ORIGINAL RESEARCH

Attitudes of Gatekeepers Towards Adolescent Sexual and Reproductive Health in Ghana

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Abstract

Adults constitute gatekeepers on adolescent sexual and reproductive health (ASRH). This qualitative paper discusses the views of adults on ASRH problems and challenges based on 60 in-depth interviews conducted among adults in Ghana in 2005. Adults were purposively selected based on their roles as parents, teachers, health care providers and community leaders. The major ASRH problems mentioned were teenage pregnancy and HIV/AIDS. The results indicated a number of challenges confronting ASRH promotion including resistance from parents, attitudes of adolescents, communication gap between adults and adolescents and attitudes of health care providers. Among health workers three broad categories were identified: those who were helpful, judgmental and dictators. Some adults supported services for young people while others did not. Some served as mediators and assisted to 'solve' ASRH problems, which occurred in their communities. It is argued that exploring the views of adults about their fears and concerns will contribute to the development of strategies and programmes which will help to improve ASRH. *(Afr J Reprod Health 2014; 18[3]: 142-153)*

Keywords: Adolescents, Adults, Gatekeepers, Ghana, Adolescent Sexual and Reproductive Health

Résumé

Les adultes constituent les gardiens sur la santé sexuelle et de la reproduction des adolescents (SSRA). Ce document qualitatif examine les points de vue des adultes sur les problèmes et les défis de la SSR en se basant sur 60 entrevues en profondeur menées auprès des adultes au Ghana en 2005. Les adultes ont été intentionnellement sélectionnés en fonction de leur rôle de parents, d'enseignants, de fournisseurs de soins de santé et de dirigeants communautaires. Les principaux problèmes de la SSR mentionnés étaient la grossesse chez les adolescentes et le VIH / SIDA. Les résultats ont indiqué un certain nombre de défis auxquels est confrontée la promotion SSRA y compris la résistance des parents, les attitudes des adolescents, le manque de communication entre les adultes et les adolescents et les attitudes des fournisseurs de soins de santé. Parmi le personnel de santé, trois grandes catégories ont été identifiées: ceux qui étaient utiles, de jugement et de dictateurs. Certains adultes ont appuyé les services pour les jeunes tandis que d'autres n'ont pas. Certains ont servi en tant que médiateurs et ont aidé à «résoudre» les problèmes de la SSR, qui ont eu lieu dans leurs communautés. L'on affirme que l'exploration des points de vue des adultes sur leurs craintes et préoccupations contribuera à l'élaboration de stratégies et de programmes qui contribueront à améliorer SSRA. *(Afr J Reprod Health 2014; 18[3]: 142-153)*

Mots-clés: adolescents, portiers adultes, Ghana, santé sexuelle et de la reproduction des adolescents

Introduction

The Government of Ghana developed an adolescent reproductive health policy in 2000 and a national HIV/AIDS and STI policy in 2004 to respond to the reproductive health needs of adolescents. In spite of the implementation of these and other programmes there are a number of challenges. There is evidence of early marriage among young people in the country. For example, among women ages 20-24 years, 5% and 25% were married by ages 15 and 18 respectively in 2013[1]. Also, childbearing among adolescents is not uncommon in the country. For instance, the GDHS report reveals that about 13% of adolescents' ages 15-19 years had ever had a child[2]. This is consistent with the findings of a nationally representative survey among adolescents in the country[3]. Even though the median age at first birth in Ghana increased from 20.1 years in 1993 to 20.7 years in 2008, at 62/1000 for women ages 15-19 years the level of adolescent fertility is high.

This situation could be attributed to the low prevalence of contraceptive use among adolescents. Eight per cent of married women ages 15-19 were using any modern method of contraception compared to 19% of married women in the 35-39 and 40-44 year groups. Fear of side effects remains the most cited method-related reason for non-use of contraception among currently married women ages 15-29 (34.1%)[2]. Studies on pregnancy among young women in Ghana have revealed that a number of them were mistimed[4,5]. These mistimed pregnancies could have implication for abortions among adolescents. Contraceptive use among these women was 8% in 2008[2.] The low level of contraceptive use coupled with the high adolescents' fertility rate has both social and demographic consequences for the adolescents and the country.

Studies investigating sexual intercourse among adolescents have reported mixed results. For instance, a study among young people aged 10-24 years found out that about 63% (54% males and 69% females) had ever had sex[6]. According to the GDHS report, by age 18, 44% and 26% females and males had ever had sex[2] Awusabo-Asare and colleagues in their 2006 study on the other hand observed that differences in age at first sex begin to emerge at around age 14 for both males and females with more females than males having had first sex between ages 17-19 years[3]. Furthermore, a study conducted in Ga Mashie in urban Accra among girls, using qualitative methods, observed that by age 15, girls had initiated sexual intercourse[7]. This early age at first sex among adolescents could expose them to the risks of unplanned pregnancies and sexually transmitted infections including HIV with their attendant effects on reproductive health outcomes. Among the sexually active, those in the younger age groups are more likely to report having had an STI or an STI symptom than older groups. For instance in 2008, 4.9% of women and 2.0% of men in the 15–19 year group reported having an STI or an STI symptom[2]. Adolescents reported low exposure to family planning messages. For instance, no-exposure to all three media sources (radio, television, newspaper/magazine) among adolescents 15-19 was 39% for men and 44% for women[2].

Adults, as parents/guardians, service providers and community leaders are responsible for meeting the needs and aspirations of young people. As people involved in the planning and implementation of services, adults play important roles in the lives of young people such as providing the environment within which they grow up, serve as custodians of tradition, norms and mores of the society, influence the opinions of young people, and generally shape the discourse on all issues, including sexual and reproductive health[8,9,10]. To a large extent, adults as professionals and service providers conceptualize what constitute sexual and reproductive health problems for young people, and they also design and implement programmes to address them, thus, creating a complex relationship between adults, as authority figures as well as providers, and young people as recipients in a wide range of settings[8].

This complex relationship between adults and young people may manifest itself in various forms: as gatekeepers, umpires and commentators. As gatekeepers, adults may filter the information and services that young people might receive[11]. The nature of the relationships between young people and adults can either enhance or create barriers for adult-adolescent interaction, including the provision of services to young people. For instance, dimensions of parenting, as represented by monitoring and supervision, have been found to influence adolescent sexual risk-taking behaviour in various forms[12,13].

The role of adults as gatekeepers who filter information and/or services could be vital for the planning and dissemination of ASRH information. The aim of this qualitative paper is to explore the views of adults on adolescent sexual and reproductive health. The intention is to understand their views, fears and concerns, and through that identify areas for action on ASRH information and services in Ghana.

Theoretical issues

This paper adapts Lewin's gatekeeping model which was first used to describe a wife or mother as the person who decides which foods end up on the family's dinner table[14]. Although the model was applied originally to the food chain, the gating

process can include a news item winding through communication channels in a group. The gatekeeper decides which information will go forward, and which will not. In other words a gatekeeper in a social system decides which of a certain commodity (materials, goods, and information) may enter the system. Gatekeepers are able to control the public's knowledge of the actual events by letting some stories pass through the system but keeping others out.

Gatekeepers can also be seen as institutions or organizations. Gatekeepers exist in many jobs, and their choices hold the potential to colour mental pictures that are subsequently created in people's understanding of what is happening in the world around them. The gatekeeper's choices are a complex web of influences, preferences, motives and common values. Therefore it is essential to understand the psychological factors (cognitive structure, motivations and conflicts) of the gatekeeper who controls the channels[14]. The cognitive structure relates to judgement criteria, and the motivation dimensions are the values, the needs and the obstacles to overcome. Conflict is the result of two or more opposing forces working at the same time; its presence will affect the fundamental decision[8].

The dimension of cognitive structure of the model can be applied to individuals and institutions in charge of ASRH information and services[14]. For instance, ASRH information and services orientations of health care providers, teachers and parents/adult community leaders are influenced by ethnicity, religious and socio-economic factors. The model emphasizes urge to know what the values of various groups are, and to evaluate relative strengths of those values and how certain values are associated with specific positions on ASRH information and services. He pointed out that the relative strengths of values could vary, for instance, among health care providers, teachers and parents/adult community leaders. The concept of conflict in the model can be applied equally to provision of ASRH information and services. The key conflict faced by health care providers, teachers and parents/adult community leaders is what is considered appropriate ASRH information and service.

Data and methods

The population of Ghana in 2010 was 24,658,823 over a land area of about 238,533 square kilometres. Adolescents (age 10-19) constituted 22.4% of the total population[15]. Ghana is a unitary state divided into ten political/administrative regions and 216 Metropolitan, Municipal and District Assemblies (MMDAs). The MMDAs constitute the lowest level of political administration. As of 2010, 50.9% of the people lived in urban areas, which are defined as settlements with 5,000 people or more. The level of urbanization ranges from 16.5% in the Upper West Region to 90.5% in the Greater Accra Region[15].

Ecologically, the country consists of three broad zones, namely the coastal belt (Central, Greater Accra, Volta and Western Regions), the central forest belt (Ashanti, Brong Ahafo and Eastern Regions) and the northern savannah (Northern, Upper East and Upper West Regions). The northern savannah accounts for about half of the total area of the country. The pattern of development in the country has followed this broad pattern with the level of socioeconomic development being higher in the coastal savannah and declining towards the north[16]. The main religious groups in Ghana are Christians (68.8%), Muslims (17.6%) and traditionalists (5.2%). Ghana is a multiethnic country with over 50 ethnic groups. The main ethnic groups are the Akan, who account for nearly half of the population (47.3%), the Mole-Dagbani (16.6%), the Ewe (13.9%) and the Ga-Adangbe (7.4%)[15].

The data for this paper were drawn from 60 in-depth interviews (IDIs) conducted in 2005 in Ghana. The data were collected as part of a project entitled *Protecting the Next Generation: Understanding HIV Risk among Youth,* in collaboration with the Guttmacher Institute of New York, USA. Undertaken in three other African countries (Burkina Faso, Malawi and Uganda), this phase of the project was designed to provide information on the sexual and reproductive health of adolescents from the perspective of adults who interact with young people regularly and who influence the sexual and reproductive health and health-seeking behaviours

of adolescents. The interviews covered four broad areas: perceptions of the current situation of adolescent sexual and reproductive health, views on who should be responsible for meeting the information and service needs of adolescents' sexual and reproductive health, personal experiences in dealing with these issues, and possible strategies for meeting the SRH needs of adolescents.

The respondents consisted of health care providers (20), teachers (16) and parents/adult community leaders (24) sampled from four communities (Table 1). Half each of the research participants were selected from two rural (Tolon-Kumbungu and West Mamprusi) and two urban (Accra and Kumasi) MMDAs. The number of respondents (60) was informed by the diversity within the study populations as shown in Table 1. Although the intention was to interview equal numbers of males and females in both rural and urban settings, 21 males and nine females were interviewed in the rural districts and 16 males and 14 females in the urban areas. This is due to the fact that in some of the selected areas, especially the rural areas, the teachers and health care workers were primarily male. Health care workers were selected from private and public institutions in both areas while the teachers were selected from public and private non–religious based schools in the urban areas. In the rural areas the teachers were selected from only public schools because there were no private schools in the rural areas. Some of the respondents performed multiple roles, such as being a parent, teacher and community leader. All the parents selected lived with a young person aged 12–19 years.

Table 1: Distribution of respondents

	Urban	**Rural**
Health Care providers		
Government	2	2
NGO/Private Clinic	2	2
Drug Store/Pharmacy	2	2
Traditional	2	2
Faith-Based	2	2
Teachers		
Primary		
Private	2	-
Public	2	4
Secondary		
Private	2	-
Public	2	4
Parent/Community Leader		
Community Leader	4	4
Mother of 12-19 year old	4	4
Father of 12-19 year old	4	4
Total	30	30

Four graduate students, two males and two females, from the University of Cape Coast, constituted the interview team. The four students were selected on the basis of their previous experience in data collection and ability to speak English and the dominant languages in the selected MMDAs. Training was organized for the assistants by two supervisors and one resource person. Activities included role-playing and translating the interview guide into the various Ghanaian languages to be used. Time was also devoted to the ethics of research, the concepts of informed consent and the use of the screener to identify the various categories of interviewees.

Interviews were conducted either in English, Ga, Akan, Ewe, Mamprulli, Dagbani or Hausa, depending on the area and which language the respondent was most comfortable with. Mamprulli and Dagbani are the two main local languages spoken in the two districts selected in the northern

savannah belt. Hausa, although not a Ghanaian language, was added because it is spoken widely in the three northern regions and among migrant populations from these regions in other parts of the country. Akan is the main language spoken in middle belt and is spoken by over half of the population of Ghana while the indigenous language of Accra, the national capital, is Ga[9]. Nonetheless, as the national capital, nearly all the languages spoken in the country are represented there.

The interviews were tape-recorded and transcribed by the field assistants. Interviews, which were conducted in the local languages, were translated into English. For analysis, a 30-code scheme grouped into categories around the main themes was developed. The 60 transcripts were imported and coded using *QSR N6* qualitative software. To ensure that coding was consistent, initially two people coded the same transcripts and the results were compared. After achieving a common understanding, the rest of the transcripts were coded. Text searches on relevant codes were read and matrices were prepared based on the substantive points. With each transcript treated as a unit of analysis summary texts were developed and recorded in appropriate topical matrices.

The Institutional Review Board of University of Cape Coast approved the project in Ghana. In addition, consent to participate in the interview was obtained from all the participants. Where the person could read in English, she or he was given the consent form to read and sign if she or he agreed to participate in the interview. For those who could not read and write in English or their own language, the form was read to them in their language, and if they agreed to participate they thumb printed. On average, interviews lasted one hour and 30 minutes.

Results

Adolescent Sexual and Reproductive Health Problems

The two adolescent sexual and reproductive health problems most commonly reported (either spontaneously or when probed) by the adults interviewed were unintended pregnancy and HIV/AIDS. Other problems indicated were induced abortion, other STIs and promiscuity. While recognizing that some of these problems are common to all adolescents, some adults indicated that younger and older adolescents face slightly different problems. To these respondents, younger adolescents (12–14 years) are still under the influence of their parents and, therefore, less prone to pregnancy and other problems; and a number of them are not physically matured and so they are less likely to engage in sex compared with older adolescents (15–19 years).

Teenage pregnancy

Teenage pregnancy emerged as the major adolescent reproductive health problem for females as observed by a study among adolescents in Ghana[3]. This was expressed as follows:

Teenage pregnancy is the number one problem. Others include school drop-out, truancy and "Kayaye" (i.e. migration of the youth to the south as head porters

—Rural female health worker, 54 years

The most common problem is teenage pregnancy. It is becoming a major worry of parents because when girls become pregnant the responsibility rests mostly on their parents and not the boys because most of the boys are unemployed.

—Rural female parent, 50 years

However, according to some of the adults in rural areas, the pregnancy of a married woman, irrespective of age, could not be described as 'unwanted', since once a woman was married, she was expected to get pregnant and give birth. Adolescent pregnancy was only classified, as 'unwanted' if the female involved was not married:

For the married ones unintended pregnancy does not exist. Having many children is a pride in this community; hence the issue of unintended pregnancy does not exist among the married men and women. For them, every pregnancy is wanted. Unintended pregnancy is found with the unmarried young men and women.

—Rural male parent, 50 years

Teenage pregnancy was considered to be a major problem for females and, in particular, those in school. According to respondents, a young woman who becomes pregnant while in school is forced to drop out, and most of those who drop out are unable to return to school after delivery. Many respondents felt that this issue is less serious for young men, as they may deny responsibility for unintended pregnancies and can continue with their education even if they accept responsibility for a pregnancy. As a parent and a health worker pointed out:

Boys may continue schooling because the burden of pregnancy rests more on the girls who will have to drop out of school and may not have the opportunity to continue her education again, especially if her parents are not rich.
—Rural female parent, 50 years

Girls carry pregnancy, take care of the baby and suffer with it. Boys only make the girls pregnant. If the boy is unemployed, he may ignore …. Depending on how both families handle the case the boy may or may not be allowed to further his education.
—Rural male health worker, (drug store), 32 years

HIV/AIDS

HIV/AIDS was also reported to be a major sexual and reproductive health issue for adolescents because, unlike pregnancy, HIV/AIDS can affect males and females equally. However, comments on HIV/AIDS were less frequent compared with those on teenage pregnancy, especially from community leaders. This relative importance attached to pregnancy and HIV/AIDS was observed among young people in the study areas and that pregnancy prevention was the main motive for using condoms at last intercourse[3].

There has not been any official test to prove that HIV/AIDS is an issue in this community but looking at the sexual behaviour of adolescents in this community, they stand the risk of being infected because most of them do not know how to use the condom so some of them engage in unprotected sex. Also, during the holidays, students from poor families go to the south with the intention of searching for temporary jobs but for some of them are just not the work per se, they engage in commercial sex and therefore they stand the risk of getting HIV/AIDS.
—Rural female health worker, 56 years

No one has ever been diagnosed as an HIV/AIDS patient in this community. We have not had any AIDS case yet. However, the awareness of HIV/AIDS is there.
—Rural male community leader, 40 years

With HIV/AIDS considered to be less of a problem in their areas most of the discussions were in general, rather than in specific terms. The major concern expressed about HIV infection in communities is the stigma and discrimination associated with the epidemic. Respondents' concern was shame and disgrace for other family members, as well as for the infected person, as indicated in the dialogue:

HIV/AIDS is a problem in the sense that it is a disgraceful disease. When you get it, it brings disgrace to the family. It is a disease no one wants in his or her home. When you get it, no one likes you any longer, probably only your mother and sisters. Other members of the family will shun you because they think when they share a cup with you they can be infected. Also, someone marrying from the family will face a lot of problems because he or she will be told there is AIDS in the family, shaming them.
—Urban female parent, 42 years

Rural communities considered HIV/AIDS to be a problem that exists in other areas (urban), such as Accra and Ouagadougou in Burkina Faso, as indicated in the statement:

I haven't come across a case about HIV/AIDS in this community. The few I have heard about came from Burkina Faso. The women go as far as Ouagadougou to do business. Recently, it was rumoured that two of such traders died of AIDS. But these were adults not teenagers.
—Rural female health care provider, 54 years

One of the implications of the statement is that some of the communities do not accept the

existence of HIV/AIDS in their community or appreciate the overall implications of the epidemic. To them, the epidemic is far removed from their lives and they may not recognize the importance of prevention activities. The few reports on HIV/AIDS infection in both rural and urban areas were from health personnel who had dealt with cases at their facilities. The results present a number of issues: First some of the communities do not appreciate the overall implications of the epidemic; secondly, stigma and discrimination to the family and not the infected person is their main reason for considering the epidemic to be a problem.

Challenges of Adolescent Sexual and Reproductive Health Promotion

One of the expectations was that key adults would offer services and support to young people in various ways. However, from the discussion some of the adults reported that they were unable to play their expected roles for several reasons. The main factors were resistance from some parents, attitudes of adolescents themselves, communication gap between them as adults and young people and attitudes of health care providers.

Resistance from parents

Professionals such as teachers and health care workers are held in high esteem. They are regarded as knowledgeable and able to provide advice to young people. However, some of the health care providers and teachers indicated that they were unable to provide services and information on sexual and reproductive health due to the attitudes of parents. According to them, some parents were not cooperative in addressing sexual and reproductive health problems. Some parents were of the view that if adolescents were introduced to sexual and reproductive health issues they would engage in premarital sex. The issue emerged from discussions with some of the parents as the following quotes illustrate:

It is the use of these contraceptives that is spoiling our children. It is because of the condom and family planning medicines that the children don't fear going into sex.
—Rural father, 64 years
Because of the availability of condoms, children may be tempted to engage in early sex since they have already learnt how to protect themselves against premarital pregnancy, STDs and HIV/AIDS.
—Rural female community leader, 40 years

Some of the adolescents will take advantage of the information on contraceptive use and develop the habit of having sex. Many problems will arise as a result of this.
—Rural mother, 45 years

When they are taught how to use the condom, some of them are likely to put it into practice. Then also some of the video centres show indecent films and even on our Television.
—Rural male community leader, 40 years

This apparent conflict emerged as one of the major factors affecting the provision of sexual and reproductive health services to adolescents in some communities[14]. Similar observation was made in a study in the Northern and Upper East Regions of Ghana. About four out of ten community opinion leaders who participated in the study indicated their disapproval for the use of contraceptives by adolescents[17].

Some community leaders and teachers also blamed parents for complicity leading to their inability to address some of the adolescent sexual and reproductive health problems in their communities. According to them, some parents defend what might be considered to be unacceptable behaviour of their children. Key informants who reported such experiences attributed it to "ignorance:"

I called the parents and informed them that their daughter was going wayward, and the mother did not allow me to complete what I was saying and she started insulting me.
—Urban female teacher, 46 years

The boy refused to accept responsibility even though there was every indication that he was

responsible for the pregnancy. Also, the boy's parents were supporting him and not trying to be objective in their approach to the case.
—Rural male community leader, 40 years

However, some studies have revealed that teachers also resist ASRH services. For instance, 52% of teachers believed contraceptive use should be initiated within marriage or after 18 years of age and 91% disapproved of condom demonstration and provision in schools. About 36.2% were willing to counsel the sexually active adolescents about contraceptive use[18]. On the contrary, in a study in India almost all the parents and teachers contacted during group discussions felt that information on reproductive health should be provided to adolescents[19].

Attitudes of adolescents

Some community leaders, parents, teachers and health care providers felt that they were unable to address sexual and reproductive health needs of young people because the youth themselves were not co-operative. The following quotes summarize their observations:

A young boy impregnated a young girl but did not want to accept responsibility so the mother drove the girl to the boy's house to live with them.
—Rural mother, 51 years

Boys always try to deny responsibility of pregnancy. I always tell them that we are dealing with human life, which is very important, and so it is difficult for a girl to tell lies on a boy she has never had sex with before.
—Rural male health care provider, 36 years

Some of the professionals, especially the health care workers, complained that adolescents do not accept the professional advice they give them and that they rely on peers. These observations were reported by health workers in both rural and urban areas, as illustrated in the following statement:

Adolescents do not often accept the correct information we give them about their sexuality. When you educate them on their sexual behaviour, they go back and repeat the wrong things that their peers taught them. For instance, some of them say they cannot enjoy sex when they use condoms.
—Rural health care provider, 32 years

The results point to differences in perception between the young people and the adults. It appears the adults would want to provide information and services on their terms while the young people expected something else. Thus, the adults as gatekeepers would wish to dictate the rules of the game, which to some extent, are unacceptable to the young people.

Adult-child communication gap

While some of the parents, community leaders and providers recognize the need for comprehensive information and services on sexual and reproductive health for young people, some of them considered the topic to be sensitive. As a result, they approached discussions of sexuality with care, especially with children of the opposite sex. The fathers who were interviewed reported feeling more comfortable talking to their sons than daughters about sexual matters. Available evidence elsewhere indicates that, in the case of the daughters the interaction was more of instructions and caution rather than dialogue[12]. Those adults attributed their inability to discuss SRH issues with their children to cultural expectations of same-sex dialogue on sexual and reproductive health issues. As one father pointed out:

It is not easy dealing with adolescents. You need to be patient and very tactful especially when it comes to sexual matters. The culture doesn't allow us to talk to children about sex, especially the opposite sex. Also, some of these adolescents are very rude and disrespectful. Hence, it is not easy talking to adolescents outside your family, except those who are friends to your children or those who are your friends' children.
—Rural father, 50 years

Mothers tended to report talking to both their sons and daughters on sexual matters, but

indicated that they tended to talk more to their daughters than sons. Similar observation was made in a study in Lomé, Togo. Women reported taking that responsibility with their daughters because they argued that when premarital pregnancy occurs, it is always the girl who suffers and the girl's mother is blamed[20].

Some parents reported feeling comfortable talking about social issues such as education and morality, but not specifically about sexuality. According to them, when they do talk about sexuality with their children, it was mainly about abstinence. As one parent remarked:

For my children, I talk about abstinence and nothing else. For other children, I also add that if they can't abstain, then they should use condoms. I don't like talking about the use of condoms, but once a while I'm forced to because they see and hear of it on television. However, I stress that it is not safe at all, and using it means you will have early sex and will therefore not grow into healthy and responsible adults.
—Rural father, 50 years

Similarly, a study in Lesotho observed that majority of participants in focus group discussions stated that they could at best discourage premarital sexual relations among adolescents[21]. This is often due to their discomfort and the false belief that providing the information will encourage increased sexual activity[22]. This parent-child communication gap on sexual and reproductive health has emerged from both quantitative survey and in-depth interviews with adolescents in Ghana[23,24]. These present major challenges to the use of parents as educators of ASRH.

Attitudes of health care providers

Since its inception at the end of the 1800s, the modern health system in Ghana has come to symbolize good, reliable and efficient health care. The attitudes of modern health care professionals are important, as they influence the nature and quality of services offered. Depending on their attitude, health care providers can either facilitate the use of services or constitute a barrier to adolescents seeking sexual and reproductive health services. In in-depth interviews with adolescents, the attitudes of health providers in respecting adolescents as individuals, ensuring confidentiality and meeting their needs for information and services emerged as important considerations for young people who either sought or contemplated seeking health care[24].

In the study, three broad attitudes emerge from the responses of health care workers. These are those who were helpful and showed empathy to the needs of young people, those who were less sympathetic, and those who tried to impose their views on young people seeking care, as well as other community members.

In both rural and urban areas, some of the health care providers seemed to show empathy to the sexual and reproductive health challenges and needs of adolescents, especially unplanned pregnancy and early marriage. There were reported cases where a health worker had intervened at the household level, as in the following narrations:

She wanted me to help her have an abortion but l advised her to give birth because of the risk associated with abortion. The girl is my niece and her mother was annoyed so l had to look for some elderly people to send the girl home and apologize on her behalf.
—Rural female community leader, 40 years

I invited the girl's parents and the boy's parents and told them of the girl's plight and advised them to give her a well-balanced diet to enable her recover from the anemia. We (the staff) also visited her and ensured that she attended antenatal clinic regularly.
—Rural female health worker, 54 years

Empathetic providers were able to create a positive and welcoming image at their health facilities. Such providers formed a much needed bridge between the young people and their homes and also represented the youth-friendly face of the Ghana Health Service. Some of the private and public providers used referral systems to assist young people to access health care at other facilities when their facility did not offer the services sought for. Referrals were reported to be

used frequently in cases of abortion and sexually transmitted infections (STIs).

There were those health care providers whose modes of operation can be described as being less sympathetic towards adolescents who presented sexual and reproductive health cases at their facilities. This manifested itself in practices such as turning away those who came to ask about services, especially those seeking abortion and STI services. As gatekeepers[14], some of them dictated the type and nature of services young people should have. Thus:

As a health worker, girls come to me saying, "Madam, I'm pregnant and I want to terminate it."Most often I find out whether they are attending school or not. If she is a schoolgirl, I tell her that instead of thinking about her studies, she has been thinking of sex. We have always been talking to you about condom, so why do you go into sex without [a] condom? Then I tell them that I am not in a position to do it [perform an abortion]. I don't even know how to do it, and I don't know how you can do it. So I cannot help you, and they go away.

—Rural female government health worker, 54 years

This was the situation of a health care worker who felt that the girls should not have had sex in the first place for them to become pregnant, and therefore was not in a position to help them. Such attitudes could lead to situations whereby young people may not have confidence in the health system. There were similar reported unsympathetic attitudes towards young people who sought services for sexually transmitted infections. According to one service provider:

Anyone who comes with a gonorrhea case, I tell him to go and bring the girlfriend(s). In fact, with the "gonorrhoea" cases it is boys who come up with such issues. If he brings the girlfriend(s), I put them on antibiotics for seven days. If it doesn't go, I advise them to go to hospital. Some will say they don't have girl friends; they didn't get it through sex. For such people, I always tell them: You'll come back here with the same sickness and I'll charge you again. If you treat yourself leaving your girlfriend, you'll get the gonorrhea again.

—Rural male health worker, 32 years

Technically, the approaches adopted by the providers are in line with the protocol of the Ghana Health Service in dealing with treatment of STIs. Treatment protocol for gonorrhea demands that the person seeking treatment should come along with his or her partner. The observations indicate how the strict application of rules could lead to denying services to people when they need them (this may not happen to only young people) and suggest that some mechanisms should be developed to address the needs of young people without compromising public health procedures.

Some health care providers were judgmental towards adolescents seeking reproductive health information and services. Such attitudes of providers create barriers between the provider and clients. For instance, one rural male health worker remarked:

At an adolescent health programme, a young girl asked whether she could use condom. That was a very challenging thing and she wanted me to teach her how to use it. We are trying to form Virgin Clubs in their schools, so if the girl wanted to use condom, then it is a problem. We are trying to tell them not to have sex, and she is insisting on the use of condom. I didn't know how to convince her not to have sex.

—Urban female health provider, 47 years

Some of the health care personnel were aware of the negative attitudes of their colleagues towards young people. Accordingly, they reported that some of their colleagues are unable to communicate with young people in a friendly manner. To them, such attitudes alienated young people and could explain why some young people were not using their facilities and services. As pointed out by one health worker:

Another problem is the attitude of health care providers towards these kids. They need to learn to talk to them nicely and make friends with them. In this way, they [adolescents] will talk freely. But if you are harsh and mistreat them, then it is a lost case.

—Urban female health worker, 49 years

There were both supportive and judgmental

providers. Similar observations were made in a study in Ethiopia where majority of health workers who participated in the study had positive attitudes even though nearly one third of health care workers had negative attitudes toward providing RH services to unmarried adolescents[25]. There is no doubt that health care providers are in position to influence ASRH services and information. For instance, a study in Kenya and Zimbabwe among 10-19 year-olds found that adolescents considered friendly staff among the most important factors when seeking services in such places[26].

Discussion and Conclusion

The role of adults as gatekeepers emerges in various forms from the study. The varying perceptions, attitudes and behaviours have implications for addressing the sexual and reproductive health needs of young people in Ghana. The results point to the need for programmes which promote dialogue between young people and significant adults such as teachers and health care workers. There is the need to create enabling environments at various levels which will make it possible for ASRH information and services to be provided. In both urban and rural areas, young people trust teachers and health care workers, and this came up in the adolescent survey and the in-depth interviews.

Teachers can also form an important bridge in SRH in Ghana since they are expected to teach family life education in the school system. With over 80% of young people attending school, teachers can play important roles in promoting sexual and reproductive health education in both the schools and in communities. While the Ghana Health Service has initiated a programme to create youth-friendly services and a youth-friendly atmosphere at their facilities, the results indicate that there are still pockets of challenges, and that new strategies will need to be adopted to deal with various attitudes that create barriers. Also, there is a need for further studies on the dimensions of attitude-related problems in order to ensure adequate provision of youth-friendly services.

A number of the parents acknowledged that they felt uncomfortable discussing SRH issues with their own children. This discomfort may be because the traditional system entrusted such responsibility to grandparents and other adults. Nevertheless, given that parents play major roles in the lives of their children and parental monitoring tends to promote protective behaviour among adolescents, programmes to help parents engage in open-minded and constructive discussion with their adolescent children will be desirable.

In spite of modernization and associated social and cultural changes, some traditional aspects of life such as respect for elders and community leadership still exist, especially in rural areas. This is an asset that can be utilized to promote better handling of young people's sexual and reproductive health issues. The community approach may help to overcome the embarrassment that some parents reported when discussing sexual and reproductive health issues with their children. While parents and their children may be reluctant to talk to each other about sexual and reproductive matters, conversations between young people and other relatives such as aunts, uncles or even a trusted community leader may be productive[8,10].

There was also disagreement among respondents about who was most responsible for adolescent's problems. Community members blamed teachers and health care workers for corrupting children by teaching about sex and providing contraceptive methods; the professionals point fingers at parents and other community members for making it difficult for them to deal with the SRH needs of young people; health care providers blamed young people for ignoring their professional advice and instead listening to their peers. Therefore, there is the need for the stakeholders themselves to be brought together to develop common strategies to support programmes.

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