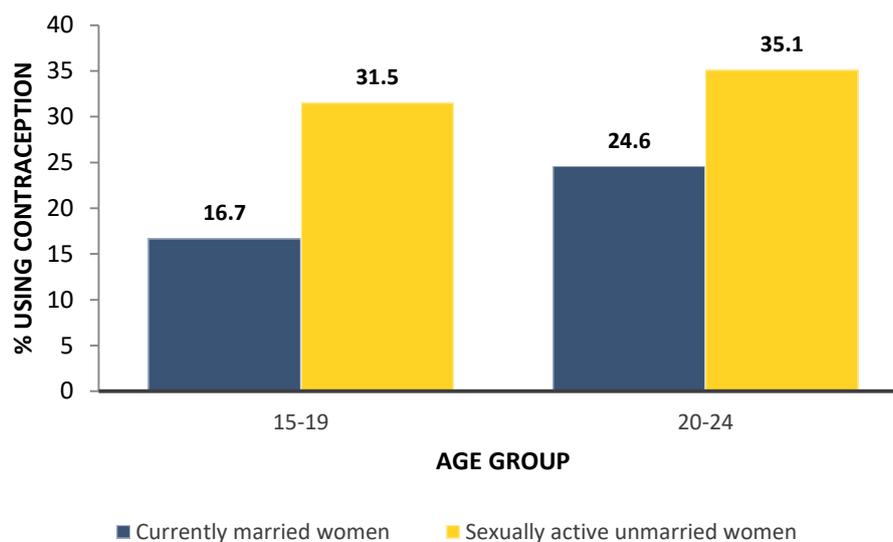
All respondents were single except for one interviewee who reported she was cohabiting. The lack of married respondents is acknowledged as a bias in the study and indicates that the Corners generally cater for unmarried youth.

OVERVIEW OF GDHS ANALYSIS

The GHARH project carried out an in-depth analysis of the 2014 GDHS to assess key issues and progress in adolescent sexual and reproductive health (Smith, Pereira and Bishop 2016). Key findings from this analysis are presented here to contextualize the current study.

In Ghana, the median age at first sexual intercourse is 18 years for females and 20 years for males; 6.4% of 15-19 year olds girls were married or in union compared with only 0.5% of boys. Nearly 17% (16.7%) and 24.6% of married women aged 15-19 and 20-24 respectively were currently using a modern method at the time of the 2014 survey (Figure 1). By contrast, over one third of unmarried sexually active women in each age group were using a modern method. Higher use among unmarried women could reflect stigma around pre-marital pregnancy and the desire to avoid an abortion (Bleek, 1987).

FIGURE 1: CURRENT USE OF CONTRACEPTION AMONG YOUNG WOMEN, BY AGE



Source: Ghana Demographic and Health Survey 2014

In BAR, 19.8% of all women aged 15-19 and 29% of all women aged 20-24 were using a modern method of contraception at the time of the 2014 GDHS. The regional numbers are too small to disaggregate by marital status, but trends indicate that, similar to national trends, use is higher among those who are unmarried.

The 2014 GDHS also showed that 20% of females and 27% of males aged 15-24 had comprehensive knowledge about HIV. In BAR, comprehensive knowledge was much lower among women (13.8%) than among men (24.1%). Lastly, 68% of girls and 52% of boys hold accepting attitudes to gender-based violence (GoG, 2012). Among 15 to 19-year-olds, nationally 35.1% of women thought that beating a spouse was justified and in Brong Ahafo, 40.9% of women were in agreement.

RESULTS

ADOLESCENT HEALTH CORNER ROUTINE DATA

Each Corner submits a monthly report to GHARH based on routinely collected data from the Corner’s GHARH register. Each quarter, GHARH produces a report; therefore, at the time of this analysis, there were three quarterly reports available for the 10 Corners that opened in early 2016. In these reports, client volume is disaggregated by age and services.

FIGURE 2: NUMBER OF CORNER CLIENTS BY QUARTER, JANUARY–SEPTEMBER 2016

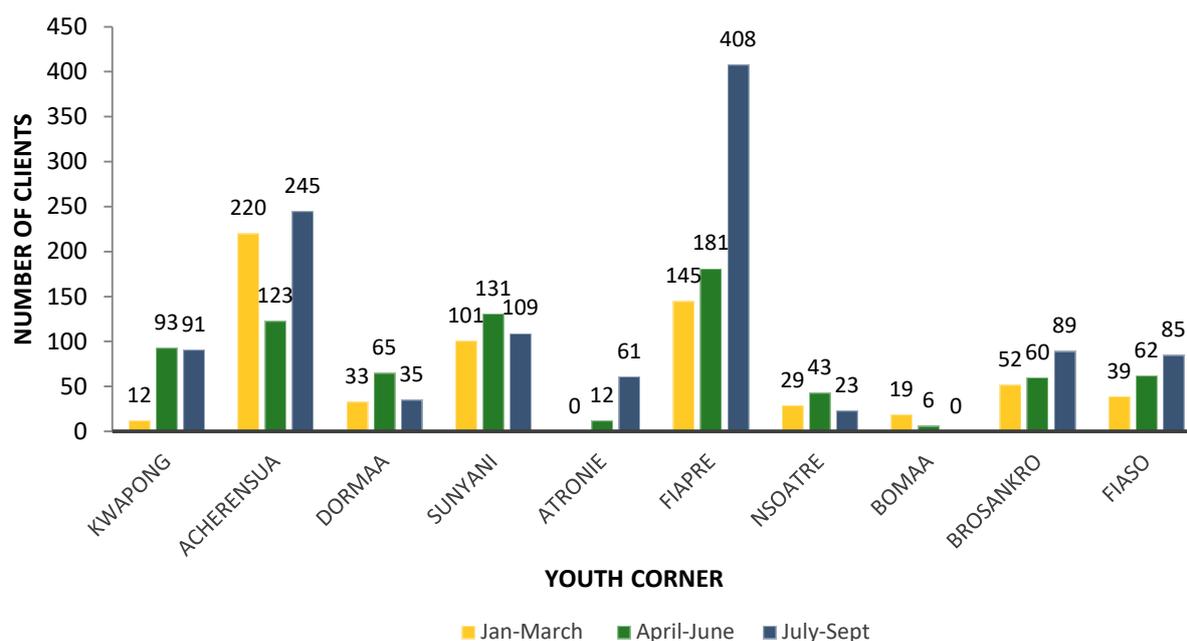
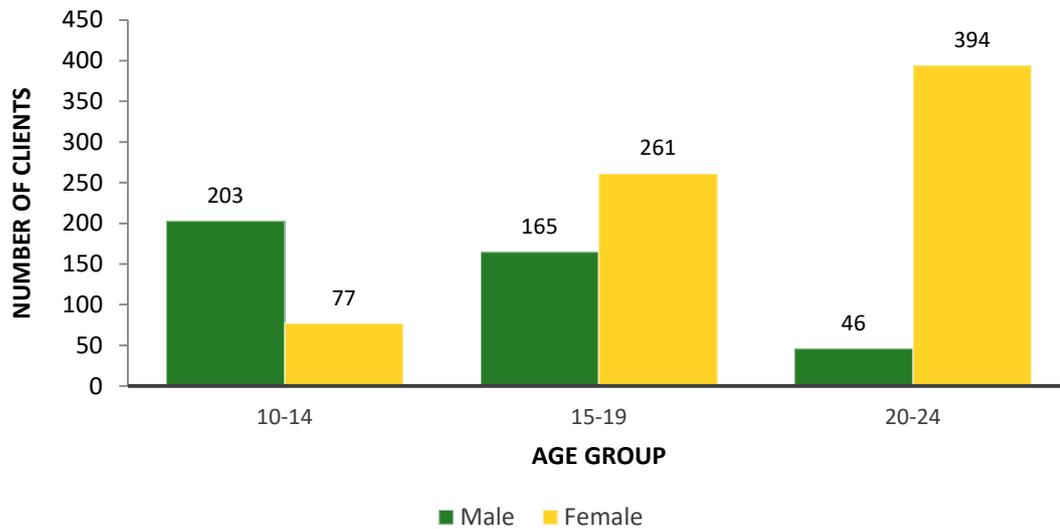


Figure 2 shows the number of clients in each of the 10 initial Corners between January and September 2016. Fiapre and Acherensua are the high volume Corners included in this study, with Fiapre, in particular, showing a substantial increase in numbers of clients over time. This may be attributable to good relationships with neighbouring schools and effective outreach.

The low volume corners (selected for the study on the basis of the first quarter results) are Kwapong and Bomaa. Kwapong seems to have made progress in attracting clients but still only averages about one client per day. Bomaa saw no clients from July to September 2016.

Only half of the Corners have achieved an increase in numbers of clients over the nine months whilst some, such as Dormaa and Nsoatre, have registered declines between quarters two and three. This may be due to seasonal factors such as the school holidays when secondary school pupils may return to their home communities. It may also be due to agricultural obligations which also coincide with this period.

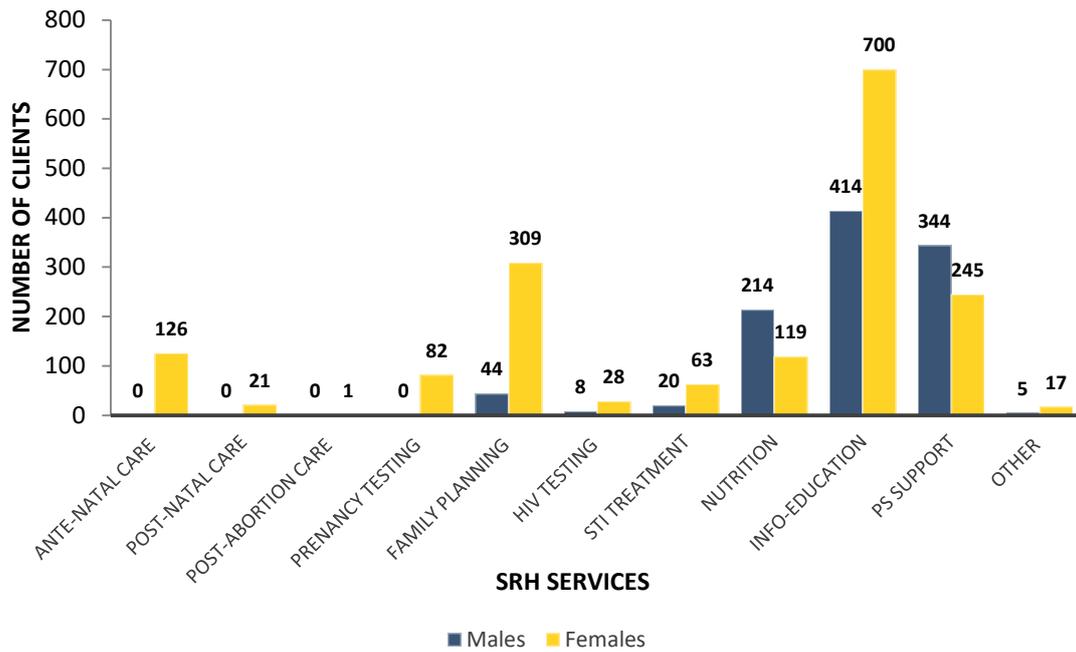
FIGURE 3: NUMBERS OF MALE AND FEMALE CLIENTS REACHED, BY AGE GROUP, JULY - SEPTEMBER 2016



The majority of clients were girls, although in the 10-14 age group almost three times as many boys came for services (Figure 3). Girls begin to be sexually active from age 15 and begin child bearing in their late teens or early 20s (GDHS 2014). Their demand for both family planning and ante-natal and post-natal care thus explains the increase in numbers in the two older age groups. Very few young men aged 20-24 appear to use the Corners; more sensitization needs to be done to attract males in this age group. Outreach may need to focus on colleges and vocational training settings as well as the community.

Boys primarily accessed nutrition information, general information/education, and psychosocial support (Figure 4). Young women came for general counselling as well as for family planning and ante-natal care. The large numbers recorded as receiving information/education may also reflect the fact that the Corners are frequently used for playing games (Scrabble, Ludo, Oware, etc.), particularly by young men. Although young men may come for social reasons, providers capitalise on their presence by offering information on topics such as HIV or condom use. These individuals may have been recorded as receiving information even though it was not the primary purpose of their visit. This underscores the success of the games in attracting clients, especially young men. The games also serve to 'defeminise' the setting, making it attractive to both sexes. The games help create rapport between clients and providers, even when the former are not seeking services.

FIGURE 4: SERVICES RECEIVED BY SEX OF CLIENT, JULY–SEPTEMBER 2016



When the Corners first opened, there was no register tailored to the specific services offered by the Corners. To address this gap, the GHARH project, in collaboration with GHS, developed a register to collect this information and facilitate reporting to GHARH. In the first nine months of operations, Corners were required to fill in a register for GHARH, noting the age and sex of the client, the services provided and referrals given (if any).

FIGURE 5: GHARH REGISTER FOR ACHERENSUA CORNER

District: Acherensua Senegal
 Date: Day 17 Month 7 Year 16
 Organization/Partner: Falldium

Please Tick as Appropriate

Date	Age	Sex (M/F)	Services Provided										Referral										Phone				
			Infoducation	Psychosocial Supp /Counseling	Antenatal Care	Postnatal Care	Nutrition	Post-abortion Care	Family Planning	Preg Test	STI	Other (Specify below)	Infoducation	Psychosocial Supp /Counseling	Antenatal Care	Postnatal Care	Nutrition	Post-abortion Care	Family Planning	Preg Test	STI	Other (Specify below)					
1	9/9/16	23	F	✓	✓																						
2	9/9/16	23	F	✓	✓																						
3	9/9/16	21	F	✓	✓																						
4	9/9/16	14	F	✓	✓																						
5	12/9/16	23	F	✓	✓																						
6	12/9/16	22	M	✓	✓																						
7	12/9/16	24	F	✓	✓																						
8	12/9/16	23	F	✓	✓																						
9	12/9/16	21	F	✓	✓																						
10	12/9/16	12	F	✓	✓																						
11	13/9/16	19	M	✓	✓																						
12	13/9/16	24	F	✓	✓																						
Total				12	3	2	0	0	0	9	4	5	6	1													

Specify Others: Services Provided bagging/ discharge
 Specify Others: Referral

As shown in Figure 7, the provider who completed this register from Acherensua Corner ticked ‘information-education’ for every consultation—hence the high numbers shown receiving this service in Figure 6. The family planning column does not specify the method offered, which means it is not possible to measure the uptake of short-term versus long-acting methods. It is also not possible to use the information in the register to calculate Couple Years of Protection (CYPs), a standard impact indicator. Furthermore, the register does not seem to differentiate FP counselling and method distribution. Client 5 is recorded as having received both ante-natal care and family planning. It is assumed that she received family planning information rather than a commodity.

Other GHS registers used at the Corners (see Annex 5) do note the method used and provide detailed notes about the client consultation. These are forwarded to the regional Directorate of Health and not easily accessed by GHARH. An additional register, also shown in Annex 5, includes detailed notes of each consultation along with age and sex of the client. However, these are not used by GHARH. A GHS stocktaking register notes the commodities distributed, but this is not a reliable indicator of consistent family planning use.

It is recommended that there is greater harmonisation of the general GHS registers and the Adolescent Health Corner registers and that method mix is duly recorded². This is particularly important to monitor uptake among adolescents and because increasing access to LARCs is a national goal (Marston, Renedo, Nsorma Nyaba et al 2016).

YOUNG PEOPLE’S SRH CONCERNS

The major health concerns reported by young people were STIs, pregnancy and abortion. HIV and AIDS were also mentioned, but not as much as STIs, which were reported in virtually all the FGD discussions. The most widely reported STIs were candidiasis (also referred to as ‘white’) and gonorrhoea. Other concerns which were raised by a few of them were bilharzia (schistosomiasis) and body odour.

“I think sexually transmitted diseases is the main problem. Because when they go to the hospital, they feel shy to talk about it. So they find it difficult to treat. Sexually transmitted diseases like gonorrhoea and candidiasis.”

FGD, Female respondent, Corner user, 24 years old, single, secondary schooling education, hairdresser

The participants attributed the perceived high prevalence of STIs to unprotected sex and the practice of having multiple sexual partners.

“Because we the youth of today like sex too much and because of this, we get this disease early and for the fact that we always want to have the sex raw (unprotected), it is easy to get the disease.”

FGD, Male respondent, Corner user, 22 years old, single, secondary schooling education, unemployed

² Since data collection for this study, GHARH and GHS collaborated to harmonize the various forms. The harmonized form, shown in Annex 6, was rolled out to all Youth Corners nationally in November 2016. The GHARH project is now able to access routine data through this register, rather than requiring Youth Corners to complete separate registers for the project.

“It is because we men of today take so many partners - for instance just one boy can have about five girlfriends and as such may transmit the disease from one partner to the other and it continues. That is why this disease has become more of a burden to us the youth.”

FGD, Male respondent, Corner user, 23 years old, single, secondary schooling education, unemployed

An additional issue was teenage pregnancy, which was given the same importance as STIs by most of the participants.

“This area, I think it’s mainly teenage pregnancy and then some STIs.”

FGD, Male respondent, Corner user, 23 years old, single, high school education, student

“Our greatest problem here is teenage pregnancy.”

FGD, Male respondent, Corner non-user, 16 years old, single, junior high school, student

It was reported that some of the young girls who get pregnant resort to unsafe abortion.

“I think abortion is the biggest problem of them all.”

FGD, Female respondent, Corner user, 15 years old, single, Junior High School student

“Abortion is what mainly goes on here. Sometimes when a girl gets pregnant, the boy is unable to look after her. As such, the only option is to terminate the pregnancy so that she can continue the work she was doing prior to the pregnancy.”

FGD, Male respondent, Corner user, 15 years old, single, junior high school, student

In a number of rural settlements where people rely on streams and ponds for water supply, water-related diseases such as bilharzia exist. This was given as much attention as some of the reproductive health problems.

“Another problem here is bilharzia and burning sensations when urinating. Sometimes, there is no blood in the urine but you can feel pains in your penis.”

FGD, Male respondent, Corner non-user, 15 years old, single, junior high school, student

The reported SRH concerns (STIs, teenage pregnancy and abortion care) are addressed by the Corners, while the other two—personal hygiene and environmental-based diseases such as bilharzia—are addressed under the School Health Education Programme (SHEP).

AWARENESS OF ADOLESCENT HEALTH CORNERS

The general view among FGD participants was that the Corners are useful and that they need to be supported to adequately deliver services so that young people will patronize them, and parents and the community members will give the necessary support. The perception about some of the benefits of the Corners is summed up thus:

“Before this youth corner was established, we had nothing like this opportunity to sit together and discuss such issues or even to receive information on sexual and reproductive health, but anytime we got infected, we either go to the pharmacy or a herbalist to seek treatment, but with this youth corner we come for the information, and we seek treatment elsewhere, we usually

seek treatment from herbalists because we believe their herbs treats such infections or diseases faster.”

FGD, Male respondent, Corner user, 22 years old, single, secondary schooling, unemployed

Both users and nonusers indicated that the major challenge was making the Corners known to the community. To this end, respondents made the following recommendations:

- An information van for suburbs and various communities around the Corners;
- Announcements on local FM stations and community narrowcasting services;
- Community outreach involving house-to-house visits by the providers and peer educators;
- Use of teachers, since most of the target population, especially those aged 15-19, are in school;
- Peer education within schools and communities;
- Education of parents to sensitize them about the centre; and
- Community Durbars (traditional ceremonies).

Some of these suggestions are either being pursued or have been tried. Nonetheless, publicity about the Corners needs to be intensified.

CORNER LOCATION, OPENING HOURS, AND SIGNAGE

Location

Most of the Corners are within the grounds of larger health facilities. Young clients felt secure in the knowledge that they could be referred to the hospital if their health problem was serious.

“The location is good. The way it is close to the hospital, when you come and they cannot solve your problem, they will just refer you to the hospital.”

FGD, Female respondent, Corner user, 24 years old, secondary schooling, hairdresser

“As it is near the health centre, it is good because maybe someone might get sick and since it is closer you can go to the clinic too after here. So it’s good that it’s closer to the health centre.”

FGD, Female respondent, Corner user, 20 years old, secondary schooling, unemployed

In some places, the Corner is along the main road in the town, which to some of the respondents was an advantage in that one could easily find the facility.

“...because it is close to the roadside, he or she can just ask and the person would be directed to the place easily.”

FGD, Female respondent, Corner user, 21 years old, Higher education, unemployed

Respondents also commented on the appearance of the facility. According to some, the Corner is like any other house in the communities, hence entering the building did not attract unwanted attention. This enhanced access.

“The location is good. When they were building it at first, it didn’t even click to me that it will be a youth corner. It was like someone’s house. The location is good because when you enter the building nobody sees you.”

FGD, Female respondent, Corner user, 23 years old, Junior High School, seamstress

On the other hand, the health facilities within which some of the Corners are located are at the outskirts of the communities, making access difficult. In some cases, the Corner was difficult to spot and not instantly recognisable as providing health services

“As for the location, emm, it’s really a corner, so..., the visibility is not that ... properly seen. Even the trees are like kind of surrounded the building and then it is so far, you cannot see the corner as they say”

Interviewer: *“And has that affected people’s knowledge of the corner, where it is, its location?”*

“Yeah. It’s more or less like a building. If you are not told that this is the corner, because it is located in an area with other buildings around, you might just see it as a normal house and then you would just pass by.”

FGD, Male respondent, Corner user, 23 years old, Higher education, student

Opening hours

The facilities open from 9:00 am to 5:00 pm, the normal working hours in Ghana. This coincides with the period that young people are in school or at work, making it difficult for some of them to access the facility. According to respondents, they would prefer to access services in the early morning or after 5pm.

“What is really disturbing is the fact that by 7pm when one would have had his/her partner and ... you get there only to realise that the place is locked and there is no way one can get a condom from here at that time ... that can be very disturbing.”

FGD, Male respondent, Corner user, 23 years old, secondary schooling, unemployed

Since the Corners are attached to health facilities, the locations and working hours are determined by the broader facility. While it may not be possible to have standalone Corners, some flexibility in working hours or avenues for accessing condoms beyond working hours, such as condom dispensers, should be considered.

“As for me it is the condoms that are available here that I am so excited about ... but at times when we get here at night, we don’t get condoms so if there could be a box or some left here or something that we could slot money in and take the condoms in the absence of the worker, I would have been pleased.”

FGD, Male respondent, Corner user, 23 years old, secondary schooling, unemployed

Signage

All of the Corners should improve their signage. The current signage is too small and is usually on the veranda of the Corner where it is not noticeable. Respondents suggested that signs be larger and additional signs placed by the roadside so that people can more easily find the Corner.

“I have not seen any youth corner sign – board. If I say I have seen it, I will be telling a lie. Maybe the direction the guy gave me if there was sign – board that I didn’t see, it is different.”

Exit interview, Male respondent, 22 years old, secondary schooling, student

FIGURE 6: SIGN AT ACHERENSUA CORNER



CHOICE OF SRH SERVICE PROVIDER

In addition to the Corners, young people seek SRH services from hospitals and clinics, drug stores (pharmacy shop), itinerant drug sellers (peddlers), and Mallams/herbalists. According to informants, the choice of a service point is influenced by a number of factors. For instance, in the case of abortion, respondents indicated that young people tended to rely on pharmacy shops (drug stores) and itinerant drug sellers, since there are usually no questions asked.

“If it is abortion, most of the time we go to the drug store to buy medicine to destroy the pregnancy.”

FGD, Female respondent, Corner non-user, 15 years old, single, junior high school, student

“Some of them buy from drug peddlers. Those who buy medicine from the drug peddlers normally buy those drugs with the warning that pregnant women are not supposed to take it. They will intentionally buy that one and use it as medication to terminate their pregnancies.”

FGD, Female respondent, Corner non-user, 15 years old, single, junior high school, student

Health facilities (hospitals/clinics) were used for a variety of services such as basic education around SRH, family planning, treatment of STIs, post-abortion care, and other ailments. The Corner, according to the younger participants (15-19 years), provides an avenue for young people who are unable to discuss SRH issues elsewhere.

“Some people cannot talk to their mother or friends so they can come to the adolescent corner to talk to the providers.”

FGD, Female respondent, Corner non-user, 15 years old, single, junior high school, student

Other advantages, according to participants, is that health workers at the Corners have the capacity to provide information on a wide range of issue on health and life generally, whereas this is not the case with pharmacy shops and itinerant sellers.

“I think coming to the Corner will help because if you buy medicine in a vehicle, you will take the medicine though the seller will even not tell you the dosage, but at the corner after the medication they will top it up with information. ...but if you buy the medicine in the vehicle they cannot give you such information.”

FGD, Female respondent, Corner non-user, 16 years old, single, junior high school, student

Some participants raised challenges associated with the use of products from pharmacy shops and itinerant sellers. Participants pointed out that one could be sold drugs which were past their expiry date. With regard to the herbal medicine providers, the participants noted that they often possessed inadequate knowledge or lack of comprehensive information.

“Maybe the drug store that you will buy the medicine from, the seller might not be well abreast with medicine he or she is selling.”

FGD, Female respondent, Corner non-user, 16 years old, single, junior high school, student

However, the respondents indicated that young people use drug stores, herbalists and itinerant drug sellers because they are readily available in the community, they can be consulted at any time, and young people believe they will be able to receive quicker solutions to their problems than they would get from health facilities.

Some young people used health facilities for family planning, post-abortion care, and treatment of STIs after attempts with drug peddlers, herbalists, and pharmacy shops failed. The narration below illustrates the steps that one young person went through before visiting a Corner.

Interviewer: *What brought you to the youth corner today?*

“What brought me here is that I am a student at a...senior high. ...I was always thinking of how I will stay in a relationship with a lady that will not lead to pregnancy which will distract my schooling and her schooling. It was a great worry to me so I discussed it with a friend, and he told me they have built an adolescent health corner at Acherensua so I should go and consult them and know if they have any help for me. Another friend also advised me to go to the drug

store to buy medicine so that if I have sexual intercourse I will drink or she will drink so that she won't get pregnant. Truly, I closed my ears towards the advice my first friend gave me and went to the drug store. When I went to the drug store they gave me a medicine called Anofranol. So first of all if am about to have sexual intercourse with the lady I take the medicine, I took the medicine continuously for about three to four times and sometimes when I am in class I feel that my veins are contracting. Then I realised that it was the drugs that I am taking that is giving me the side effects, so I decided to act on the advice my first friend gave me and rushed and look for the adolescent corner. So I left my school to come to the adolescent health corner at Acherensua. Indeed, when I came the nurses sat down with me patiently for me to explain all my problems to them. I was a guy who had never used a condom before, they advised me that the best way and solution they can do for me is to teach me the way to wear a condom to have sexual intercourse and the best way to prevent pregnancy when having sexual intercourse with a lady and not getting any teenage pregnancy to distract my education.”

Exit interview, Male respondent, 22 years old, secondary schooling, student

YOUNG PEOPLES' PERCEPTIONS OF THE CORNERS

Positive perceptions

Focus group participants who had used the Corners generally had more positive perceptions of them than those who had never been.

In Acherensua, users thought that the Corner had reduced stigma around STIs.

“Because of the information we have received from the Corner, we are no longer afraid to associate ourselves with someone who has an STI. Before we were afraid that having something to do with an infected person would cause a problem for us but now we have a deeper understanding.”

FGD, Male respondent, Corner user, 22 years old, single, secondary schooling, mason

Others thought that the Corners had reduced the incidence of teenage pregnancy in the community.

“In the past, there used to be a lot of cases of teenage pregnancy but since the corner was inaugurated I can see that that has stopped. I have not heard that any pupil has become pregnant since the youth corner opened.”

FGD, Male respondent, Corner user, 17 years old, junior high school, student

Clients also praised the way that the Corners dealt with mental health issues.

“The positive thing I have heard is that you can come here even if you are not happy. They have movies to watch, books to read—you can get happy any time and if you come with a problem they will help you find a solution so that is very good.”

FGD, Female respondent, Corner user, 18 years old, junior high school, student

Negative perceptions

Negative perceptions were largely related to fear of family planning methods and the belief that these would leave young women sterile.

"I have heard that if you have not given birth before and you use family planning for a long time when you find a man who will marry you, it will be difficult to give birth. It has created fear so we find it difficult to use family planning."

FGD, Female respondent, Corner non-user, 18 years old, junior high school, student

"I have heard in this community that women using family planning experience an irregular flow of blood during their period. It is also said that some of the women's bellies grow bigger because the blood does not flow properly. This discourages those who want to come and do family planning at the corner."

FGD, Female respondent, Corner user, 22 years old, single, secondary schooling, hairdresser

Young men perceived that the counselling that young women had received at the Corners had made girls less willing to have sex with them if they knew the men had multiple partners. To them, this was a downside of the Corners.

"For us men it has become difficult for us to coax women into sleeping with us because they have been informed about the consequences of risky sexual behaviours. This has affected our ability to get ladies to sleep with us - before we could sleep with (many of) them "rough rough" (indiscriminately) and this is the problem I have with this Corner."

FGD, Male respondent, Corner user, 23 years old, secondary schooling, mason

Other negative views related to a long waiting time, especially at Fiapre Corner.

"At times when you come here, they can see that you are suffering but they will just be sitting there chatting as much as they like but when they come to attend to you, that one everything is ok."

FGD, Female respondent, Corner user, 20 years old, cohabiting, secondary schooling, unemployed

Perceptions of providers

In general, the providers were viewed very positively by the Corner users. They were said to be patient, welcoming, and non-judgmental.

"They don't shout or rebuke you – they smile with you and talk to you calmly so that you can also tell them your problem. She won't shout at you, she won't criticise you or say that you are a bad child or something, she won't say that. She will smile with you and you can tell her all your problems so she can help you solve them. They won't worry you in any way."

FGD, Female respondent, Corner user, 17 years old, junior high school, student

"The reason why I like coming here is that they get time to sit down with you and give you good advice. They draw your attention to whatever they are doing and whenever I come here I can ask all questions that are bothering me."

FGD, Female respondent, Corner user, 16 years old, junior high school, student

"They do not disclose confidential information about clients to people. They would only advise you not to repeat your mistakes so that the problems do not recur. That is how they are. They are very good."

FGD, Male respondent, Corner user, 15 years old, junior high school, student

There appears to be a slightly different dynamic between providers and non-educated users, who may interpret discretion as disdain.

“Some providers don’t receive us well - for instance for someone like me. I don’t know whether is because I have not had much education that some feel they can treat us any old how. For instance, you can come here looking forward to buy a condom then she (the Provider) just enters, picks up the condom and hands it to you - it is not the best of practice.”

FGD, Male respondent, Corner user, 24 years old, secondary schooling, unemployed

The average age of the providers in all 10 facilities was 31.8 (range 26-43). The higher volume Corners have younger providers (average age 31) compared with the low volume Corners (average age 36.5). Young clients felt that it was preferable to have younger providers as they could better relate to their problems.

“If the provider is much older than you, you see her as a mother and you cannot relate to her very well as compared to the younger ones to whom I can tell everything I want and they will not criticise me because they are still at my level and they understand me better.”

Exit interview, Female respondent, 21 years old, primary schooling, hairdresser

In addition, some male clients preferred to consult a male provider and female clients wanted to see a woman. The male and female respondents below saw the same (female) provider and came away with very different experiences.

“I can’t go to a male and be talking about stuff like that to him - you’ll feel embarrassed or something. So as she is a female and very young, it’s like she’s a sister to me so you can just tell her everything. [If it had been a male provider] I don’t think I could have even been so outspoken. I would have just told him I don’t have any problem and I’ll just walk out.”

Exit interview, Female respondent, 16 years old, secondary schooling, student

If I had had a male provider I wouldn’t have felt shy. You see we are all males and when males meet, it’s ok.

Exit interview, Male respondent, 16 years old, junior high school, student

It is therefore preferable to have a mix of male and female staff at each Corner.

Service quality

Four general areas emerged from discussions with young people about the quality of services they received: the knowledge level of the providers, confidentiality, friendliness/welcoming staff, cleanliness, and perceived ability to be cured.

Participants noted that they found Corner providers knowledgeable about their work. This put confidence in the services offered at the Corners.

“I believe, what most of us look at is, where we can be cured after seeking treatment, if say, this is the place that I can come to and be cured of my ailment, I will visit the place irrespective of the cost even if it means I would have to go and borrow.”

FGD, Male respondent, Corner user, 23 years old, single, secondary schooling, farmer

“The health personnel are knowledgeable in treating most of the diseases.”

FGD, Male respondent, Corner non-user, 16 years old, single, junior high school, student

Confidentiality also emerged as one of the most important attributes of service quality. Participants of various ages noted that whether information was kept confidential would define whether people would patronize the Corners or not.

"Sometimes they think about confidentiality. Maybe if I come here and discuss my issues with them will they compare it with others, will they inform my mother's friend or my friend?"

FGD, Female respondent, Corner user, 20 years old, single, junior high school, unemployed

Participants mentioned the friendliness of the providers and other staff members. According to the young people, they will patronize facilities where the providers are friendly and where they do not feel stigmatized.

"And they also look at whether the staff at the Corner are friendly or not and whether they are able to keep secret or not."

FGD, Female respondent, Corner user, 20 years old, single, junior high school, unemployed

"The staff over there are patient, they are not people who will be shouting at you when you are pregnant and you go there to tell them your problem. So everybody feels free."

FGD, Female respondent, Corner user, 17 years old, junior high school, student

The facility environment was also a factor that attracted them to the Corners. Those who mentioned this reason commended the facility and the providers for providing a hygienic and attractive environment.

"Yes, this place is more hygienic as compared to that of the traditional healer."

FGD, Male respondent, Corner non-user, 16 years old, single, junior high school, student

In general, the quality of information and services at the Corner was considered superior to those in other outlets, such as herbalists, drug stores, traveling salesmen, fetish priests, and the pharmacy. Young people felt that providers' information and diagnoses were more accurate at the Corners.

"This corner has really helped and is better because they specifically tell you about what is wrong with you, unlike a Mallam (faith healer) who may attribute the cause of your ailment to someone else like your father or auntie which may breed hatred or enmity between people."

FGD, Male respondent, Corner user, 23 years old, single, secondary schooling, mason

"Coming to the youth corner is better because when you come they will teach you how to go about things. If you go to buy a drug from the drug store it might not work, so coming here would be better."

FGD, Female respondent, Corner user, 17 years old, junior high school, student

Counselling quality

The quality of counselling was viewed positively by clients. In particular, the discussion of family planning methods was comprehensive and providers usually gave clients the opportunity for free and informed choice. Having been informed of the pros and cons of each method, clients could choose their preferred method.

"When you come, they will explain to you the effects of it or when you do it the number of months it will take and all that. So they will explain it to you for you to make your own choice. We have one month or three months [injectables] so if you have not used it before she will advise you that you choose the one month and try to see before later if you see it's suitable to you, then you can go for the three months own. So she will give you good advice both positive and negative - so if it's ok by you then you take the one month then later come for the three months."

FGD, Female respondent, Corner user, 16 years old, junior high school, student

The providers were skilled at integrating counselling on personal hygiene, STIs, and HIV with family planning counselling. Receiving this information gave clients satisfaction.

"I came to get family planning - specifically the three month injection. They also gave me information on the family planning. For instance, she asked if I had experienced any side-effects that I would want to talk about. But I kept on telling her that I have not faced such problems before. They also gave me information on how to clean my vagina and how to clean myself after having sex with my boyfriend. Also if he has multiple sexual partners, then you have to advise him to use condoms so that he will not infect himself with any diseases and end up giving them to you. These days HIV infections and 'white' (candida) are on the rise. So if you know your boyfriend has multiple partners you have to buy him condoms otherwise he will infect you with these diseases.... I was really satisfied with the service I received and they even advised me on STIs in addition to the family planning service I came for."

Exit interview, Female respondent, 21 years old, primary schooling, hairdresser

The providers seem skilled at addressing other health issues such as drug and alcohol abuse.

"Drug abuse is something that worries us a lot. It is a major problem in this community, especially weed and joints. There were some of our JHS students who were smoking weed before they graduated... Some of our fathers smoke weed. Even our brothers who completed school and are at home, some of them smoke weed and we all stay in the same house. So, would your father who smokes weed advise you not to smoke weed? And so, coming to the Corner has made us realise all those things and making it possible for us to avoid them. It helps us because they make us aware of the effects we would get when we do those things... So these are the things they explain clearly to us to enable us avoid them and to create a difference between us and our friends at home."

FGD, Male respondent, Corner user, 18 years old, junior high school, student

"They normally give advice on drug abuse and then sometimes alcohol abuse too, because, most of these things tend to take control over you when you absorb them in. Because, when you are drunk, you might end up doing stuff that might lead to you having unprotected sex, or probably getting someone pregnant - so they advise us to minimise the intake."

FGD, Male respondent, Corner user, 16 years old, Junior High School, student

They also address gender-based violence and mediate family disputes.

“A typical example is the males asking us to come to their rooms and visit them or them sending us to get them some items and bring them to their rooms. They force us to have sex with us. We are taught how to even talk nicely to them when they are still insisting to have sex with us and how to stop them doing this.”

FGD, Female respondent, Corner user, 16 years old, junior high school, student

It is not clear whether any of the providers' training included sexuality education or how to counsel young people around same sex relationships, which are illegal and taboo in Ghana. One informant in Fiapre explained how he had visited the Corner to learn 'how to take care' of himself, and during his consultation received stigmatising and inaccurate information about homosexuality and HIV.

SERVICE DELIVERY

There is significant variation of services offered at each of the Corners. The two higher volume corners (Acherensua and Fiapre) had a greater number of services available, and if services were not available at the Corner (such as emergency contraception and abortion in Fiapre), they were available by referral. Bomaa, the worst performing Corner, had large numbers of services which were unavailable (especially relating to STI/HIV counselling and testing) and had poor privacy and confidentiality. See Annex 3 for the services offered at each Corner.

This section provides information from interviews with providers on specific services offered at the two high volume and two low volume Corners.

Family planning

Most providers gave comprehensive information about each method and allowed the client to make an informed choice.

“I am a family planning counsellor and I don't talk about one method or leave another out. When am counselling I talk about all the family planning methods and the clients will choose what they want based on what I have told them.”

Provider at Corner 2

Some providers, however, believed that not all family planning methods are suitable for adolescents. They seemed to influence clients' choice of method in certain situations.

“I don't think all the methods are suitable for all you people. Let's take the depo for instance. We went for a workshop and we were told that when you want to get pregnant after taking depo it takes a long time but when they come in for Norigynon (monthly injectable), as soon as they stop they can become pregnant. So when I have an adolescent who has come in for depo I do ask her the reason why she likes depo but the best method I will recommend is the Norigynon because when you stop you become pregnant more easily than with depo and implants such as Jadelle.”

Provider at Corner 5

One provider (in a low volume Corner) implied mistakenly that a potential family planning user would need a blood test to see which method was most suitable for her.

“I think the lab technician should be around and my community nurse should be taught about what blood group fits a particular family planning method. So when you come and I ask about the client’s blood group and the person is not aware then I will test and give the person the method that is good for them.”

Provider at Corner 3

Some providers lacked basic equipment for inserting LARCs. This effectively denies young women the full choice of methods at the Corner. LARCs are at the forefront of Ghana’s drive for family planning and are suitable for those who need long term protection to pursue education or employment opportunities, yet the required instruments were not available for the procedures to be performed.

“We don’t have the instruments for removal and insertion such as forceps, drums, scissors, tray like those things we use for family planning. We are supposed to do the dilation of the uterus but because we do not have delivery beds and the things we need to use for that so we can’t do it here. We do refer so when we get all these things we can do on our own.”

Provider at Corner 10

In one Corner, to circumvent the problem, the provider borrowed equipment from the main health centre.

“There is a bigger family planning centre at the municipal health directorate so that is where I pick some of their equipment up from and after that I sterilize and give it back to them. So when I get two or three clients then I go for the equipment and return it after use. I don’t have my own.”

Provider at Corner 2

Few providers mentioned discussing the management of side-effects, which is one of the main reasons for FP non-use or discontinuation.

HIV and STI counselling and testing

Some providers carried out HIV and STI pre- and post-test counselling at the Corner.

“For all the STIs except Gonorrhoea, we just do the counselling. It’s only Gonorrhoea that we can’t do here. But syphilis and HIV, we do it here... We do the counselling and test.”

Interviewer: *“But have you been personally trained to do that?”*

“Yes. I went for a workshop in Sunyani.”

Interviewer: *“How are cases of those who test positive for HIV or STIs managed?”*

“After testing, we counsel them. That’s the post counselling. If it’s positive, we refer them ...At times they fear to come and do the test... maybe someone who been just flirting around without using condom would definitely fear to come and do the test. So, maybe after counselling and educating that person, the person would just realise that after all even if I have HIV I am like any other person who is having diabetes or hypertension.”

Provider at Corner 4

Some providers had not been trained in STI and HIV counselling and testing and, therefore, had to refer clients to the main health centre or neighbouring maternity unit.

“All the diseases you have mentioned, we do the counselling but for HIV and STIs, we refer the person to the maternity unit because we don’t do it here. We don’t have the equipment to do it at the corner here.”

Provider at Corner 6

Ante- and postnatal care

Some Corners provide ante-natal and post- natal care, but many refer to the nearby maternity facility. Young women prefer not to receive ante-natal care alongside other older women as they may be afraid of meeting their own mothers or mothers’ friends. For this reason, if the Corner was able to provide the necessary services, young women preferred it.

“Because they feel like if they go to the facility they will meet their mother’s age group and because they have heard that this place is for adolescents sometimes they prefer coming here because, when they come here, they meet their age group. You don’t meet people older than you at this place. They are all your age group.”

Provider at Corner 1

At some Corners, the maternal care facility collaborated with the Corner providers to have an ‘adolescent day’ for young mothers.

“Every Thursday is adolescent antenatal care. We did it because that is the place where we do the antenatal care because this facility is not yet ready. So the doctors and the adolescent corner people (staff) decided to do the adolescent antenatal at the hospital, so it’s every Thursday of the week.”

Provider at Corner 5

Some Corners do not provide antenatal care because they lack the equipment to do so. Such Corners relied on nearby facilities for support or referred clients

“Actually the place is not well equipped and it’s not helping. The midwife doesn’t stay here. She will come here when needed so if there is anything we have to talk about or she has to do I will call her then she will do everything that she is supposed to do. If we want to refer we do refer. I think if we had all the equipment and the necessary things we need here it will help us.”

Provider at Corner 10

Referrals

The Corners refer both in and out. They often refer clients to the main health centre or hospital for HIV testing, or may send pregnant women to the main maternity facility for antenatal care. They also receive referrals from health facilities.

The Corners receive referrals from adolescent groups in schools and from peer educators. Corners, such as Bomaa, which did not engage with peer educators, had few referrals and low numbers of clients overall. A specific problem is that providers have no way of knowing

who has been referred unless the client tells them. They are also not able to provide feedback³ to those who refer, such as teachers.

“When teachers refer children that is fine. We can call the teachers and find out. Some of the teachers complain that when the student comes, they do not bring any feedbacks. We tell them to give feedback to their teachers but they don’t do so. We do not also get the feedback. The relationship is there but the feedback is weak and needs strengthening.”

Provider at Corner 3

A formal referral system should be established. For example, young people could come with a referral form. The referral and its source would then be noted in the register and appropriate feedback given.

Outreach and peer education

Outreach and peer education for the Corners is carried out by the Ghana Youth Authority in conjunction with local NGOs and youth associations. This works with varying degrees of success for specific Corners and can, to a degree, explain differences in attendance. In general, respondents had not encountered many outreach educators. They thought that outreach could be increased in schools, particularly those which had adolescent reproductive health clubs. In particular, there was a perceived need for distribution of condoms in schools.

“What I think is, when you are going to provide condoms to the people in this community, they should be distributed in a way that whether you have sex or you don’t have sex, the condom should be given to you. So the educators should go to the schools around here; from JHS, SHS, to the tertiary level and make sure that you give a condom to everybody or any adolescent who is capable of having sex.”

FGD, Male respondent, Corner user, 20 years old, higher education, student

Linkages between the Corner and local schools also worked in other ways. In some cases, the teachers brought their pupils to the Corner.

“It was our teacher who brought us here one day and today is my second time.”

FGD, Female respondent, Corner user, 17 years old, junior high school, student

Respondents felt that good outreach would better communicate the role and purpose of the Corner and decrease stigma around its use.

“I think if you come into the community and talk about the activities and services of the corner it would help. So that those in the community can know that it is not only abortion that is done here but also they give counselling about STIs. So if they see someone coming there they won’t think that they came to do abortion but that maybe they are doing something else. So you if you come out to educate people about the motive of the corner it would help.”

FGD, Male respondent, Corner non-user, 17 years old, secondary schooling, student

³ Teachers often requested some kind of feedback and it seemed to increase their sense of involvement with the Corners. However, providers must provide this without breaching clients’ confidentiality.

There is also a need for more home visits, and outreach to public spaces particularly to attract married youth, who may not be in school.

“I think if they go to every place, it will be good since it’s not everybody who is in school. Although it will help those of us in school, if they don’t go to other places how can other people who are not in school also benefit?”

Interviewer: Other places like?

“Other places like the markets and the churches.”

FGD, Female respondent, Corner user, 16 years old, junior high school, student

Importantly, young people interviewed said that outreach improves parents’ perceptions of the Corner and may make them more willing to let their children use it.

“I also suggest that when they are going to educate our parents in their homes, they should be accompanied by one of the elders so that the nurses will be respected. Some of our parents may not know what you are about to say. They don’t know you and will not even receive you well. They will be like ‘Oh I am busy, I do not have time to converse with you, we are going somewhere.’ But if the nurses are accompanied by an elder, just the sight of the elder will make them sit and listen to what the nurses have to say to them.”

FGD, Female respondent, Corner non-user, 19 years old, secondary schooling, student

Clients expressed an interest in being informal peer educators and, indeed, harnessing the enthusiasm of satisfied clients may encourage others to come to the Corners.

“We should try to make one or two of them our friends. Let’s do some self-arrangement with them by advising them to stop this and that. Then one day you tell them to escort you to a place, then lo and behold you bring them to the corner. If you bring her to the corner and you advise her, maybe she might listen to you.”

FGD, Female respondent, Corner user, 15 years old, junior high school, student

Some study participants stated that peer education could benefit from using modern technology and social media to spread information, including Facebook, WhatsApp, and Instagram.

“Since we are in the 21st century, all they know about using technology but they don’t use it wisely - they know how to go on social media but they will not use it to benefit them. So if there’s something like the youth corner, if they use the technology they have, they will come here to listen to some things about their health.”

Exit interview, female respondent, 16 years old, secondary schooling, student

LEISURE ACTIVITIES

The Corners have a number of games for young people to play while they are waiting to be seen. Some young people come to the Corner specifically to play games, which appeal to both boys and girls. The games serve a wider purpose rather than simple entertainment. They relax the clients and enable them to interact with providers in a less formal manner.

“When we come here we talk to the nurses and play games and they see us as human beings and that make us happy when we come here.”

Male respondent, Corner user, 16 years old, secondary schooling, student

“Apart from the games, it is a place where we meet a lot of friends and chat with them. This helps ease us some of the problems we have and we become relieved before we get home.”

FGD, Female respondent, Corner user, 16 years old, junior high school, student

“It is exciting to meet friends at the corner and engage them in discussion, especially after school and after all household chores have been done. So, you can tell your friend that ‘at this place, you can play games, you can play dummy, so let’s go and play. We can also get advice from there.”

FGD, Male respondent, Corner user, 17 years old, junior high school, student

There is a TV set which shows reproductive health informational videos, although clients reported that they also watched regular movies from time to time. Episodes of the GHARH-funded soap opera YOLO, which has a reproductive health theme, were also shown in the Corners.

“At times when you come they show some movies like the YOLO and I like that one very much.”

FGD, Female respondent, Corner user, 20 years old, secondary schooling, unemployed

Some suggested that after an episode of YOLO had aired, additional information could be given about relevant adolescent reproductive health topics

“Looking at something like YOLO you could see that after an episode, they could take like five minutes to tell people, just to create awareness about these things and stuff. And you know that youth nowadays like watching those things becomes it’s us, the youth, who are the actors.”

FGD, Male respondent, Corner user, 23 years old, higher education, student

Some participants mentioned informally that they had come to the Corner because they had heard it mentioned on YOLO. This presents a unique branding opportunity. It may be useful to add the soap opera’s logo to the Corner signs with a sentence such as ‘As seen in YOLO’.

Some interviewees recommended that the Corners arrange more active games and sports such as football. This would fit with the healthy lifestyle approach the providers are trying to promote.

“Adolescence is a period of life that people are very energetic so I believe as part of the adolescent corner, something like a football academy should be established as young people join the corner. It will sell the corner to the extent that more people will patronise the place, and at the same time receive information.”

FGD, Male respondent, Corner user, 22 years old, secondary schooling, unemployed

EDUCATIONAL MATERIALS

Information and educational materials were usually available for the young people. In general, they were well appreciated. However, many respondents requested books and leaflets that they could take away and share with others at home.

“So, when they give you the leaflets, and you read them, then you acquire information that you can share with friends. You keep sharing and then it keeps on spreading so that the educational side of the whole issue would be addressed well. So it's not like you come to the Corner, they solve your problem and leave you to go like that. At least, they give you something to go away with so that you could read it to a friend and then, if possible, he or she would come for more advice.”

FGD, Male respondent, Corner user, 23 years old, higher education, student

Some respondents wanted material to take home as proof they had been to the corner for their suspicious parents.

“We would be glad to get some home because it's good sometimes even for evidence that you came to the youth corner since sometimes your parents will doubt when you told them you were coming to the Corner so, if you get some of the books, when you go home, you can show your mum that you went to the corner and say ‘this is what they gave me.’”

FGD, Female respondent, Corner user, 16 years old, junior high school, student

A number of young people thought that the reading materials were too complex for those with little or no education. They wanted more pictures and illustrations.

“For those of us who can't read, they can include pictures that when you see it, you will know that this is what it means.”

Exit interview, Female respondent, 16 years old, secondary schooling, student

“I think if we make the pictures eye-catching, even if they can't read, they will ask the nurse to explain to them. Also they should design some of the educational materials in such a way that we can take it home if the nurse is not able to explain the pictures to us. If we take the material to our homes, a friend who can read and understand can assist us by explaining the issues to us.”

Female respondent, Corner user, 18 years old, secondary schooling, student

TYPICAL CLIENTS AND UNDERSERVED GROUPS

Respondents believed that typical clients of the Corners were unmarried and educated. Boys and girls were said to come in equal numbers, but more boys came for the games, whilst girls came for services. Young people were also asked which groups were underserved and did not frequent the Corners. They perceived that married women and women who had given birth did not come as much as unmarried individuals. Both users and non-users said that this was because they perceived the Corner to be for ‘bad boys’ and ‘people who don't listen to their parents’. Respondents added that pregnant high school students may feel shy about coming as they are ashamed of having had sex before marriage.

“And then the next problem, for someone who is pregnant, is that she would feel that coming to the corner would make them disgrace her the more. She would feel ashamed that (people would say) ‘why is it that you, a girl in JHS 2, is pregnant? Don't you know that it is a sin? Even in the Bible, it is a sin.’ And so, all those issues which they would bring up, would make her feel shy. But what I want to tell people is that that is all lies. They are not coming to judge you. Rather, they are coming to talk to you so that it would be beneficial to you.”

FGD, Male respondent, Corner user, 16 years old, Junior High School, student

Very poor, vulnerable groups such as the Kayayei (female market porters) also did not use the Corners. It was suggested that they might come if they could get free food.

Other underserved groups included people with physical disabilities and those who are hard of hearing. Participants noted that the needs of wheelchair users and blind or deaf clients are not addressed through the Corners. This was reflected in the nature of the buildings – some of them are not accessible to physically challenged persons. There is a lack of materials for the visually impaired and hard of hearing.

“For me I think disabled people are not encouraged to come here because of the kind of perceptions people have about this corner. The public think that this place is all about wearing of condoms and things related to sex and such like. They may be shy because they may think, people will say ‘do people like them also get partners to have sex with?’ and so to prevent that, they may not come. But if they had their special place they will attend. So it is through education that they would also patronise it.”

FGD, Male respondent, Corner user, 24 years old, secondary schooling, unemployed

“We leave most deaf people at home because even if I speak they would not hear. So, if we get someone who would interpret the sign language for them, it would be very useful.”

FGD, Male respondent, Corner user, 21 years old, secondary schooling, unemployed

To date, these groups have been given little attention in ASRH programmes.

COMMODITY SUPPLY AND STOCKOUT

Commodity supply is the responsibility of Ghana Health Service. Six of the Corners had suffered from stockouts, mainly of contraceptive methods. For example, Dormaa had a stockout of Norigynon (one month injectable). In Acherensua, there had been stockouts of condoms and the treatment for candida. Fiaso Corner had had recent stockouts of injectables, and in Norigynon and Atronie there were no female condoms or IUDs. In such cases, providers suggested another method, ordered the requested method from another facility, or sent the client elsewhere. Half the Corners had a shortage of equipment such as specula which impeded their work.

COST OF SERVICES AND COMMODITIES

The National Health Insurance system (NHIS) in Ghana works with a minimum package of services with standard charges. The Adolescent Health Corners are not considered standalone facilities; otherwise, they would need accreditation from NHIS in order to manage cases that go beyond counselling services. The corners are seen as an additional package of services provided at the accredited facilities to which they are attached.

Thus, services under the current arrangement are not free, although services and commodities received at the Corners are supposed to be free for young people (those under the age of 25). Currently, adults pay a token sum for family planning services. An adolescent who needs FP services is not exempt from payment since there is no clear policy on services for adolescents (Dr Osei Kuffour Afreh, Deputy Director Public Health, Brong Ahafo Region - personal communication, November 2016).

In addition, due to stockout, providers sometimes have to source family planning methods from other facilities, which means that clients are charged for the commodities. Numerous interviewees noted paying for their method or service – for example, 5 cedis for an injectable contraceptive, 15 cedis for an implant, and 8 cedis for a pregnancy test. Stockouts are not just inconvenient for the provider but can also discourage users (especially first time users) from coming back to the Corner.

“If the person comes and it’s not available, it means that sometimes you try and convince them to try another method but they may refuse to take it, so it sometimes sends them away. Some would agree to take the Pill or the three month injectable - others too won’t like to take any of them... Sometimes, you have to call your friends at other sub-districts to see if they have any. If they do, they will have to sell it for you to use.”

Provider at Corner 6

DATA COLLECTION AND REPORTING

In all Corners except two (Bomaa and Nsoatre), the registers were up to date. All Corners except one (Bomaa) have a system whereby young people could be called for follow-up consultations. Providers often noted clients’ mobile phone numbers in the register and, for example, called them when they needed another contraceptive injection

In general, providers were happy with the GHARH registers although, as this was in addition to their reporting for GHS, it made their job quite onerous. They receive little feedback from GHARH or GHS on their routinely collected data. Few Corners used data for decisionmaking. For example, the low numbers of clients at Bomaa and stockouts of various family planning methods could have been flagged by the field supervisors and steps taken to rectify the situation. In contrast, a couple of providers in one of the high volume Corners took it upon themselves to look at their data each month and assess their performance.

“Yes, based on the data, you will tell whether you are performing or you are not performing. So if you are not performing, you will improve upon your services.”

Provider in Corner 1

At least three providers remarked they never received feedback from GHARH⁴.

“We send data to Ghana Health Service and Palladium they have got their books here.”

Interviewer: *“Do you get feedback do they get from the data summaries?”*

“No, we don’t get feedback”

Provider at Corner 5

“They do not give me any feedback. Palladium has never given me any feedback.”

Interviewer: *“Are the data used by GHARH to fine-tune or better orientate services-at facility level?”*

“They just take their data and they are off. They won’t even buy bread for you. They will also be demanding for water whiles they have not bought any water for us.”

⁴ The GHARH project typically provides feedback to the district focal person, rather than directly to the provider.

Provider at Corner 3

PROVIDER TRAINING AND SUPERVISION

Training

The majority of providers interviewed had received training from GHS on adolescent reproductive health. They found this useful, had learned new approaches, and gained relevant technical skills as well as information about the physical changes and psychosocial aspects of adolescence.

“I learnt that we should be free with the adolescent and we should let them be free when they come to us. We should not be shouting at them and we should help them to make an informed choice. We should not dictate to them saying ‘do this’, ‘do that’—we should let them feel free so that always they can come to us. So some of them even have our numbers so that if they are in their house and having any problems during the weekends we can meet. They call us saying that they are having a problem and I tell them to meet me at the work place and I give them medicine especially when they are spotting.”

Provider at Corner 5

In some Corners, particularly those with a low volume of clients, not all personnel had been trained. Bomaa and Dormaa did not have main providers who had been trained in adolescent health issues.

“Oh you know most of our staff haven’t gotten that chance. We were three, the others have been on transfer - I had to train them so that when I’m not around there is someone there to take over.”

Provider at Corner 8

Interviewer: “So did you receive any training before you started working for the corner?”

“For me, no. My in-charge went for the training.”

Provider at Corner 9

Some providers had not been trained in how to insert implants and IUDs even though the methods were available.

“With the Jadelle we have that but personally, I have not been trained on that.”

Provider at Corner 8

Supervision

The majority of providers were satisfied with the quality and frequency of supervision, although more frequent supervision was requested by several providers.

“They always come here monthly for the reports and supervise us. And even last Friday, some two people, one lady and one man, they came here to supervise us and do some interviews. They were from Palladium group [the implementer of GHARH] in Accra.”

Interviewer: “What does the supervision consist of?”

"It was just interview and they took our register and just recorded some things from it."

Interviewer: *"So the supervision that you receive, how regularly is it done?"*

"I think this is the first time for the external supervisors to come here but those people from Sunyani come every month."

Provider at Corner 6

"Supervision every two weeks would be good so that they can know what is going on here."

Provider at Corner 9

Several providers welcomed a new WhatsApp supervisory tool that is currently being tested. Others referred complex cases to staff in the nearby hospital or to the District-level staff.

Interviewer: *"But if you, as a provider, has a complex case, who would (you or do) you immediately contact? Maybe you have a problem which is complex for you to handle and you need to contact someone."*

"We contact the coordinator at the district office. And right now, they just created a group WhatsApp too for us. But it's the coordinator at the district office."

Provider at Corner 6

PROVIDERS' JOB SATISFACTION

Providers were asked if the work they carried out gave them satisfaction. The majority said yes as they were helping adolescents to live better lives and, in particular, to free them from the consequences of unplanned pregnancy. However, several admitted that within GHS there was a high turnover of staff and the frequent reassignment of personnel to other areas.

"You know with this our district, that reshuffling issue is rampant here - they will just move you... They just write you a letter telling you that you are going here so our life is at stake we don't know what will happen to us. But for now I'm here."

Provider at Corner 8

Provider job satisfaction seemed to be highly correlated with the success of the Corner and providers' motivation to be proactive in their work. At one of the Corners, poor performance was perhaps a reflection of the provider's negative attitude combined with stockouts of key family planning products.

"I am not satisfied. If the child comes and you give the information without the family planning methods, are you successful? You have just talk about it. Is like somebody telling you that, I have headache and you tell him that take paracetamol and you don't give him paracetamol. So if I have all the methods then I can check out and say that am satisfied. Also in this hot sun you will want me to go for outreach without any motivation – this do not make the job successful."

Provider at Corner 3

Those providers who were self-motivated were able to provide solutions to challenges they encountered and attract young people to visit the Corner without any incentives.

COMMUNITY PERSPECTIVES ON THE CORNERS

Discussions with providers, young people, and teachers revealed considerable support for the Corners within their communities.

Parents

Although some parents thought that the Corners encouraged sexual activity among adolescents, providers and clients reported that in general, parents were in favour of the Corner. They perceived it to prevent pre-marital pregnancy and encourage good behaviour.

“They see us to be helping their children, because at times some of the mothers would complain ‘my child is a bad person, he doesn’t sleep early.’ But after we have talked with that child, that girl would stop going out in the evening, would understand the need to study hard and become a nurse or a doctor... So it helps the parents too. They appreciate it.”

Provider at Corner 4

Some female clients said that their mothers encouraged them to visit the Corner to get contraception.

“I started this family planning long ago (about four years ago). I had already given birth to one child before I started my apprenticeship training. My mother didn’t want me to give birth while I was doing my apprenticeship because it might distract my work. In view of that she encouraged me to come for family planning.”

Exit interview, Female respondent, 21 years old, Primary schooling, hairdresser

A number of mothers had accompanied their daughters to the Corner and supported them during consultations.

“Some girls are even being brought in by their parents... last Tuesday I had somebody who was brought in by her mum. She 16 years. She is in JHS 2 and the mother has seen that what she is doing and thinks that if she doesn’t take care the child will become pregnant.”

Provider at Corner 5

“What I have seen is that especially when they are pregnant, their mothers will hold their hands and bring them to me for antenatal or other things they need.”

Provider at Corner 8

Teachers

As community stakeholders, four teachers were interviewed about the Corners. They talked favourably of the Corners and noted their positive impact on the community.

“Yes, it has made a difference. I think teenage pregnancy was on the increase but because of the opening of the corner it has reduced. It has made the education given spread widely. It has made their conditions good and improved their dress their behaviour and their communication better.”

Teacher associated with Corner 3

Some of the teachers interviewed, especially in the high-volume Corner communities, had a lot of contact with providers and regularly sent or brought their pupils to visit the facility.

“Sometimes I talk to the providers on the phone and then sometimes they come to the school and also when am also passing by I visit. So that is why I get to know what they do here and I tell the children to also come. So anybody who confides in me with such issues I just tell the person to please pass here after school and I call the service provider to say that one of my students will be passing by.”

Teacher associated with Corner 1

The teachers are seen by young people as important gatekeepers who are able to influence their parents to see the benefits of the Corner.

“Teachers can play a crucial role in this because children listen to their teachers a lot and will tell their parents about what his/her teacher has said in school and through that a lot of people will gradually get to know about the Corner.”

FGD, Male respondent, Corner user, 24 years old, secondary schooling, unemployed

Providers also agreed that teachers could be good advocates for the Corners. Nevertheless, confidentiality between the provider and the young client needs to be kept even if the teacher shows an interest in the Corner. In the case cited below, this does not seem to have occurred.

“They also follow up cases or people who visit the corner. The other day I was here and they (nurses at the corner) came and told me that one of the pupils came to them with a problem so they were going to her house to see how she was doing or check on her.”

Teacher associated with Corner 1

Religious leaders

The Church is a central institution in much of Ghanaian society. Preachers and pastors were mentioned by many respondents, especially in high volume Corner communities, as potential key advocates, especially with community elders. Other community stakeholders thought that involving the Churches would be beneficial as they already organise a number of youth-related activities.

“I believe it is pastors or religious leaders (who could be good advocates) as we are all religious as adults. Children and leaders of the community among others attend church throughout the week but I believe that if an elder in the community hears his pastor making mention or talking about this youth corner, people will patronise and accept it more.”

FGD, Male respondent, Corner user, 24 years old, secondary schooling, unemployed

“I also think the pastors can be good advocates for the corner. It will help because some people are shy of their pastors and they believe their pastor a lot so if the pastors become advocates it is good. The pastors when they stand in front of their pulpit and talk about it, people believe in them so they will patronise the Corner.”

FGD, Male respondent, Corner user, 15 years old, junior high school, student

None of the respondents mentioned the involvement of Muslim leaders. Further research is needed to see if members of the Islamic community feel they could be involved.

Traditional leaders

Traditional chiefs and other community leaders were seen as potential advocates for the Corners by young people, providers, and teachers.

“The chief in the community is the one who can advocate for the corner easily. Because he is among the elders in the town, whatever he says we will listen more than to any other person. Let’s assume if I tell people to come to the corner they might not take me seriously. But he being an elder in the community and knows what is good for us. People will listen when he talks.”

FGD, Male respondent, Corner user, 23 years old, secondary schooling, mason

“Someone can be sent to the chief’s palace for the gong to be beaten to inform the community that this is what has come to the community and that when you go to the hospital, there is a corner over there where they provide advice on the prevention on teenage pregnancy.”

FGD, Male respondent, Corner user, 17 years old, junior high school, student

Some providers were already supported by traditional leaders as they carried out their work.

Interviewer: *“So in organizing the outreach programs to the schools, the homes, who are your main supporters? Who are the ones who help you a lot to make your activities successful in the community?”*

“The assemblymen, ‘nananom’ (chiefs) and the village committee.”

Provider at Corner 9

Informants said that Durbars would be good occasions to disseminate information about the Corners and to get the community on board. Durbars are gatherings during which traditional rulers sit in state and meet their people.

“Before the corner was opened a durbar was held to announce and after I went to home visit and even they have a public address system which I went there to speak to them inviting everybody to come.”

Provider at Corner 2

Durbars could also be used to give feedback to the community as to the role and efficacy of the Corners.

“At this point in time we should organise a community ‘Durbar’ and invite the parents and their kids who have used the services of the corner. The kids can tell the gathering what they have learnt from the corner and the changes that have come into their lives. This will make them (parents) to know or appreciate the work of the corner and its impact on the children’s lives.”

Teacher associated with Corner 1

DISCUSSION

The Adolescent Health Corners initiative has shown a promising start. The Corners appear to have had a positive effect on both SRH knowledge acquisition and on the uptake of services. The Corners provide an innovative approach to service provision, with both games and community outreach being used effectively to attract and retain young clients. The added leisure dimension encourages young people to frequently visit the Corners to socialise.

Figure 7 summarizes the differences between the high and low volume Corners, to help identify those aspects that may influence clients to visit, and return to, a Corner.

FIGURE 7: DIFFERENCES BETWEEN HIGH VOLUME AND LOW VOLUME CORNERS

HIGH VOLUME	LOW VOLUME
Condoms, Pills, injectables, implants all available	Condoms, Pills, injectables, implants not all available
IUDs available in Corner or by referral	IUDs not available
Antenatal and post-natal care available	Antenatal and post-natal care not available
HIV/STI Counselling offered	HIV/STI Counselling not offered
Good mental health counselling	Poor/no mental health counselling
Educational materials accessible to illiterate clients	Educational materials not accessible to illiterate clients
Good, non-judgmental provider attitude	Poor provider attitude (blames young people for their problems)
Good outreach in collaboration with local stakeholders/traditional institutions	Poor/no outreach
Good relations with peer educators	Poor/no relations with peer educators
Good engagement/feedback with schools and teachers	Little contact with schools
Acknowledgment of socio-cultural and economic context of adolescent sexual behaviour	Poor acknowledgment of socio-cultural and economic context of adolescent sexual behaviour
Younger providers < 32 year old	Older providers > 32 years old
Gender balance of providers	Providers of one gender only
Good provider job satisfaction	Poor provider job satisfaction
Good provider knowledge of reproductive physiology	Poor/inaccurate provider knowledge of reproductive physiology
Out-of-hours availability of provider	Provider unavailable out of clinic hours
Optimal privacy and confidentiality	Poor privacy and confidentiality
Good geographic access to Corner from road/community	Difficult access
Records up to date	Records not up to date
Records used to monitor and tailor services	Records not used for decision-making
Few stockouts / good prediction of stock	Frequent stockouts /poor production of stock
Good variety of games to attract both boys and girls	Poor variety of games

The more successful Corners had younger providers, who were also often available out-of-hours to furnish condoms or to manage problems, for example menstrual disruption. It is recommended that a gender balance of providers is available in each corner as girls often want to see a female provider and boys a male health worker.

It also appears that the providers at the high volume Corners were proactive and took initiative. For instance, in the high volume Corners, the providers ensured that products were always available. They established working relationships with neighbouring schools as well as with the community leaders.

Three out of the 10 Corners had principle providers who had not been specifically trained in adolescent reproductive health issues and approaches; this needs to be addressed. Provider knowledge was generally good, although a minority had incorrect beliefs about family planning methods. One provider conveyed stigmatising and incorrect information about homosexuality. Providers should receive non-discrimination training, and it must be made clear that the services are for everyone without discrimination based on age, sex, gender, marital status, or sexual orientation.

Some Corners experienced stockouts and equipment shortages, which need to be addressed. Although commodities are the responsibility of GHS, GHARH supervisors could monitor stock during their visits and encourage providers to better predict shortages. Additionally, a formal system should be set in place that can ensure referrals to a nearby facility, for example for implants or STI/HIV testing. Currently, referrals and relations with other facilities appear to be ad hoc.

Although the services are advertised as being free, in reality, because of complications with the national health insurance system, most clients end up paying a small fee, especially for family planning commodities. GHARH and GHS should clarify if it is possible to amend the insurance system so that young Corner clients can be covered.

It is clear that pregnant adolescents prefer services that are uniquely for them, and the Corner is the best way to deliver these. In Corners which are not able to offer maternity services for young women, it may be necessary to arrange an 'adolescent only' day at the main maternity unit or to furnish providers with the equipment and expertise to deliver such services at the Corner. This may mean having an ad hoc arrangement with a midwife.

The Corners acknowledge the sociocultural context of ASRH and share priorities with the community, such as reducing teenage pregnancies. Community involvement and accountability has been key to the Corners' success and sustainability. Many schools are actively engaged with the Corners. Young people receive services as a secondary schooling activity, which makes it less stigmatising. Parents also view the Corners favourably, with mothers often bringing their daughters in for services. As the Corners become better established, more partnerships can be built with religious and traditional leaders.

In general, young people had little say in the running of the Corners and had not been asked their opinions on the nature and quality of services. In over half of all 10 Corners, young people had no say as to how the services should be run. It may be useful to develop a youth steering committee to suggest activities, identify underserved groups, and help with sensitisation. The Corners did not seem to have a close relationship with the peer educators recruited by the Ghana Youth Authority and local associations. These relationships need to

be better consolidated and involve young people who use the Corners and can positively recommend them.

The GHARH Corner register which is used for monitoring purposes should be better harmonised with the GHS registers as the numerous forms are onerous for providers to fill in each month. In particular, the GHARH register needs to collect data on method mix and on clients' marital status to better monitor FP services (and their impact in terms of CYPs) as well as client profiles. It also needs to incorporate a mechanism to record referrals and provide feedback to the referrer if necessary⁵. To date, little feedback is given to providers with regard to the data they collect. For example, Bomaa Corner had seen no clients during the third quarter of 2016. This should have been noted by the programme supervisors and GHS, and steps taken to find out why.

In summary, the Corners have great potential to improve adolescent sexual and reproductive health in the Brong Ahafo Region. Close supervision and monitoring as well as improved provider training and enhanced community engagement can ensure that quality services are delivered across the board and that the Corners become a flagship initiative for the GHS.

RECOMMENDATIONS

As most of the Corners have not yet been operating for one full year, the recommendations below are intended to help GHS fine-tune service delivery and optimise outreach to expand the client base as the Corners become established. The recommendations should be viewed in the context of the existing “Standards and Tools for Monitoring Adolescent & Youth-friendly Health Services (AYFHS) in Ghana” which comprises excellent guidelines for youth-friendly service delivery.

DEMAND CREATION

Several actions can be taken to improve awareness of the Corners and generate greater demand for their services:

- Improve the signage within the Corner and in its vicinity, so that Corners are more visible within the community.
- Use media and technology to increase awareness. Capitalise on the popularity of the GHARH-funded YOLO soap opera by using it to brand the Corners ('as seen on YOLO') to attract more young clients. Use social media accounts and groups (for example, Facebook and Whatsapp) so clients can exchange information about the Corners.
- Sensitize mothers of teenage daughters so they encourage them to attend the Corner. The Corners should be advertised in areas frequented by women of all ages, including the main health centre and markets. Sensitization activities and outreach could emphasise that the services would benefit their teenage children.

⁵ Since data collection, a harmonized register has been developed and rolled out to all Youth Corners (see Annex 6).

- Encourage a synergised and coordinated community response involving schools, Churches and Mosques, parents, and traditional leaders. This could include inviting religious and community leaders to view the Corners and emphasising their benefits for the community as a whole, for example in reducing teenage pregnancy. Organise Durbars to sensitise local communities as to the Corners' location, function and services. Ensure the Corners are not seen in the community as being for 'bad boys' or naughty girls' by promoting positive messages that looking after one's reproductive health needs can help one be more productive and stay in school .
- Create stronger linkages between the Corners and the schools, including by working with schools' Adolescent Reproductive Health Clubs.
- Maintain leisure activities, as these are highly effective for reaching young clients, and consider adding additional offerings, such as football or art.

SERVICE PROVISION

Services can be improved by making adjustments to Corner operations and processes, building the capacity of service providers, and improving monitoring.

Operations and processes

- Establish a youth steering committee at each Corner made up of young clients who can suggest activities, identify underserved groups, help with sensitisation, and provide feedback to providers.
- Ensure critical services are available at each Corner, including making all contraceptive methods and STI/HIV counselling and testing available (even if by referral). In addition, provide comprehensive counselling about the likelihood and management of side-effects of contraceptive methods to increase uptake and prevent discontinuation.
- Establish a formal referral system for each Corner, with appropriate form and records, to ensure that clients can access needed services. Include referral information in routine monitoring.
- Provide informational material that young people can take home as well as suitable informational material for illiterate young people.
- Install condom vending machines so young people can access condoms at any time.
- Provide realistic information about the costs of services and commodities to adolescents. Discuss with GHS how the insurance scheme could cover adolescents, especially for family planning.
- Twin high volume Corners with low volume Corners and mentor them to improve service provision and demand creation.
- Whenever possible, ensure that providers are young (<32 years of age), and a gender balance of providers is available in all Corners.

Build capacity of providers

- Ensure all providers are trained on ASRH counselling and services. In particular, ensure providers are trained on and have the necessary equipment to insert LARCs, and train providers on the importance of guaranteeing unbiased choice for young women choosing a contraceptive method.
- Train all providers in youth-friendly approaches; non-discrimination; sensitivity to lesbian, bisexual, gay, transgender, and intersex people; and gender based violence.
- Encourage use of Whatsapp and other technologies for the management of complex cases and for in-service opportunities to renew or update ASRH knowledge.
- Ensure all providers can access the “Standards and Tools for Monitoring Adolescent & Youth-friendly Health Services (AYFHS) in Ghana” (GHS 2010) and that they are familiar with them.

Improve monitoring

- Regularly apply a checklist such as the one used for this study to each Corner, for example quarterly, so that any gaps in services or commodities can be identified and rectified. This may facilitate a more efficient ordering supplies and prediction of stockouts.
- Increase indicators for routine data collection. Record contraceptive method mix data in order to calculate CYPs and other indicators. The marital status of clients should be recorded in order to monitor service uptake by married women.
- Harmonise the GHS reporting tools with the GHARH tool⁶
- GHARH should enable GHS to monitor District level data to assess if Corner trends in service use are similar.
- GHARH should support GHS to ensure data is better used for feedback, performance monitoring and decision-making in order to motivate Providers.

⁶ See Annex 6 for the harmonized register.

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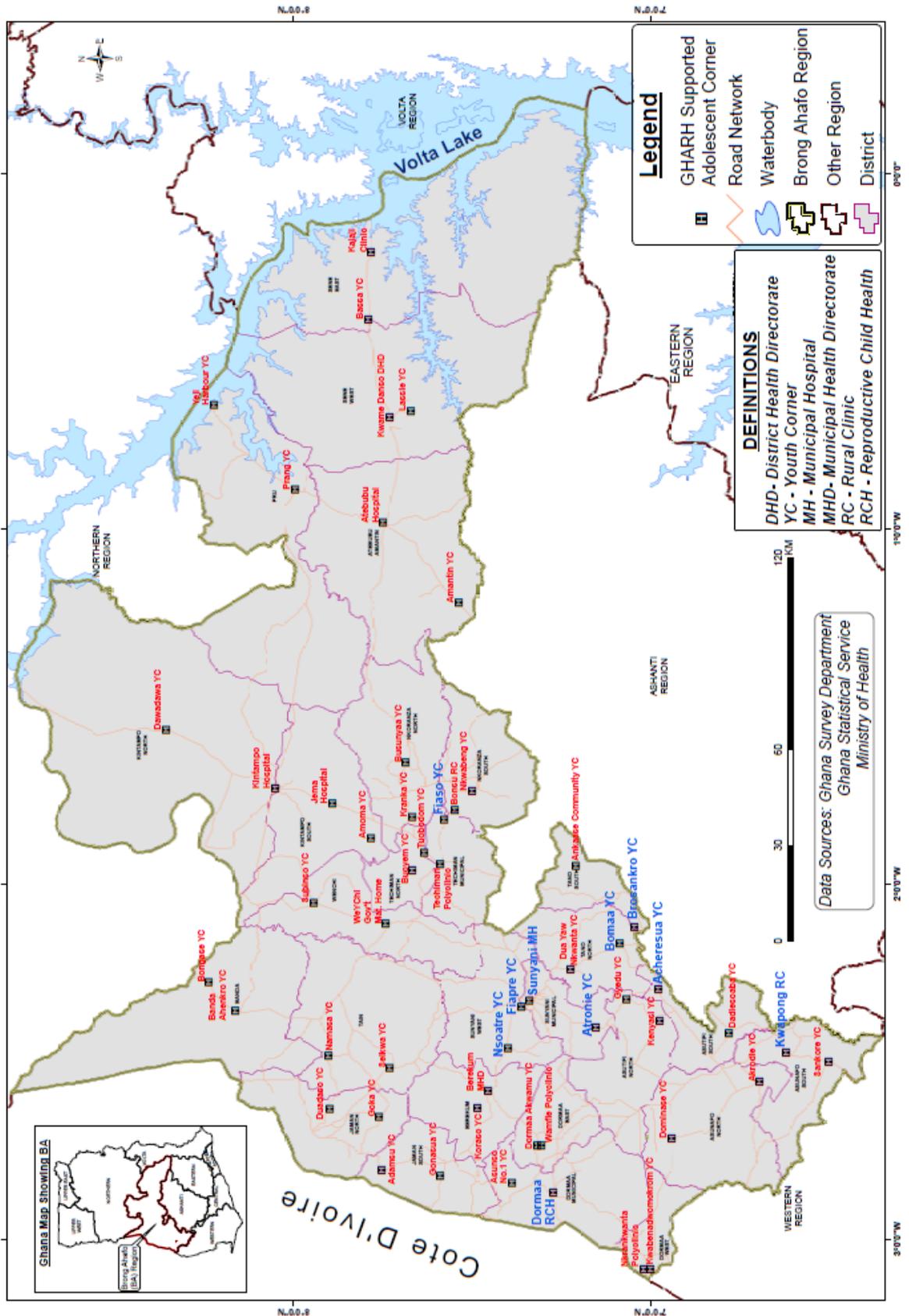
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ANNEX 1. ADOLESCENT HEALTH CORNERS IN THE BRONG AHAFO REGION

GHARH-Supported Adolescent Corners in the Brong Ahafo Region



ANNEX 2. LOCATION AND TYPE OF ADOLESCENT HEALTH CORNER

Adolescent Health Corner	Rural/ Urban	Date Opened	Status
Sunyani Municipal Hospital, Sunyani Municipal Health Directorate	Urban	16 th December 2015	Within the hospital premises, but a standalone structure
Fiapre Health Centre, Sunyani West District Health Directorate	Urban	7 th December 2015	Within the Health Centre premises and attached to other structures
Nsoatre Health Centre, Sunyani West District Health Directorate	Urban	7 th December 2015	Within the Health Centre premises
Dormaa Reproductive and Child Health (RCH) Unit, Dormaa Municipal Health Directorate	Urban	9 th February 2016	Attached to the RCH Unit
Acherensua Health Centre, Asutifi South District Health Directorate	Urban	9 th January 2016	Within the Health Centre premises, but a standalone structure
Atronie Health Centre, Sunyani* Municipal Health Directorate	Rural	16 th December 2015	Within the Health Centre premises, but a standalone structure
Brosankro Health Centre, Tano South District Health Directorate	Rural	8 th January 2016	Within the Health Centre premises and attached to other structures
Bomaa Polyclinic, Tano North District Health Directorate	Rural	8 th December 2015	Within the Polyclinic premises, but a standalone structure
Kwapong Rural Clinic, Asunafo South District Health Directorate	Rural	18 th December 2015	Attached to the clinic
Fiaso Health Centre, Techiman Municipal Health Directorate	Rural	18 th November 2015	Attached to other structures

*Atronie Corner did not start providing services until June 2016 due to staffing issues

ANNEX 3. SUMMARY OF CHECKLIST FINDINGS

Service/item provided

Service/item not provided

Available by referral

Services Provided	High volume Corners		Low volume Corners		Other Corners					
	Acherensua	Fiapre	Kwapong	Bomaa	Bronsan-kro	Fiaso	Nsoatre	Dormaa	Sunyani	Atronie
Pregnancy testing										
Antenatal care										
Postnatal care										
Family planning										
Male Condoms										
Female Condom										
Pills										
Injectable										
Implants(Jadelle)										
IUDs										
Emergency contraception										
Abortion										

Services Provided	High volume Corners		Low volume Corners		Other Corners					
	Acherensua	Fiapre	Kwapong	Bomaa	Bronsan-kro	Fiaso	Nsoatre	Dormaa	Sunyani	Atronie
Post-abortion care	Green	Green	Red	Red	Green	Red	Green	Green	Green	Red
HIV counselling and screening	Green	Green	Red	Red	Green	Green	Green	Green	Yellow	Green
STI counselling and screening	Green	Green	Red	Red	Green	Green	Green	Green	Green	Green
Psycho-social support for GBV	Red	Green	Red	Red	Green	Green	Green	Green	Green	Green
Information and education	Green	Green	Red	Red	Green	Green	Green	Green	Green	Green
Service quality										
Are there erected sign posts at the gate of the facility indicating availability of adolescent sexual and reproductive health services?	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Are the opening hours clearly displayed?	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Are there IEC/BCC materials available on adolescent and young people's SRH?	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Are there accessible IEC materials for those who are not literate? Eg videos, pictures	Green	Green	Green	Red	Green	Green	Green	Red	Green	Green
Have all health workers working in the Corner been sensitized on adolescent issues?	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Have the main provider(s) been trained in adolescent SRH issues?	Green	Green	Green	Red	Red	Green	Red	Green	Green	Green
Is there evidence of auditory privacy?	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green

Services Provided	High volume Corners		Low volume Corners		Other Corners					
	Acherensua	Fiapre	Kwapong	Bomaa	Bronsan-kro	Fiaso	Nsoatre	Dormaa	Sunyani	Atronie
Is there evidence of visual privacy?	Red	Green	Green	Red	Green	Green	Green	Green	Green	Green
Are consultations and records kept confidential?	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green
Is there a system of client follow-up, reminder or recall (e.g., for injectable)?	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green
Is there youth involvement in the service design?	Green	Red	Green	Red	Green	Green	Green	Red	Red	Red
Do young people have a say in how the services are run?	Red	Red	Green	Red	Green	Green	Green	Red	Red	Red
Is there a complaints procedure?	Red	Red	Red	Red	Red	Green	Red	Red	Red	Red
Are all relevant community groups sensitized on adolescent issues?	Green	Red	Red	Red	Green	Green	Green	Green	Green	Red
Are there stock outs of commodities since the Corner opened?	Green	Red	Green	Red	Green	Red	Red	Red	Red	Green
Are there shortage of essential equipment since the Corner opened?	Green	Green	Red	Green	Green	Red	Green	Red	Red	Red
Is there an interaction with local schools or youth groups?	Green	Green	Green	Green	Green	Green	Green	Green	Green	Red
Is there an updated health profile of the catchment area from GHS showing the numbers of adolescents/young people?	Red	Red	Green	Red	Red	Green	Red	Red	Red	Red
Are the records up to date?	Green	Green	Green	Red	Green	Green	Red	Green	Green	Green
Are the policy documents available? (RH services policy and standards)?	Red	Green	Red	Red	Green	Green	Red	Red	Red	Red
Are financial documents available for this Corner?	Red	Red	Red	Red	Green	Green	Red	Red	Red	Red

Services Provided	High volume Corners		Low volume Corners		Other Corners					
	Acherensua	Fiapre	Kwapong	Bomaa	Bronsan-kro	Fiaso	Nsoatre	Dormaa	Sunyani	Atronie
Does the Corner charge fees for ASRH services?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Has the Corner done outreach work since January 2016?										
Does the Corner use volunteers?										

ANNEX 4. LITERATURE REVIEW

Global evidence

In a global review of what does not work in adolescent sexual and reproductive health, Chandra-Mouli, Lane and Wong (2015) note that the dosage, intensity, and duration of approaches to improve ASRH is important but, as yet, poorly understood. The authors emphasise the need to improve knowledge in the field and accelerate the expansion of proven approaches. Scaling up ASRH services has considerable implications for supplies and commodities. Hainsworth et al (2014) noted that sustainable scale-up requires advocacy complemented by intensive capacity building at all levels of the health system, district work plans and budgets, and collection of age-disaggregated data to estimate numbers of potential clients.

To date, there is little disaggregated data on the behaviour and attitudes of young people with regard to SRH, especially unmarried youth or those under the age of 15. WHO recommends that health information systems gather, analyse, and use age-disaggregated data on adolescents' need for, and use of services and commodities so that provision can be better planned and tailored to their needs (WHO 2014). The GHARH health information systems embedded in the Corners can thus contribute important information to district, regional, and national planning.

Research around youth-friendly services highlights the need for tailored services responding to different market segments (such as married and unmarried young women and men). Although many programmes focus upon young, unmarried adolescents, young married women may benefit from services to postpone their first birth and space subsequent births. However, spousal or family disapproval may make it hard for young, married women to access contraception (Chandra-Mouli, McCarraher, Phillips et al 2014).

Once young people access services, societal disapproval, provider bias, or supply chain difficulties sometimes prevent them from receiving the FP method they require. Stock-outs may affect young people more severely than other groups as they may not have the time, money, or autonomy to access commodities elsewhere. Young people become quickly discouraged with services if they cannot get the methods or services they need (FP2020 2013-4).

Global evidence suggests that young people's sexual encounters can be sporadic and unplanned, and may involve elements of risk taking. For this reason, young people often prefer short-term family planning methods (pills, injectables, condoms) and may be fearful of the side-effects associated with LARCs (Wood and Jewkes 2006). Adolescents have higher rates of discontinuation than older women, but the obstacles to consistent use are poorly understood and often context-specific (Ali, Cleland and Shah 2012). For example, providers may have negative views about young people's premarital sexual activity or erroneous perceptions that long-acting methods are unsuitable for nulliparous women (Hytell, Rasanathan, Tellie et al 2012, Sidze, Lardoux, Speizer et al 2014).

Multi-country, peer-reviewed research shows that, in general, stand-alone centres targeting youth are neither the most impactful nor cost-effective way of offering young people SRH services (Erulkar, Onoka and Phiri 2003). In many cases, youth are stigmatized when visiting stand-alone centres, because their motivation to attend them is made public by the

nature of the centre. Stand-alone centres appear to be more successful when they integrate life-skills approaches and offer broader counselling opportunities, as well as community outreach, as the Adolescent Health Corners do.

Evidence from Ghana

This study builds upon work already documented by GHARH which highlights the importance of understanding socio-cultural factors which contextualize SRH service provision for youth. Using the 'Reality Check' approach in the Brong Ahafo region, GHARH found that sexual activity among youth is high and starts in early teens (Palladium 2015). In a review of GDHS data for young people aged 15-24 in the Brong Ahafo Region, Darteh and Nnorom (2012) observed that of those who had ever had sex, 67% had experienced planned sexual encounters. In the year prior to the survey, 58% of males had more than one sexual partner, compared to 15% of females. Although 68% reported that they had ever used condoms, only 27% of males and 23% of females were confident that they could insist on condom use.

Aninanya, Debpuur et al (2015) note that since the International Conference on Population and Development (ICPD), the Government of Ghana has supported adolescents through the Adolescent Reproductive Health Policy (2000)⁷, the National Youth Policy (2010) and National HIV/AIDS and STIs Policy (2013) initiatives, while Ghanaian health services promote youth-friendly initiatives (Ghana Health Service 2009). However, evidence suggests that many Ghanaian adolescents do not use SRH services, particularly due to stigma around premarital sex. Awusabo-Asare and Annim (2008) found that two out of three young women and four out of five young men with STI symptoms did not seek treatment. Approximately half of unmarried sexually-active female adolescents and over one-third of sexually-active male adolescents did not use contraception.

A recent survey of 260 adolescent respondents by Abdul-Razak (2016) in Sunyani municipality found that non-use of family planning was associated with poor attitude among contraceptive service providers (48.5%), lack of knowledge of contraceptive methods (47.3%), fear of side effects of contraceptive use (45.8%), high cost of modern contraceptives (39.6%), and religious prohibitions and beliefs (36.5%). Other reasons included long distance to contraceptive services (28.8%), lack of or poor counselling (25.0%), partner or family members opposed to use of modern contraceptives (20.4%), infrequent sex (17.3%), cultural or traditional beliefs (12.7%), and difficulties associated with getting preferred contraceptive methods (11.9%).

Research in Ghana's Upper East Region showed 32% of out-of-school adolescents experienced difficulties accessing HIV testing services (Saaka 2005). Additional qualitative research found that adolescents were particularly deterred from accessing health services by costs and negative provider attitudes (Baba-Djire, Agyarko-Poku, Opoku et al 2013).

Underserved groups include people with disabilities as well as the poorest, most marginalised young people who tend to be highly mobile and thus difficult to reach. In Ghana this may include the Kayayei—female market porters who are often uneducated, highly mobile, and shelterless, which makes them particularly susceptible to gender-based violence (Awumbila and Ardayfio-Schandorf 2008). Adolescents living with HIV are also especially

⁷ The 2000 ARH Policy is under review together with the National Population Policy.

vulnerable because they experience stigma and discrimination both in health facilities and in the community (Dako-Gyeke, Dako-Gyeke and Asampong 2015).

GHARH research indicates that youth are very open to talking about sexual issues and there is no basis to suggest that such discussions increase sexual activity. In addition, clear information which is neither advisory nor moralising needs to be provided about the risks of early sexual activity, the need for safer sex and contraception, and informed choice for induced abortion (Palladium 2015).

ANNEX 5. GHANA HEALTH SERVICE REGISTERS

Marital Status	Sex (M/F)	Address (Location / Community / Hse No.)	Method of Choice	1st ever use of method (Y/N)	Age (circle if < 20 or > 35 yrs)
Y	F	M.C.15 Acherensua	Jadde	N	24
Y	F	Acherensua zongD	implant	N	33
Y	F	Acherensua 0517242134	implant	N	31
Y	F	subr. 50 SB. 25 0246744927	implant	N	31
Y	F	Acherensua 054742485	Depo	Y	24
M	F	Konkontso 0247139867	Depo	Y	31
M	F	Acherensua	Depo	Y	28
H	F	Acherensua	implant	Y	28
M	F	Acherensua Konkontso Boyston Kwanta	Depo	Y	27
S	F	Acherensua Camp 50 0556418975	Depo	Y	23
M	F	Acherensua 0247766573	Depo	Y	32
M	F	Acherensua 0516438805	Depo	Y	25
M	T	Acherensua 0178 0248011684	Depo	Y	35
M	F	Acherensua	Depo	Y	26
S	F	Acherensua	Depo	Yes	25
S	F				

Ghana Health Service register noting method type as well as age and marital status of client.

3/1/21	Aelia FRANCISCA	24	F	Achenesua	To know Family
1/2	Gifty Serpung	13	F	Achenesua	Family of who was 1 week wins
21	Ruth Adjei	22	F	Achenesua	pregn
21					
21					
21					
21					
4/	Brago Comfort	19	F	Achenesua	Gener
4/	Stella Nuruna Mohamed	24	F	Achenesua	F.P
4/					
4/					

Corner register (1)

To know more about Family planning	What is family planning. The importance who can start when to start types, how it works prevention of STI/HIV
Family planning client who was bleeding for 1 week 2 days and thinks it nothing.	We told her not to do so again. She menstruated for only three days not week so we prescribed Mifep 800x3 daily
Pregnant mother	The importance of ANC, exercise, rest and sleep, eating of fruit and vegetables, all danger signs in pregnancy such as Headaches, Anaemia, bleeding, abdominal pains, swelling, excessive vomiting etc report to her clinic as soon as possible.
General body pain	Come for treatment, rest and sleep, exercise prevention of STI, HIV.
F.P	Service provided. prevention of STI/HIV

Corner register (2) detailing consultation information as well as age and sex of client. This data is not used by GHARH.

ANNEX 6. HARMONIZED ADOLESCENT HEALTH CORNER REGISTER

Reg. No.	Time	Date	Client Information	BASIC CLINICAL STATUS	COUNSELLING SERVICES	SCREENING/TESTING SERVICES	FAMILY PLANNING SERVICE	ABORTION SERVICES	PREGNANCY CARE SERVICES	Other AHT Services	
Reg. No.	Time	Date	Name:		Age:	Sex	Psychosocial Support (Indicate Specific code)	Pregnancy Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/> HIV Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/> Breast Examination Yes <input type="checkbox"/> No <input type="checkbox"/> Testicular examination Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis B Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/>	Last Menstrual period Uterine size Indications Incomplete abortion Survivor of Rape/Incest Indications Mental Health Risk Physical Health Risk Type Elective Spontaneous Induced Method Electric/MVA Dilatation & Curettage Medication	Gravity Parity Denatation Age Hb at Regist. BP HT(m) Wt(kg) Wt(lng) Sicking status (+/-) Post. Referral On the basis of: Neg. Sicking Type PMTCT Test Results (+/-) Post. ARV Neg.	Other AHT Services Specify IAC Material Given Yes No Emergency Contraception Yes No
			Marital Status Not Married <input type="checkbox"/> Married <input type="checkbox"/> No. of Chn <input type="checkbox"/>		Phone Number:	Level of Education Primary <input type="checkbox"/> JHS <input type="checkbox"/> SJS <input type="checkbox"/> Tertiary <input type="checkbox"/> Others <input type="checkbox"/>	Family planning <input type="checkbox"/> STI/HIV <input type="checkbox"/> Parenthood <input type="checkbox"/> Pregnancy Related Abortion <input type="checkbox"/>	All Ever User Continuing User Parity Method of Choice Male Condom Female Condom Depo Provera Norplant Microbail Microgynon Iudelle Implanon Net IUD/Copper T	In-School <input type="checkbox"/> Out-of-School <input type="checkbox"/> Religion Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Traditional <input type="checkbox"/> Others <input type="checkbox"/>	HT (m) WT (kg) BMI No	Indicate Specific code Family planning <input type="checkbox"/> STI/HIV <input type="checkbox"/> Parenthood <input type="checkbox"/> Pregnancy Related Abortion <input type="checkbox"/>
Reg. No.	Time	Date	Name:		Age:	Sex	Psychosocial Support (Indicate Specific code)	Pregnancy Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/> HIV Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/> Breast Examination Yes <input type="checkbox"/> No <input type="checkbox"/> Testicular examination Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis B Testing Post. <input type="checkbox"/> Neg. <input type="checkbox"/>	Last Menstrual period Uterine size Indications Incomplete abortion Survivor of Rape/Incest Indications Mental Health Risk Physical Health Risk Type Elective Spontaneous Induced Method Electric/MVA Dilatation & Curettage Medication	Gravity Parity Denatation Age Hb at Regist. BP HT(m) Wt(kg) Wt(lng) Sicking status (+/-) Post. Referral On the basis of: Neg. Sicking Type PMTCT Test Results (+/-) Post. ARV Neg.	Other AHT Services Specify IAC Material Given Yes No Emergency Contraception Yes No
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CODE FOR PSYCHOLOGICAL SUPPORT
 1. Drug & Substance Abuse 2. Gender & Sexual Based Violence 3. Interpersonal Violence 4. Basic Coping Mechanism 5. Negotiation Skills 6. Education 7. Employment