What emerging adults are saying about sexual and reproductive health programmes: Evidence from a suburb in Accra, Ghana

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INTRODUCTION

Adolescent sexual and reproductive health and rights (ASRHR) issues ranging from family planning to induced abortion and sexually transmitted infections are topical challenges which have witnessed global response over the past few decades. The 1994 International Conference on Population and Development (ICPD'94) drew attention to the relevance of countries acknowledging the urgent and critical sexual and reproductive health (SRH) needs of the youth (United Nations, 1994). This has led to significant improvements in ASRH programmes globally over the past 30 years. They have currently been included in the Sustainable Development Goals (SDGs), specifically Goal 3 which seeks to "ensure healthy lives and promote well-being for all at all ages." SDG targets 3.7 and 5.6 reiterate the need to ensure universal access to quality SRH services. By 2030, Target 3.7 seeks to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs" while 5.6 seeks to "ensure universal access to sexual and reproductive health and reproductive rights".

In Ghana, the policy environment encourages advancements in the health and development of youth. However, according to the Ghana Adolescent Health Service Policy and

Strategy (Ghana Health Service, 2016), existing policies on adolescent health have mostly centred on HIV/AIDS prevention and risky sexual behaviour. This could be attributed to the high HIV/AIDS prevalence in some parts of sub-Saharan Africa (UNAIDS, 2014; WHO 2015) which resulted in a majority of studies focusing on HIV/AIDS prevention and reducing risky sexual behaviours. This reduces the comprehensiveness of the policy due to its limited ability to explore, prioritize and tackle a wider range of other health issues facing adolescents. An evaluation report on the Adolescent Health and Development (ADHD) programme suggests that adolescents and young people's "access to appropriate health information had not improved significantly over the period of the review", and the "utilization of health services by adolescents and young people remained poor despite an overall improvement" in some indicators (Ghana Health Service, 2016, p5). In addition, most of the interventions and policies target adolescents (10 to 19 years) to the neglect of the young adults (20 to 24 years) who are equally vulnerable regarding sexual and reproductive health issues.

Furthermore, the literature indicates that very little has been done with respect to male youth and their sexual and reproductive health (Cleland and Ali, 2004; Creanga et al., 2007; Parr, 2003; Westoff, 2006; USAID, 2017). Few studies involve men; nevertheless, the need to consider the male perspective is critical as studies indicate that men play a key role in the quest to improve women's health, especially in the sub-Saharan African context. Without access to SRH knowledge, young men may face challenges of their own, as well as impede partner's contraceptive use (Parr, 2003; USAID 2017), normalize sexual risk-taking behavior, and succumb to other unhealthy behaviors due to them being uninformed. These are critical messages in most SRH programmes. For example, in Ghana, a 2004 adolescent survey found that 30 percent of female youth indicated that they are unable to use contraceptives, specifically condoms, because their partners opposed its use (Awusabo-Asare et al., 2004). This number has risen to 42 percent for unmarried sexually active women (GSS, GHS, ICF International,

2015). Therefore, understanding the male perspective on SRH programmes, their experiences, knowledge and benefits are equally paramount.

Studies conducted with adolescents and youth in various parts of Ghana indicate exposure to ad hoc SRH programmes with their mixed findings in relation to accurate knowledge on some SRH topics. Adolescents' knowledge of different topics ultimately improved after participating in SRH interventions (Amankwaa et al., 2018; Kyilleh et al., 2018; Van der Geugten et al., 2015). Most adolescents reported challenges with access to SRH services (Amankwaa et al., 2018; Kyilleh et al., 2018; Van der Geugten et al., 2015). Challenges also existed with parents/caregivers and teachers feeling deficient in their ability to provide SRH education to their wards and students, respectively (Amankwaa et al., 2018; Tabong et al., 2018).

Ghana is rapidly urbanizing, with the Greater Accra Region being the most urbanized region (GSS, 2021). As urbanization increases without commensurate health and economic conditions in sub-Saharan Africa, the urban youth living in resource-constrained environments will continue to experience limited opportunities and high risks for adverse reproductive health outcomes, including unintended pregnancies (Mumah et al., 2015). The increasing desire to study health challenges of the youth in this setting indicates an enhanced appreciation and understanding of their challenges and developmental stages. Eliciting in-depth and societal level information from young people through qualitative interviews further provides a means of directly generating insights on their viewpoints. Therefore, this study uses in-depth interview and focus group discussion data from emerging adults (18 to 24 years) to gain insights on their knowledge and/or experiences with sexual and reproductive health programmes, and also seek their views on how current interventions could be improved.

Theoretical Framework

We consider two theoretical approaches that inform the study and data analysis: the Health Belief Model and the Multi-Component Approach to generating demand and improved access to SRH services. Studies have identified the Health Belief Model as consisting of the needed strategy of interventions that produce the required changes that can provide "a better appreciation of the theories of behavior change" and "promote the capacity to employ them expertly in research and practice". The Health Belief Model is based on six key concepts, namely, perceived susceptibility, severity, benefits, barriers, cue-to-action and self-efficacy (Abraham and Sheeran, 2015). In summary, the theory is based on the understanding that an individual will take a health-related action if: 1) he/she feels a negative action can be circumvented; 2) he/she has an optimistic belief that by taking a recommended action he/she will avoid a negative condition; and 3) he/she trusts he/she can take a recommended health action. Applying this to the discussion on the effectiveness of SRH interventions and programmes that can permit the youth to adopt responsible behaviour, the Health Belief Model encourages positive health actions that avoids a negative health consequence as a prime motivation. In other words, the model explains that in order for behaviour change to occur, the individual must believe that the change is both advantageous and feasible and that the advantages of the change should overshadow any perceived cost of making the change. Hence, if an individual perceives SRH information or interventions as not beneficial, he/she is unlikely to make changes to improve his/her and perhaps engage in healthy SRH. This is especially if they perceive their unhealthy lifestyle as appropriate per their understanding, thereby leading to adverse effects on their health.

Apart from the young person's attitudinal changes and ultimately behaviour change due to the information received, the multi-component approach with regards to generating demand and improved access to SRH services is also an important basis for this study. Studies link this approach to successful SRH interventions for adolescents (Kesterton and Cabral de Mello,

2010; Bowring et al., 2018). It goes beyond the adolescent or emerging adult as an actor to the various roles required to demand generation for the programmes. Essentially, adolescents benefit from different interventions tailored to ensure their demand for the programmes.

DATA AND METHODS

Study design and recruitment

The study uses in-depth interview and focus group discussion data from youth aged 18-24 years. The male and female youth were categorized into three distinct socio-economic stages: tertiary students, informal workers, and apprentices. Thirty individual interviews comprising 15 males and 15 females were conducted, with five individuals from each socio-economic stage. In addition, 10 focus group discussions were conducted and were segmented by gender, socio-economic stage and age (only for the informal workers and apprentice groups were segmented into 18-20 year and 21-24 year age groups).

The study was conducted in the La-Nkwatanang Madina Municipality whose capital, Madina, has been one of the most densely populated urbanized localities in Accra. All informal workers and apprentices were selected from various locations in Madina and its environs. The higher educated students were recruited from two public universities located around the municipality, the University of Ghana (UG) and the University of Professional Studies, Accra (UPSA). The interviews were conducted between December 2020 and January 2021, with a 5-day training session conducted with six interviewers during the last week of November 2020. The interviews were conducted in Twi and/or English (the preferred language of the participant).

Data Analysis

All the interviews were audio recorded and transcribed by the six interviewers. The study used data analysis software, Atlas.ti, and employed the use of thematic analysis separately for the individual and group interviews. Patterns were identified within the data after ascribing both deductive and inductive codes to the text, which were then grouped into various levels of themes (Braun & Clark, 2006).

FINDINGS

Participants' Characteristics

A total of 30 IDI and 72 FGD participants were recruited for the study (see Table 1). Their ages ranged from 18 to 24 years with female IDI participants averaging about one year older than their male counterparts. FGD participants were averagely the same age – 21 years old. Most of the male informal workers and apprentices had some level of senior high school education while female participants had a mix ranging from no education to some level senior high education. Equal numbers of five male and female participants in each socio-economic group were recruited for the IDIs. Unfortunately, a smaller proportion of male informal workers were selected for the FGDs than the other groups.

Table 1: Characteristics of IDI and FGD participants

IDI Participants	**Males**	**Females**
Average Age (Age Range)	21.5 (19-24)	22.7 (20-24)
Educational Attainment		
None	6.7	6.7
Primary	6.7	13.3
Junior High School	6.7	20.0
Senior High School	46.7	26.7
Tertiary	33.3	33.3
Socio-economic Groups		
Informally employed	33.3	33.3
Apprentice	33.3	33.3

Tertiary students	33.3	33.3
Total	**15**	**15**
FGD Participants	**Males**	**Females**
Average Age (Age Range)	21.2 (18-24)	21.0 (18-24)
Educational Attainment		
None	0.0	5.6
Primary	2.8	8.3
Junior High School	25.0	33.3
Senior High School	36.1	30.6
Tertiary	36.1	22.2
Socio-economic Groups		
Informally employed	27.8	38.9
Apprentice	36.1	38.9
Tertiary students	36.1	22.2
Total	**36**	**36**

Knowledge and experiences with reproductive health activities and programmes

Programmes and activities mentioned and experienced by emerging adults:

The findings indicate that the emerging adults received education on SRH from their various Junior and Senior High Schools. The talks were centred on preventing sexually transmitted infections/diseases, pregnancy prevention methods through contraceptive use and abstinence, as well as personal hygiene.

> *I learnt you should protect yourself by wearing condoms when having sex to prevent pregnancy and STDs so I learnt a lot. (Female informal worker - IDI)*

The participants had knowledge about some of the Ghana Health Service-led programmes and services but said they rarely used them; although some had received education from private organizations such as Marie Stopes.

I have heard about hospitals that have counsellors that talk to teenagers about these problems and all that, but I am not… I have never been to them. (Male tertiary student – IDI)

I: What about the Marie Stopes? Why will you go to them?

P: You see they educated me on contraceptives, most at times when they come all they educated us on is about contraceptives, the use of contraceptives and then condom and stuffs….I will go to them because I know what they have done before, they have done that before. (Male tertiary student – IDI)

Participants also mentioned receiving information from traditional media – television shows with ASRHR messaging on such as the "You Only Live Once (YOLO)" [a TV show for youth].

Benefits received from some reproductive health activities and programmes:

The participants indicated some benefits derived from reproductive health programmes which included how to use condoms, abstinence, and preventing unwanted pregnancy through available family planning services.

It was beneficial to me in so many ways. I learnt it was bad for a lady to have an abortion so I decided to abstain at the time. (Male apprentice - IDI)

So, the benefits I had was if it happens that we are going to have sex we should protect ourselves and one way is using the condom, so with the condom they taught us how to use it or to do family planning and stuff, that helped us. (Male apprentice - IDI)

Some friends in senior high school who had partners accepted and started using the injections and IUD to prevent pregnancy and after completion I never heard of them getting pregnant. So, it helped them. (Female informal worker - IDI)

Some were of the view that programmes were tailored in a way not to take the views of young people, who are beneficiaries of the programme, into account. They were therefore, unable to fully appreciate the SRH programmes.

> *I think most of them are not open minded, and they are sharing their personal views, while I have an opinion to share, they don't want to listen. They have their view, that is, this is what is supposed to be done so they are not listening to me…Most of the things I know today are things I read on my own. All I learnt from these programmes is how well to wear a pad. That is, it. (Female tertiary student - IDI)*

Appropriate content and information must be shared:

Another finding noted was the desire of the youth to receive accurate and relevant SRH information from those they relied on to teach them. Female university students tended to report this. One indicated that during her senior high school days, programmes that were organized to address SRH did not tackle relevant and pragmatic issues that contemporary youth are faced with. They were rather treated as novices; thus, although helpful, the right information was not always given:

> *We just go back to our rooms and laugh and discuss among ourselves how naïve the teachers think we were. But honestly, some are helpful. (Female tertiary student - IDI)*

> *I remember I went for a programme and we were told that when you have sex your mother will find out. The first day I had sex I was worried and all that because it wasn't planned but when I got home my mother didn't notice and I kept looking at her side but she didn't notice it. That actually made me sexually active because my parents couldn't notice I had sex. That was when I realized most of what they said were lies…(Female tertiary student - IDI)*

Ways to improve SRH education and services for youth

SRH programmes to be made available for university students:

One suggestion to improve services for university students was for sexually active individuals to receive frequent education on SRH topics. Some youth had no knowledge of some issues as university students.

> *For example, like me, I didn't know anything about it [contraception] even I was in university level 100 and I didn't know anything about condoms, emergency contraceptives. Yes, I didn't know anything about it, I think the education should be more frequent because a lot of youth are out there and they don't know anything about it. (Male tertiary student – IDI)*

The participants also suggested that SRH topics should be included in the University's curriculum since they were unable to abstain; and the counselling centre was the appropriate department to teach these topics.

> *So, I think it should just be added to the curriculum, that's why the [counselling] centre can have a topic that is meant to educate this sexual thing. Besides, we are in the University too, we are asked to balance everything, so you balance, small sex, movies and everything is balanced. So, you can't say you are abstaining. (Female tertiary student – FGD)*

Using telehealth services and social media channels:

Some university students suggested that demand generation strategies could utilize m-health services – use of the phones, online support, and social media channels. One participant referred to undergraduate students as online babies that preferred such mediums for accessing information. Social media was also mentioned as a mode of informing youth about SRH topics.

The need for confidentiality protocols was also emphasized as a requirement through this medium. Young people mentioned that for such programmes to be effective and efficient within the university environment, anonymity and/or confidentiality was paramount. Even though they spoke of the relevance of having in person programmes, they believed that in person meetings/programmes would lead to profiling, and negative and judgemental comments from other students, faculty, programme organizers, etc. Tertiary students stated:

> *I don't know but it [an SRH programme] has its negative effects because some youth will not feel comfortable coming for these programmes. Yeah, but even though it is good, it is informative, they will deliver a lot of information over there but from the youth's perspective, I don't think they will come because if they come…like its… this kind of impression towards… maybe from my side, the way I see it because when I come for these programmes that is maybe sexually related and its effect on the youth, I am coming to learn but somebody somewhere will think that I will come there learn it and have sex, but it's to protect myself. (Male tertiary student - IDI)*

> *For the youth, I don't think they are ready to use the school counselling centre, so there should be a different method or a different way. Yeah, for now, I think they are all on their phones so I think it should be an online educational programme, yeah that one should be okay. (Female tertiary student - IDI)*

> *You know, let me say now we are online babies so if there can be something online that the person can just go, easily accessible to share something. This kind of confidentiality been trusted at its peak, I believe if not 100% more will pop up there. (Female tertiary student - IDI)*

Master crafts persons to assist in shaping and training apprentices on their SRH:

Apprentices discussed advice received from their master crafts people on SRH issues. An example of advice one female apprentice had received included issues on feminine hygiene, which was deemed important especially for those in relationships.

> *My madam advises me every day, to look neat and presentable as a lady to attract customers and she also told to me to bath twice a day, wash my clothes and I shouldn't repeat under wears twice when am in a relationship. And some because of poverty do not wear any panties at all. So far as you a lady anytime you get something small (money) save a little in order to purchase your personal items. (Older apprentice females – FGD)*

Creation of community friendly centres:

The participants felt that the need for information is imperative to the youth, therefore, creating centres that they can easily access will be of great help.

> *With that, the districts or localities should form groups just like we are discussing today, form groups and meetings which we can attend regularly like twice in week to educate us more. Because even now you find a twelve-year-old who is pregnant. While others their mothers do not advise them on these things, so people like that do what they want. So, such creation of groups will be very beneficial. (Female informal worker - IDI)*

Friendlier and more receptive attitudes should be provided:

Participants also advocated for friendlier and more receptive approaches in dealing with the youth during sexual reproductive programmes. Parental guidance and advice on SRH were also needed from the beginning, all in a welcoming environment.

I think there should be people willing to talk. Sometimes I just come to campus and I want someone to talk to about my sexual and reproductive health, my mental health, careers counselling, but all these Ghanaian people I think are judgmental so I think the youth are scared of talking because they will tag you in a negative way. So, I think people should be open minded, it is not something that happens in a day but we should try not to be judgmental and not judge other people. If I talk to you, you do not have to make me feel like what I am doing is a sin, you need to educate me on it. So, I do it the right way. (Female tertiary student - IDI)

Someone like my madam when you talk about such things then she calls you names. But when the education is more people know and appreciate it more. (Female apprentice - IDI)

Our parents, if they should open up with you in the first place, I mean when you are about growing up, they should have a chat with us about it, but then they don't create that environment so, children often tell their friends or ask for advice from them. Because if you should tell your parent, I think they will kill you. (Female tertiary student - IDI)

Male perspectives

Men are left out of the programmes or are viewed as perpetrators:

SRH programmes are generally considered critical interventions that have provided immense support to improving young people's health, however, males tended to have varying views. One of such views is that these programmes are mostly strategically done to target young girls while little or no attention is given to them young boys. Male participants mentioned:

They used to say we should avoid the women, the same way the women should avoid us. They mostly call the women and advise them on that. They usually call them to one side to educate them but mostly it was the women they group to one side to advise. (Young male apprentice - FGD)

Others also stated that during such programmes males are made to be seen as the perpetuators or the evil ones who lead their fellow female students astray and so should be avoided at all cost. The education also included comments that indicated a disapproval of their risky behaviours which they did not like. Despite gaining useful information, the "attacks" on males deterred them from attending or enjoying the programmes. Young male mentioned the following:

For us at that time it [SRH education] was like against us. What they were saying was against us, it was against us, so the boys there did not… we were learning one or two of them [SRH information] like the use of condom and others but we were not happy with the rest. (Young male apprentice - FGD)

They were talking about this teenage pregnancy and they should be smart they shouldn't be following boys who would come and destroy their lives, yeah that was the main thing they were talking about. They didn't even say anything about using condom or anything, they just said they [girls] should not follow boys, they were making us look bad…so I said I wouldn't go for that thing again. (Young male apprentice - FGD)

Okay it was good for me, for this I would say it depends on the kind of person you are, if you are the kind of person who likes to have a lot of sex and all that you would think they are trying to bash you and all that but they are really trying to educate you, you get me? (Male tertiary student, IDI)

Yeah, what they said and I didn't like was that… when we were in school, we did bad things we were dating so when they come and say if you are not ready to date don't date, those who do that is not good, at this point the boys become "hot". So, the whole place became quiet but when they said when you have sex use condom then the whole place became noisy but when they say those things it looked like it was against us so we didn't agree with the nurses on that. (Young male apprentice - FGD)

Men have no interest in the programmes:

In addition, some males mentioned never physically attending any SRH programmes, whether at school or through other organized meetings:

I haven't attended any programme (Male informal worker, IDI)

I have never been to a programme like that. (Male - IDI)

Any programmes? No none (Male tertiary student, IDI)

Finally, some males also did not see any relevance in such programmes. They talked about their own opinions about the programmes along with others they had heard. They shared the following:

I: Okay so what about your friends, what have they said about such programmes? Them attending such programmes what have they said about it?

P: Some of them feel it's slow, it's boring .... some of them feel it's very boring.

I: Alright. So, when they say boring, what does that mean?

P: It wastes a lot of time. (Male tertiary student - IDI)

Even my female friends afterwards some of them got pregnant, so with that I don't see any benefit they got from it. (Male apprentice – IDI)

DISCUSSION

To the best of our knowledge, this study is the first in Ghana to assess how emerging adults perceive the appropriateness of the existing SRH programmes to effectively inform them for the right knowledge and attitudes to engender behavioural change as well as improve access to health care services. Though participants expressed awareness of reproductive health programmes and services they rarely utilised these services. Some preferred SRH services offered by private institutions such as Marie Stopes.

There was a myriad of benefits of SRH activities and programmes to emerging adults and some of these varied for males and females. These benefits included protective measures aimed at abstinence, appropriate contraceptive use and the use of sanitary pads. That notwithstanding, the content of some health programmes did not reflect the SRH needs of emerging adults. They felt the information provided by their teachers or mentors did not reflect realities or lived experiences of emerging adults. The programmes seemed to be targeted at early adolescents but not relevant for young adults. Evidence from rural KwaZulu-Natal in South Africa indicates that SRH programmes that provide accurate and appropriate SRH information and service tend to increase the resilience of young people against exposure to HIV and SRH risk (Zuma et al., 2020). SRH programmes need to consider providing information suitable for the age and sexual experiences of emerging adults.

Applying the behaviour change models to the above discussions, then, it implies that in the education programmes individuals are to be made to understand that SRH is a health problem which could affect the health of every youth including those aged 18-24 years, and thus the

need for behavioural change. In view of the Health Belief Model, individuals should be made aware of the magnitude of their susceptibility to any poor health outcome associated to SRH. Therefore, accurate information and the benefits of avoiding risk-taking behaviour should play a central role in the messages of the public SRH education. This, the study suggests, may be better received than messages instilling fear and false information. Due to these barriers, knowledge gained at that level is lacking due to misinformation and that affects their current and future attitudes and behaviours.

One key objective was to understand the male perspective of SRH programmes and the significance it had for them. The results indicate that males are as vulnerable as females since there was no significant difference in the views of both sexes. Rather, men felt the programmes either side-lined them or accused them of enticing young girls and perpetuating risky sexual behaviour. Their avoidance of such programmes puts them at a disadvantage and may have negative consequences for young women while in relationships. The GHS is championing the increase in the demand for family planning using communication to enhance males' participation by engaging male opinion and religious leaders in collaboration with their partners. The evidence derived from this study suggests more needs to be done in that regard. (Government of Ghana, 2020).

As suggested by the youth in the higher education a digital approach for educating youth is one of the platforms most preferred by this category of youth. It is important to note that the GHS has embarked on such interventions. For example, GHS has introduced the GHS-FH mobile app and the YMK (You Must Know) app which have close to several thousand service providers using the application. On the GHS-FH application, there is the e-compendium of family planning services and commodities. Providers can refer the youth aptly and it is also used for promoting SRH information (Government of Ghana, 2020). The only critique is that

all these interventions which are meant to target all youth are focused primarily on adolescents aged 10 to19 years (Government of Ghana, 2020). Thus, emerging adults are lacking such an innovative and age-appropriate interventions to improve their SRH.

Stigmatized SRH issues tend to reinforce clandestine sexual activity and response. Further, emerging adults themselves suggested ways to improve SRH education and services with varying suggestions by educational status. The recommendations they made targeted not only the health service supply side but also their parents, peers, mentors and school or work systems. The findings from this study indicate a multi-component multi-sectoral approach to enhancing the effectiveness of existing SRH programmes for emerging adults in urban areas in Ghana.

For instance, the policy implementation structure in Ghana allows collaboration between the GHS and the Ghana Education Service. Among the findings of this study, the most relevant for intervention policy and programme relate to youth-centred programming. SRH telehealth interventions are beginning to take root in low- and middle-income settings. However, there seems to be an increasing interest and prospect, particularly from emerging adults who are currently pursuing tertiary education in Ghana.

CONCLUSION

The findings indicate that urban emerging adults require SRH information. In order for these programmes to be successful, diverse approaches should be used to provide information to the youth. The communication channels, content of messaging, attitudes of those providing the messages, and platforms used to target the youth must be considered to ensure proper dissemination of messages to the right people. However, we found that some organized programmes failed to deliver the appropriate messages, so they rather promote sexual activity. The youth also expressed that they feel intimidated to share their views, especially when faced

with SRH issues. They felt uncomfortable discussing their SRH issues with the parents or adult professionals supposed to attend to their SRH needs. They described the Ghanaian culture as not being conducive to listening to their challenges in a non-judgmental manner in order to advise appropriately. The findings suggest that more avenues are needed for appropriate, accurate and non-judgemental SRH education to be made available by the Ghana Health Service as well as other stakeholders that directly relate with emerging adults across all economic and educational groups (for example, university counsellors and master crafts persons). Also, the adoption and implementation of one policy for youth (10-24 years) must be revised, since some of their SRH needs differ, as indicated by the findings. In addition, males require tailored and inoffensive interventions, while the different categories of youth interviewed (informally employed, tertiary students and apprentices), also require suitable, targeted and evidence-based interventions since the findings suggest that their present needs are not being met.

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