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# Exploring the Use of Adolescent Sexual and Reproductive Health Services: Opinions of Adolescents, Parents and Service Providers

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**Abstract:** *Adolescent sexuality has become a global public health concern. Thus, in order to respond to the sexual and reproductive health (SRH) needs of adolescents in Ghana, the government has developed various policy initiatives. This qualitative study explored the influence of adolescent-friendly health services on the sexual and reproductive health of adolescents in the Tamale metropolis of Northern Ghana. A purposive sampling method was used to recruit 19 participants and in-depth interviews were conducted to gather data for the study. The findings indicated that adolescents utilized the promotive, preventive and curative services provided by the adolescent health corner and found the services useful for their SRH. Additionally, it was found that although some of the adolescents utilized the services of the adolescent health corners, they engaged in risky sexual behaviors due to poverty. Furthermore, the study revealed that the adolescent health corner in the study was unable to provide rehabilitative services due to the unavailability of professionals. Based on the findings, we conclude that adolescent sexual and reproductive health programs will have the intended impact on beneficiaries if the various medical and social welfare professionals and organizations collaborate in their efforts to enhance the development and well-being of adolescents.*

**Keywords:** *Adolescents, Ghana, Health, Sexual, Poverty, Reproduction.*

## 1. Introduction

Adolescent sexual and reproductive health has become global concern because there is mounting call for sexual

reproductive health (SRH) services that will address the needs of adolescents, especially in developing countries. Adolescents all over the world have unique sexual and reproductive health needs and accompanying vulnerabilities (Kamau, 2006). Increasingly, many adolescents are becoming sexually active before the age of 20 (World Health Organization, WHO, 2004) and are facing difficulties obtaining reproductive health care. Landmark advances in adolescent sexual and reproductive health were made in 1994 at the International Conference on Population and Development (ICPD) held in Cairo. At the conference, reproductive health was defined as a state of complete physical mental and social well-being and not merely the nonexistence of disease or infirmity in all matters related to the reproductive tract, its functions and processes (WHO, 2002).

Sexual health on the other hand, is the experience of the ongoing process of physical, emotional and sociocultural well-being as it relates to sexuality (The Pan American Health Organization and WHO, 2001). Sexual and reproductive health therefore implies that people are able to have a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if, when and how often to do so (Odoi-Agyarko, 2003; Roudi-Fahimi & Ashford, 2008). The ICPD 1994 conference recommended that reproductive health education, information, and care be accessible to adolescents. Also, at the conference, the vulnerabilities of adolescence were highlighted and the need for greater recognition of adolescents as special individuals with special needs was emphasized (United Nations, 1997). The 38 countries from sub-Saharan Africa, including Ghana which participated in the conference committed themselves to a program of action aimed at providing adolescents with SRH services that would help adolescents understand their sexuality and be protected from sexual health risks (United Nations, 1997).

Fulfilling the commitment made at the ICPD, Ghana's Ministry of Health in 1996 initiated the Adolescent Health

Development Program (AHDP) to provide health services for adolescents (National Adolescent Health and Development Program, NAHDP, 2005). Also, the Reproductive and Child Health (RCH) unit of Ministry of Health (MOH) carried out an organizational analysis of strengths, weaknesses, opportunities and threats of the MOH to enable it develop a cost effective program to address the reproductive health needs of young people with emphasis on adolescents (NAHDP, 2005). The need for adolescent-friendly health services was recommended by all stakeholders to help address adolescent SRH and other health issues. The suggestions emphasized that existing adolescent corners in public health institutions should be revamped and new ones created, primarily to handle adolescent SRH challenges (Ghana Health Service, 2009).

Moreover, to respond to the sexual and reproductive health needs of adolescents, the government of Ghana developed an adolescent reproductive health policy in 2000 and a national HIV and AIDS and Sexually Transmitted Infections policy in 2001 (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterson, 2006). The provision of services to adolescents in Ghana was based on the belief that improved adolescent health will directly contribute to achieving key Millennium Development Goals, such as combating the spread of HIV and AIDS, reducing maternal deaths, and developing and implementing strategies for decent and productive work for young people, which will reduce poverty and hunger (Ghana Health Service, 2009). Adolescent health corners are counseling rooms or exclusive places for adolescents within Reproductive and Child Health units, which provide adolescent-friendly SRH health services that are acceptable, appropriate, accessible, affordable, equitable, efficient and effective (NAHDP2005). Currently, there are 129 adolescent health corners that provide promotive preventive, curative, and rehabilitative SRH services to adolescents in various regions in Ghana (Ghana Health Service, 2009).

## 2. Statement of the Problem

Many young people in sub-Saharan Africa face the risk of HIV, sexually-transmitted infections and unintended pregnancies (Biddlecom, Munthali, Singh and Woog, 2007). This notwithstanding, pregnancy and sexually transmitted infection (STI) prevention and treatment services and HIV testing are under-utilized among sexually-active adolescents. The majority of sexually-active adolescents are not well prepared to prevent pregnancy since a large proportion of them do not use contraception (Biddlecom et al., 2007). Also, they may not seek treatment for STIs because of lack of knowledge about places for getting treatment, lack of awareness of STIs or because of perceived barriers in accessing SRH services (Biddlecom et al., 2007).

The most common barrier to obtaining either contraceptive methods or STI diagnosis and treatment by teenagers is social stigma, in the form of either fear or embarrassment that may explain why their access to SRH services are not optimally met (Amuyunzu-Nyamongo, Biddlecom, Ouedraogo & Woog, 2005; Biddlecom et al., 2007; Dehne & Riedner, 2008). Furthermore, adolescents are likely to try several means at once or go through sequential steps to treat a health problem through self-medication (Biddlecom et al., 2007) given the adventurous nature of most adolescents. This may worsen the situation and consequently delay the healing process as most sexually-active adolescents are more in need of sexual and reproductive health services due to their possible exposure to sexually transmitted infections.

Despite the call by ICPD and Ghana's commitment, which was reflected in the establishment of the adolescent health corners, adolescents face SRH risks, such as early sexual debut, unplanned pregnancies, unsafe abortions, sexually transmitted diseases, including HIV and AIDS, as well as harmful traditional practices like female genital mutilation (NAHDP, 2005). Additionally, Nabila and Fayorsey (1996) noted some risk factors that inhibited programming for adolescents' sexual and reproductive health issues. Among

these were inadequate knowledge and skills on the part of health workers to handle adolescent health issues in a more appropriate manner, lack of information, education and communication materials targeting young people, and inadequate skills by parents and other stakeholders to handle adolescent health issues (Nabila and Fayorsey, 1996).

The AHDP annual report also showed 12.4 percent of institutional based reported pregnancy among adolescents (Ghana Health Service, 2009). Also, the 2008 Ghana Demographic Health Survey (GDHS) reported that eight percent of females and four percent males had sexual intercourse by age fifteen, while 44% of females and 28% males had sexual intercourse by age eighteen (Ghana Statistical Service and Ghana Health Service, 2009). In addition, the 2008 GDHS revealed that Northern Region recorded one of the highest (23%) adolescent motherhood in the country. Moreover, the 2011 annual report of the Tamale Metropolitan Health Directorate indicated that five adolescents aged 10-14 years and 1,887 adolescents aged 15-19 years became pregnant in 2011 in the Tamale Metropolis (Tamale Metropolitan Health Directorate, 2012).

Even though in 2006, twelve adolescent health corners were established in the northern region of Ghana (Ghana Health Service, 2009), not much research studies have examined their impact on adolescent sexual and reproductive health. The sparse literature available has mostly concentrated on adolescent fertility. This research, which is part of a larger study, however goes beyond extant literature by exploring the influence of adolescent-friendly health services on the sexual and reproductive health of adolescents in the Tamale metropolis of Northern Ghana. This is vital because the seminal conference on population and development held in Cairo in 1994 emphasized the importance of SRH for adolescents in order to reduce risks related to early sexual experience, marriage and child bearing (UN Millennium Project, 2006). Early pregnancy and childbirth could adversely affect the health, as well as the future psychological and socioeconomic prospects of both

the teenagers and their children. The objectives of the study were:

1. To find out how the promotive services provided by the adolescent health corners influence the sexual and reproductive health of adolescents.

2. To find out how the preventive services provided by the adolescent health corners influence the sexual and reproductive health of adolescents.

3. To find out how the curative services provided by the adolescent health corners influence the sexual and reproductive health of adolescents.

4. To find out how the rehabilitative services provided by the adolescent health corners influence the sexual and reproductive health of adolescents.

## 3. Methodology

*Research Design*

A qualitative research methodology was employed for the study. Qualitative research methods give an understanding of the situation in its uniqueness, presenting what respondents perceive about the situation and what their meanings are (Patton, 2002). Specifically, a phenomenological approach was used because it provides a description of what people experience and how they experience what they experience (Patton, 2002). The phenomenological paradigm was useful because it provided complex descriptions of how respondents experienced the phenomenon being studied (Mack, Woodsong, Macqueen, Guest, & Namey, 2005). In this study, participants were offered the opportunity to share their experiences regarding the services provided by the adolescent health corners.

*Study Area*

The study was conducted at the Adolescent Corner within the Tamale Central Reproductive and Child Health (RCH) unit in the Northern Region of Ghana. The area was selected for the study because according to 2008 GDHS, the percentage of females aged 15-19 who had begun childbearing was 23% in the Northern region, and this was one of the highest compared to the other regions. In order to achieve the objectives of this study, the Tamale RCH unit was purposively selected because of its central location, making it easily accessible to clients. In addition, it is well resourced in terms of facilities and personnel compared to adolescent corners in other RCH units in the area.

*Participants*

For this study, a total of nineteen respondents (four adolescents, ten parents and five staff of the adolescent health corner of the Tamale central RCH) were recruited through a purposive sampling method. This allowed for the selection of individuals whose experiences provided issues of importance to the purpose of the study (Patton, 2002). The adolescents (two males and two females) were enrolled in Junior High School and were between 16 to 19 years. The parents (eight females and two males) of adolescents who had accessed the services of the adolescent health corner were between ages 36 to 49 years. The five female staff aged 51 to 53 years had worked at the adolescent health corner of the Tamale central RCH unit between one to three years.

*Data Collection Procedures*

Data was collected from respondents through in-depth interviews using open-ended questions. The open-ended interview questions allowed the researchers and participants to discuss emerging issues in much detail. Additionally, the data collection method enabled the researchers to probe participants' responses for elaboration and to explore key issues raised by respondents, which were valuable for the

study. The consent of the respondents was sought before the in-depth interviews were conducted. For the adolescents, consent was sought from their parents, as well as the willingness of the adolescents themselves to participate in the study.

*Data Analysis*

Participants' responses were recorded verbatim and read thoroughly and repeatedly. The data was organized under themes and sub-themes based on the narrative explanations and opinions of respondents. The researchers analyzed specific statements and searched for possible meanings that made the information more meaningful and understanding (Creswell, 1998). The most illustrative quotations were extracted and used to support important points that emerged from the data gathered from respondents.

## 4. Findings and discussion

The first objective of this study related to the promotive services provided by the adolescent health corner in the Tamale central hospital. The promotive services explored were information, family life education, communication, counseling and contraceptive use. During the interviews, the key informants provided explanations, which indicated that these services, utilized by adolescents, had contributed to an improvement in their sexual and reproductive health. The findings corroborate Reddy, Fleming and Swain's (2002) finding that that there is a strong positive correlation between a youth-friendly environment and sexual and reproductive health service utilization by adolescents. As expressed by four respondents:

> *". . . the introduction of adolescent-friendly health services like information, education and communication services in our health institutions has improved the sexual and reproductive health of adolescents . . . unwanted pregnancies and unsafe abortions have reduced drastically*

*among adolescents. These days, hospitals and clinics in Tamale hardly receive induced abortion cases, we do not hear of them as we used to in the time past. Adolescents with sexual and reproductive challenges now know where to go and whom to go for help". (Staff, Adolescent Health Corner).*

*". . . I usually visit the adolescent health corner for information and education on sexual and reproductive health . . . I am sexually active and currently I have two male sexual partners . . . I know having two sexual partners is dangerous for my life . . . I am from a very poor home and I need money to pay my school fees and get other necessities . . . these two men are indeed helping me meet my needs . . .". (18-year old female student).*

*"I woke up one early morning and realized that I had discharged sperms for the first time . . . became afraid and informed my brother and he took me to the adolescent health corner. … I was counseled and advised not to engage in early and unprotected sex since I am now capable of impregnating female colleagues . . . the counseling and education reduced my fears and worries and this has helped me to discipline my sexual life". (16-year old male student).*

*". . . adolescent health services are very helpful because our daughters go there for education and counseling on sexual and reproductive health . . . they have positively influenced the sexual life of my daughter because her sexual life has changed for the better . . . some of the girls take preventive measures by employing family planning methods such as using contraceptives, this service is helping girls to continue their education without picking unwanted pregnancies . . . I educate my daughter very well on sexuality, especially the consequences of engaging in unprotected sex". (Parent of an adolescent).*

The findings showed that the promotive services were useful for adolescents in terms of their sexual and reproductive health. For instance, a respondent adolescent indicated that the services helped girls to prevent unwanted pregnancies, which enabled them to continue their education. It is also important to educate male adolescents about their SRH issues since it would help reduce teenage pregnancies. As indicated by the male adolescent respondent, the counseling services helped him to discipline his sexual life. Similarly, in a study on utilization of reproductive health services by adolescents, Kamau (2006) noted that guidance and counseling on the dangers of unplanned pregnancy, provision of contraceptives as well as information, education and communication materials on HIV and AIDS were methods that were helpful for adolescents in Kenya. Additionally, as Mclyntre (2002) opines, providing information on adolescents' sexuality helps avert SRH health problems and create more mature and responsible attitudes.

As found in this study, the role of poverty cannot be ignored in discussions on adolescent sexual and reproductive health. It was revealed that although some adolescents accessed the services of the adolescent health corner, they engaged in dangerous practices, such as having multiple sexual partners. It was found that poverty was a major factor that pushed females to engage in such practices. This finding suggests the need for a multi-sectoral approach in addressing the sexual and reproductive health issues of adolescents since varied factors play a role and influence adolescents' sexual and reproductive lives. Manlove, Terry-Humen, Papillo, Franzetta, Williams, and Ryan (2002) reported that adolescents living in poverty stricken neighborhoods were more likely to engage in sexual intercourse. Also, Sarri and Phillips (2004) concluded that adolescents subjected to disadvantaged circumstances, such as living in poverty, were more at risk of engaging in sexual intercourse.

Contrary to the findings of this study regarding adolescents utilizing the services of the adolescent health corners, other studies have reported poor knowledge and

usage of contraceptives, high fertility rates and high incidence of HIV among adolescents in Ghana (Abdul-Rahman, Marrone, & Johansson, 2011). Besides, the 2008 Ghana Demographic and Health Survey indicated that about 14% of all Ghanaian female adolescents had begun child bearing, with only eight percent of them using contraceptives (Ghana Statistical Service & Ghana Health Service, 2009). These adolescent mothers were reported as having about 62% unmet need for family planning compared to 33% among 30-34 year olds (Abdul-Rahman et al 2011; ICF Macro, 2010).

Reports on adolescents' use of promotive SRH services, especially the use of contraceptives remain divisive because in this present study the respondents indicated that adolescents utilized these services, but other studies have reported otherwise. For example, Biddlecom et al (2007) note that contraceptive and STI services are under-utilized in African countries by sexually active adolescents because they simply do not know the services exist. Also, Hock-Long, Herceg-Baron and Whittaker (2003) argue that parental consent requirements impose a structural barrier that hinders adolescents' access to sexual and reproductive health services. In this present study, it is likely that the parents of the adolescents who had accessed these services found the services to be useful and therefore encouraged their children. However, other stakeholders including parents, community members and leaders who may not find these services useful would not encourage their adolescents to visit the adolescent health corners.

As concluded by Awusabo-Asare, Abane and Kumi-Kyeremi (2004), while promotive health programs are impacting positively on adolescents' sexual and reproductive health, some religious bodies and traditional rulers have argued that these programs promote sexual promiscuity among adolescents. Since pre-marital sex, particularly among adolescents is unacceptable in most Ghanaian cultural and religious settings, it is extremely difficult for the adolescence to discuss any sexual problems they might have with adults, both health and non-health professionals, for

support (Abdul-Rahman et al., 2011). In this regard, some anecdotal evidences have shown that some health workers turn away young adolescents who visited health facilities for family planning services (Abdul-Rahman et al., 2011).

In this study, the second objective explored how the preventive services provided by the adolescent health corners influenced adolescents' sexual and reproductive health. The preventive services covered were (a) outreach programs in schools and communities and (c) membership in adolescent clubs, such as virgin clubs. The findings revealed that outreach programs in schools and communities and membership in adolescents clubs enhanced the sexual and reproductive health of adolescents in the study area. The following statements from some respondents during the in-depth interviews illuminate the findings:

*". . . because of the information and education I receive from the nurses during our virgin club meetings, I want to maintain my virginity till I marry . . . the services are very good and are helping some of us from running into early sex, unwanted pregnancy and abortion . . . I serve as a role model to my peers but it is not easy for me because some of them are sexually active and always mock at me . . . "(19-year old female adolescent).*

*". . . during outreach programs, adolescents are strongly admonished to abstain from premarital sex until marriage . . . adolescents who become pregnant are advised to safely terminate unwanted pregnancies . . . wanted to terminate pregnancy were counseled and advised to visit a clinic for comprehensive abortion rather than resorting to unsafe abortion . . . most of the adolescents listen to us and do what we advise them to do". (Staff, Adolescent Health Corner).*

*". . . adolescent clubs in the metropolitan area are helping adolescents to improve their sexual and reproductive health. At meetings, they are advised about the dangers of drug abuse, indecent dressing, early and unprotected sex, as well as the need to be assertive and report negative cultural*

*practices . . . female genital mutilation, forced marriages . . .". (Parent of an adolescent).*

The responses by the participants suggest that the preventive services were useful for adolescents' sexual and reproductive health. This confirms Weissberg, Kumpfer and Selingman's (2003) view that preventive health services help reduce adolescent sexual and reproductive health problems. Additionally, Kamau (2006) suggests that advice services regarding early sexual initiation, appropriate dressing, drug abuse, pregnancy tests and relating with parents, were valuable for adolescents' sexual and reproductive health. The development of attitudes about sexuality and reproduction are strongly affected by several variables, such as peer relationships, school environment, family circumstances, as well as personal vulnerability. Thus, the benefits of preventive health services cannot be underestimated because adolescence is not a homogeneous experience.

Sexual and reproductive health outreach programs for adolescents are important, particularly in Tamale because the 2008 Ghana Demographic Health Survey showed that by region, the percentage of females aged 15-19 who had begun childbearing was twenty-three percent in the Northern region of Ghana (Ghana Statistical Service & Ghana Health Service, 2009). Assisting adolescents to prevent early pregnancy is vital because pregnancy and childbirth could negatively affect the health, as well as the future socioeconomic prospects of both the teenagers and their children. Membership in adolescent clubs was also found to be useful for adolescents in terms of their sexual and reproductive health because the meetings provided a platform for learning and sharing of experiences.

Since most adolescents are unwilling to disclose their sexual activities to adults, especially providers at health facilities, making sexual and reproductive health services available at different types of outlets is useful. Adolescents are more likely to patronize the services of adolescent friendly outlets because they get opportunities to express themselves freely (Fielden et al, 2006; WHO, 2006).

Additionally, the school and community-based adolescent clubs are essential because they could serve as avenues for health professional to access adolescents, plan and provide effective targeted sexual and reproductive health intervention programs for adolescents in a friendly environment.

*Curative Health Services and Sexual and Reproductive Health of Adolescents*

Exploring how the curative services provided by the adolescent health corners influence the sexual and reproductive health of adolescents was the third objective of this study. The curative services investigated included abortion and post abortion care, pregnancy, prenatal, delivery and post natal care. During the in-depth interviews three key informants noted:

*". . . after providing counseling services, it is important to support pregnant teenagers and their families to abort pregnancies if they decide to do so . . . if forced to keep the pregnancy, teenagers are most likely to use unorthodox methods which are likely to kill or harm them and their fetuses . . . a 15-year old girl became pregnant as a result of rape . . . the man who raped her refused to accept responsibility . . . girl and her mother came to the adolescent health corner for services. They were counseled and educated on the implications of teenage pregnancy and how the girl could be assisted . . . opted for comprehensive abortion to enable the girl continue her education. We later reported the conduct of the man to officials of Domestic Violence and Victim Support Unit of the Ghana Police Service for further action." (Staff, Adolescent Health Corner).*

*". . . the adolescent corners are very good because they are helping our teenagers a lot to improve their sexual lives . . . these days we rarely hear of unsafe abortions by teenagers . . . used to be very common sometime ago . . . because of adolescent health services, most girls now know where and whom to go to when they need help . . . very happy that such services are now available . . . adolescents should be warned*

*not to engage in unhealthy sexual life styles because of the availability of such services". (Parent of an adolescent).*

*". . . staff of the health corner advised my daughter on how to take care of herself and her baby . . . educated her on contraceptive use to avoid another unwanted pregnancy, good nutrition and personal hygiene . . . she was also advised to go back to school . . . the encouragement made her feel happy and I can see a dramatic change in how she handles herself and the baby in terms of personal hygiene and nutrition". (Parent of an adolescent).*

Given that there are only a few facility-based studies and household surveys with data on abortion in Ghana (Awusabo-Asare et al., 2004), the findings of this study regarding abortion is useful. Although under the laws of Ghana, abortion is legally permissible under certain conditions (if the pregnancy is as a result of rape or incest or if the pregnancy is a threat to the health of the mother or the fetus), abortions are underreported mainly because among various ethnic groups in Ghana, there is a social stigma associated with abortion (Bleek, 1981; Nabila, Fayorsey & Pappoe, 1997). The social stigma is often related to community sanctions and shame associated with pre-marital childbearing (Adomako, 1991). As found in this study, adolescents in the study area used the hospital for their abortions and according to the key informants the adolescents did so due to their wish to continue education, among others. This is similar to the findings of a qualitative study among female teenagers aged 13-19-years in Accra, Ghana. The researchers found that adolescents who had experienced at least one unintended pregnancy utilized clinics and hospitals for their abortions (Henry & Fayorsey, 2002).

It is noteworthy to mention that the findings notwithstanding, there are still a majority of teenagers who use unorthodox and harmful methods to terminate pregnancies in Ghana. Many scholars (e.g., Bledsoe and Cohen, 1991, Awusabo-Asare et al., 2006 and Aderibigbe, Araoye, Akande, Musa, Monehin and Babatunde, 2011)

report that the pattern indicates that most pregnant adolescents who seek to terminate pregnancies are more likely to resort to self induced abortions or untrained abortionists, which may result in complications. According to Afenyadu and Goparaju (2003), most teenagers employ harmful but inexpensive methods to terminate pregnancies. Using dangerous methods to terminate pregnancies is common among adolescents because they often seek advice from their peers, dread of being labeled by health care professionals as promiscuous, cannot afford to pay for the services, among others.

In this study it was also revealed that adolescents utilized the adolescent corners for prenatal and postnatal services. Provision of these services is vital in the Northern region where the study was conducted because the 2008 GDHS indicated that the percentage of women aged 15-19 who had begun childbearing was 23 percent, which was one of the highest in Ghana (Ghana Statistical Service & Ghana Health Service, 2009). Additionally, extant research findings (e.g., Awusabo-Asare et al., 2006; Aderibigbe et al., 2011 and Gichangi, 2003) have shown that teenage pregnancies are mostly unintended or unwanted. Adolescent mothers need sexual and reproductive health services, especially in Ghana because births to adolescents have the highest infant and child mortality (GSS and MI, 1994 and 1999; Ghana Statistical Service and Ghana Health Service, 2009).

As indicated in the 2008 GDHS, the high infant and child mortality may be due to teen mothers being more likely to experience complications during pregnancy and delivery leading to higher morbidity and mortality for both themselves and their children. Awusabo-Asare et al (2006) argue that very young females may not be physiologically mature enough to give birth and in some instances their physiological immaturity may become compounded by poor nutrition. This could impose difficult and long-term adverse effects on the health and well-being of both the mother and the baby (Hao & Cherlin, 2004; Meade & Ickovics, 2005). These negative consequences have been documented by scholars, and as a result, society is inclined to stereotype

most adolescent mothers unfavorably (Camarena, Minor, Melmer, & Ferrie, 1998; Domenico & Jones, 2007).

Moreover, since pregnancy, especially among unmarried teenagers is normally unplanned, it could lead to withdrawal of social support (Awusabo-Asare et al., 2006) and foreclosure of teenagers' ability to pursue educational or job opportunities (Ghana Statistical Service and Ghana Health Service, 2009). As indicated in the statement by a key informant of this study, pre and post delivery services, such as counseling on appropriate nutrition and educational opportunities after birth is useful for teenage mothers. Pregnancy is one of the reasons normally cited by females for dropping out of high school (Brindis & Philliber, 2003; Domenico & Jones, 2007). Research has shown that that teenage mothers experience multiple problems including social isolation, drop-out from school, low self-esteem, and neglect of their children (Elfenbein & Felice, 2003; Rothenberg & Weissman, 2002). In order to reduce the stigma most teenagers who become pregnant encounter, they should be educated on their rights, as well as the rights of their children as full members of society. This will enhance their capacity to have a voice and advocate for themselves and their children.

*Rehabilitative Health Services and Sexual and Reproductive Health of Adolescents*

The last objective sought to explore how rehabilitative services accessed by adolescents enhanced their sexual and reproductive health. The areas explored were treatment of psychological trauma, management of female genital mutilation and management of HIV and AIDS. During the in-depth interviews, both the adolescents and parents interviewed indicated they had not accessed any of the rehabilitative health services provided at the adolescent health corner. However, one of the staff at the Tamale central reproductive and child health unit who was interviewed had this to say:

*". . . we alone cannot handle the health challenges of adolescents single handedly . . . we need other professionals like teachers, psychologists, counselors and what have you, to join in the crusade of helping adolescents overcome unhealthy lifestyles which hamper their sexual and reproductive health and development".*

The findings indicated that the adolescent health corner was not resourced to provide rehabilitative health services. This might be due to lack of professionals from different fields, such as psychologists, psychiatrists, gynecologists, social workers, welfare officers, among others to offer rehabilitative health services at the adolescent health corner at the Tamale central reproductive and child health unit. Since adolescents' SRH experiences and needs are multi-faceted and varied (Raphael, 2005; Rothenberg & Weissman, 2002) the adolescent health corners are expected to provide comprehensive SRH services to adolescents. Thus, the unavailability of different health and psychosocial well-being professionals could adversely affect the services offered by adolescent health corners.

Franklin and Corcoran (2000) note that while there are hundreds of adolescent sexual and reproductive health programs available to teenager in contemporary society, it is difficult for educators and practitioners to know which of these programs serve as best practices. Successful programs are characterized as being multifaceted, incorporating counseling, mentoring, health services, and education on topics, like abstinence, delayed sexual activity, life skills, self-esteem, sex education, parenting skills, and contraception (Domenico & Jones, 2007; Raphael, 2005; Rothenberg & Weissman, 2002; Tonelli, 2004; Zero Population Growth, 1997). Although the promotive, preventive and the curative services currently provided by the Tamale central reproductive and child health unit are useful for the sexual and reproductive health of adolescents, the provision of rehabilitative services, such as treatment of psychological trauma, management of female genital mutilation and management of HIV and AIDS are equally important. Most often sexual and reproductive health

services are beneficial for adolescents if the services are comprehensive.

## 5. Conclusion and Implications

The 1994 International Conference on Population and Development (ICPD) served as a springboard for the design and implementation of sexual and reproductive health programs in many countries, including Ghana. Responding to the SRH of adolescents, the government of Ghana among other initiatives has established adolescent health corners within reproductive and child health units to provide SRH health services to adolescents in Ghana. This study explored the utilization of these services by adolescents and their families in the Northern Region of Ghana.

The findings revealed that adolescents utilized the promotive, preventive and curative services provided by the adolescent health corners and further indicated that the services were useful. It was also found that while some adolescents accessed the services of the health corners, they as well engaged in risky sexual practices due to factors such as poverty. This suggests that in addition to the medical, social, and psychological aspects of adolescents SRH, economic issues are also evident. The implication would be to recognize that adolescents from impoverished backgrounds are at further risk with regard to their SRH. Thus, it is important to support these adolescents and their families by enrolling them in national policy initiatives that address poverty.

Even though the adolescent health corners are expected to provide rehabilitative services as well, it was found in this study that these services were not provided due to unavailability of professionals from other supporting professions. Since successful programs are characterized as being multifaceted, comprehensive and long-term (Raphael, 2005; Domenico & Jones, 2007), this finding is crucial and deserves urgent attention. Given that sexual and reproductive health is a complex issue, there is the need for

collaboration among various professionals and organizations that work to enhance the development and well-being of adolescents' development and well-being. This is important because adolescents are maturing into adulthood and would continually have need of sexual and reproductive health services.

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