Gatekeepers, Umpires and Commentators in Adolescent Sexual and Reproductive Health in Ghana

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Abstract

Adults constitute gatekeepers, umpires and commentators on adolescent sexual and reproductive health (ASRH), but are yet to be given the attention they deserve on such issues. As policy makers, providers, and implementers of programmes for young people they tend to dictate the nature and quality of ASRH information and services. This paper discusses the perceptions and attitudes of adults on ASRH based on 60 in-depth interviews conducted in 2005. Adults were purposively selected on the based on their roles as parents, teachers, health care providers and community leaders. The results indicated a wide range of perceptions, attitudes and behaviours towards ASRH. For instance, some of the adults supported services for young people while some were not. Some served as mediators and assisted to 'solve' some of the ASRH problems which occurred in their communities. Among health workers in particular, three broad categories were identified: those who were helpful, those who were judgmental, and those who dictated the type of information adolescents should have. It is argued that exploring the views of adults about their encounters, fears, concerns, and areas for action, will contribute to the development of strategies and programmes which will help to improve ASRH services in their communities.

Key words: Adolescent, Adults, Gatekeepers, Umpires, Commentators, Ghana, Adolescent Sexual and Reproductive Health

Introduction

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 (Bronfenbrenner, 1979; Mehra, 2002). To a large extent, adults as professional 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, and young people in a wide range of settings (Bronfenbrenner, 1979).

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. Adults also as custodians of what has to and needs to be done, play the role of umpires who provide, manage and apply rules. The umpiring and gate-keeping roles of adults have occurred, in most cases with the view to 'acting in the best interest of young people'. Thirdly, adults may be commentators as well as observers in the drama of adult-adolescent interaction. 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 (Kumi-Kyereme et al, 2007; Wight et al, 2006).

While the role of gate keepers, as agents filtering information and/or services could be vital in communication planning, the emphasis has been on them as barriers. However, some recent thinking recognize the need to gear programme efforts in ASRH towards strong support for community-level influences as entry points for providing services (Inter-Agency Working Group on the Role of Community Involvement in ASRH, 2007; Stephenson, 2009; World Health Organization, 2004). The aim of this paper is to explore the perceptions, attitudes and some of the experiences of adults on issues of adolescent sexual and reproductive health. The intention is to understand the views of adults about their encounters, fears, concerns and areas for action which can form the basis of programmes to improve the delivery of ASRH information and services.

Data and methods

The data for this report were derived from 60 in-depth interviews (IDIs) with purposively selected key adults who interact with and/or provide information and services to adolescents on a wide range of issues, including sexual and reproductive health. They consisted of health care providers (20), teachers (16) and parents/adult community leaders (24). Of the 60 respondents, 30 were selected from two rural districts in the northern part of the country, 15 from the middle belt and another 15 from a coastal region. 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 as some of the rural areas had no schools or health centres and where these facilities existed, 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 but from only public schools in the rural areas, where no private ones existed. 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.

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. 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. Interviews, conducted in May 2005, 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.

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 Region. 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. Nonetheless, as the national capital, nearly all the languages spoken in the country are represented there. For detailed description of the project and data set see Awusabo-Asare et al, 2008[1].

Results

Commonly reported 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. Some of the adults also indicated that alcohol and drug abuse, financial problems, unemployment,

[1] Surveys data from the study are available at http://www.guttmacher.org/pubs/PNG-data.html and full description of specific methodologies are available at http://www.guttmacher.org/adolescents.php?scope=other%20country%20specific

migration of young women from the northern part of the country to the south and the negative influence of the modern media exacerbated the sexual and reproductive health problems.

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). This sentiment was expressed by a rural community leader in the following statement:

For the younger ones, they are less exposed and less experienced in the sex. Also, they still fear their parents and hence the parents have better control over them. They are, therefore, not much involved in premarital sex and hence record less unintended pregnancies and STDs compared tothe older adolescents
—Rural male community leader 40

Others were of the view that due to their age, those aged 12–14 years, especially the females, are ignorant of reproductive health-related issues and, therefore, older people tend to take advantage of their ignorance and easily lured into having sex. This issue came up in the discussions with adults in urban areas. There were also those who felt that both the younger and the older adolescents were equally exposed to risk and were involved in premarital sex and, therefore, needed to be targeted equally.

Interviewer (I): How does the issue differ for younger girls and boys who are less than 15 years old compared to older adolescents?
Respondent (R): They are not different. You come to the clinic and see a girl as young as 12 years being pregnant, so I don't see any difference.
—Urban female health worker, 47 years

The general view was that both younger and older adolescent females are at risk of unwanted sex and therefore need to be supported and educated. It was noted that the education on reproductive health should start early, although most of them were not specific on how early this should start, in order to forestall some of the problems identified.

Teenage pregnancy, especially among young women in school, emerged as the major adolescent reproductive health problem (see Akuffo, 1987). However, according to some of the adults in rural areas, a pregnancy of a married woman, irrespective of age, could not be described as 'unwanted', since once a woman is married, she is expected to get pregnant and give birth. Adolescent pregnancy was only classified as 'unwanted' if the female involved was not married. That is, in the rural communities the definition of the "wantedness" or "unwantedness" of a teenage pregnancy was tied to marital status. This was expressed as follows:

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

The key adults also viewed unplanned pregnancy among adolescents was a more pressing problem than HIV. Among those who considered HIV/AIDS to be a problem, their main concern was shame and disgrace for the wider family members as indicated in the dialogue:

I: Why is HIV/AIDS a major issue?
R: It is in the sense that it is a disgraceful disease. When you get it, it brings disgrace to the family.
I: Why do you say so?
R: It is a disease no one wants in their house. 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 mother, 42 years

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 the motive for using condoms at last intercourse (Awusabo-Asare et al, 2006).

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.

Other Sexual and Reproductive Health Problems
Other major adolescent sexual and reproductive health problems mentioned (mostly by health workers and teachers) were other STIs and casual sex. However, according to them, the young people themselves did not consider STIs to be serious problems and, therefore, do not seek professional help. Some of them reported at health centres only when they had serious problems, as in the following observation from a health worker:

Young people will normally not take STI to clinics for treatment. They would rather self-medicate, which is dangerous. Thus, by the time they seek proper care, it has reached its maturity stage and become full-blown with complications.
—Urban female health worker, 59 years

Because most young people do not report cases of STIs at health centres, the health care workers were unable to estimate the magnitude of the problem in their areas, although one urban health worker described them as “very prominent”. (The few records that were available at some facilities did not indicate age of attendees.) The other problem mentioned was casual sex. The

respondents in urban areas who mentioned casual sex attributed it to breakdown of traditional norms and practices within the urban setting.

The adults, in most cases, contrasted the behaviour of today's young people with theirs when they were young and concluded that young people today are less disciplined than in the past. To them, modernization, the anonymity of the urban lifestyle and the desire for material things have led to increase in casual sex and unwanted pregnancy among young people. The statement from one female community leader reflects the views expressed:

In the olden days, when puberty rites were performed, it held the adolescents in check. As these rites are no longer being practiced, the young ones indulge in indiscriminate sexual acts, resulting in teenage pregnancy…. With the unmarried people, they virtually carry the whole world on their shoulders. They are involved in all kinds of vices, indiscriminate and casual sex, drinking, stealing, etc.
—Urban female community leader, 59 years

The adults in rural areas in the north associated sexual immorality and promiscuity with females who migrate to the south (Accra and Kumasi in particular) to work as head porters *(kaya yei)* and later return to the community. A rural female health worker, age 52, pointed out the problem as follows:

Our district has one of the largest number of boys and girls from the northern part of Ghana who migrate to the south to engage in all kinds of menial jobs.…While in the south, because they [were] not under anybody's control, some of them, especially the girls, indulge in commercial sex as a means of earning additional income. When they eventually return to their home villages, some of them continue with such immoral behaviour.

Adults in both the rural and urban communities attributed the problem of casual sex among young people to modernization, urbanization and migration, an issue which recurred in most of the discussions.

Views of Adults on Barriers

As the key adults identified based on their interaction with young people and the roles they play in their lives, one of the expectations was that they will offer services and support to the young people. From the discussion, some of the adults reported that they were unable to play their expected roles for some reasons. The three main factors that they identified as barriers hindering their dealings with adolescent sexual and reproductive health matters were resistance from parents, attitudes of adolescents themselves and the communication gap between them as adults and young people.

Resistance from parents

Within rural communities in Ghana, professionals such as teacher 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, as 'some parents were of the view that if adolescents were introduced to sexual and reproductive health issues they would engage in premarital sex. For example, some parents felt that some of the young people had 'indiscriminate sex', because they use condoms and other family planning methods which do not make them pregnant. The issue emerged from discussions with some of the parents as the following quotes illustrate:

I attended a function at [a secondary school], and at the end of the programme, condoms were distributed. The parents who were at the function became very angry.
—Urban male teacher, 30 years

I: What types of information/services do the PPAG [Planned Parenthood of Ghana] and hospital nurses provide for the adolescents?
R: They provide them with information on HIV/AIDS, teenage pregnancy, family planning and the use of condom, which I don't like at all.
I: What don't you like about the condom?
R: Not only the condom, but contraceptives in general. 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

To the health care providers and teachers, older adults were more likely to accuse them of undermining their tradition ways of life and corrupting the youth in their communities by talking openly about sex. They also felt that socio-economic changes (modernization) were contributing to the unacceptable behaviour of young people in their areas. Over the years there have been media reports about parents who have taken action against teachers who have tried to discipline their children in school (Aklorbortu, 2007). This conflict between parents and teachers, as well as between parents and health care providers, constitute a major barrier to providing community-based sexual and reproductive health services to adolescents.

Some community leaders also blamed parents for complicity in the behaviour of their children, especially daughters. According to them, some parents defend what might be considered to be unacceptable behaviour of their children, especially daughters. Key informants who reported such experiences attributed it to "ignorance:"

R: The mother insulted me. It is a barrier so I couldn't achieve what I wanted. 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.
I: What is the source of this difficulty?
R: Maybe the mother is ignorant or she likes the way her daughter behaves
—Urban female teacher, 46 years

Attitudes of adolescents themselves
Some community leaders, parents, teachers and health care providers felt that they were unable to address the sexual and reproductive health needs of young people because they were not co-

operative, depended on their peers, and that some of them had what they described as 'poor upbringing'. An urban female health care provider and a parent summarized their observations as follows:

R: Most teenagers are rebellious. They do not listen to advice. They go and get pregnant and get STIs, and the burden falls on us to treat these diseases; also, the children they have end up on the streets.
I: What are some of the reasons why you experienced these barriers?
R: It is the teenage mind and stage—they are rebellious.
—Urban female health care provider, 49 years

R: Teenagers always prefer to deal with issues on their own, opting for abortion even before anyone gets wind of it. The fact that the boys will not even stay at home is a big barrier.
I: What is the source of these difficulties?
R: The fact that these kids drop out of school and the issue of inadequate parental control.
—Urban father, 40 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. 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 umpires would wish to dictate the rules of the game, which to some extent, are unacceptable to the young people.

Adult-child communication gap

The results showed gaps between what the key informants who were professionals felt the young people needed and what the adolescents wanted to have. In particular, health care workers felt that they knew what the young people needed and, therefore, expected them to accept their points of view and information. This was evident from the comments of some health care providers who felt that young people accepted what their peers told them rather than what they, as professionals, considered to be appropriate for them. For instance, one health worker reported that in their education campaigns they do emphasise preventive measures such as abstinence and fidelity but at most areas the adolescents were more interested in other issues such as contraceptive, which according to her, were not what they wanted to give them. Thus, she indicated that:

R: 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 but I told her to come to [place] . . . because I have to get a condom and demonstrate to her.
I: What made it challenging?
R: 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

As a gatekeeper, she was filtering the information which she felt the young person should have. What the professionals considered to be 'in the best interest' of young people and what young people themselves would like to know illustrates some of the gap that exist between providers and clients in the provision of SRH information. Thus, some of the adults seem to think that they can control the type of information that adolescents should have on sexual and reproductive health. But given the multiple sources of information, some of the young people may have more information than the adults think they have.

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 indicate that, in the case of the daughters the interaction was more of instructions and caution rather than dialogue (Kumi-Kyereme et al, 2007). 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 spend more time talking to their daughters than sons. 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.

Some parents reported feeling comfortable talking about social issues, 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." He also added:

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

This parent-child communication gap on sexual and reproductive health has emerged from both quantitative survey and the in-depth interviews with adolescents in Ghana (Awusabo-Asare et al, 2006; Kumi-Kyereme et al, 2007). These present major challenges to the use of parents as educators 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 may 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 (Kumi-Kyereme et al, 2007).

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.

Empathetic Providers
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 narration:

I:Why did you consider that [teenage pregnancy] to be a difficult issue?
R: The girl was not married and therefore she was not getting adequate feeding for herself. You know, poor feeding during pregnancy could lead to anemia, which can cause death in pregnant women. She was worried about her condition. Such pregnancy issues are worrying to us, too, and that is why I said they are difficult issues. We don't want to record any maternal or fetal death.
I: How did you deal with the problem?
R: 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 STIs.

Less Sympathetic Providers

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 facility. 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, 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 STI cases. 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.

Judgmental Providers

Some health care providers were judgmental towards adolescents seeking reproductive health information and services. For instance, one rural male health worker argued that the production and distribution of condoms should be stopped: "Because condoms are available they don't want to practice abstinence, which is the only surest way they can avoid catching the HIV/AIDS." Such attitudes of providers create barriers between the provider and clients.

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:

R: 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.
I: What do you think would have helped you deal better with these difficulties?
R: If many people are broad-minded like me.
—Urban female health worker, 49 years

There was no systematic pattern between health care providers in rural and urban settings in their attitudes toward young people: There were both supportive and judgmental providers in both areas.

Discussion and Conclusion

The role of adults as gatekeepers, umpires and commentators emerge 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, 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, teachers and health care workers are trusted by young people, and this came up in the adolescent survey and the in-depth interviews. A study in Kenya and Zimbabwe among 10–19-year-olds found that adolescents considered health facility–related factors, such as level of confidentiality, short waiting time, low cost and friendly staff, as the most important factors when seeking services in such places (Erulkar et. al., 2005). 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, they 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 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 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.

There were different opinions on the factors contributing to the existing adolescent sexual and reproductive health problems. Modernization was considered to be a major underlying cause of the problems associated with the observed adolescent sexual and reproductive health problems.
In spite of modernization and associated social and cultural changes, some traditional aspects of life such as respect for elders and community leadership still exists, 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 (Inter-Agency Working Group on the Role of Community Involvement in ASRH, 2007; Kumi-Kyereme et. al., 2007).

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 professional 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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