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EXEMPLARS IN GLOBAL HEALTH

Policy Brief

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Advancing Adolescent Sexual and Reproductive Health and Rights in Ghana

KEY MESSAGES

- The pregnancy rate among adolescents is 15%, with 67% of adolescent births being unintended, highlighting the need for improved family planning services.
- Modern contraceptive prevalence among adolescents aged 15-19 increased, particularly between 2014 and 2022, with the use of a diverse mix of contraceptives.
- Access to skilled birth attendance has increased significantly for mothers under 20, rising from 44.9% to 86.1% between 2003 and 2022.
- Despite high rates of unintended pregnancies, Ghana has made strides in ensuring safe abortion through legal reforms and community engagement initiatives.
- Investments in social protection and poverty alleviation programs have contributed to more equitable access to health services among adolescents.

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INTRODUCTION

Ghana's population structure is undergoing a transition, with the proportion of children decreasing and the youth population rising. While adolescents make up about 22% of the population, the country historically made limited investments in family planning until the 2010s. However, with the rise in maternal health spending and increased health investments, Ghana has made substantial progress in addressing adolescent sexual and reproductive health challenges, including reducing teenage pregnancies and adolescent fertility rates.

Recently, Ghana's achievements in lowering adolescent fertility has earned it recognition as one of six study countries in the Exemplars in Adolescent Sexual and Reproductive Health and Rights (ASHER) project. This project identified LMICs that have outperformed in reducing high levels of pregnancies among those aged 15- relative to the other countries and secular trends. From these countries (positive outliers or exemplars), the project documented lessons and best practices which have been applied to improve SRHR outcomes, including the prevention and management of unintended pregnancy. The findings highlighted successful interventions and provided valuable insights for other countries aiming to replicate Ghana's success in advancing Adolescent Sexual and Reproductive Health and Rights (ASRHR).

Methodology

A concurrent mixed-methods research design was employed to address the research objectives, with findings triangulated from various components. Primary data collection employed qualitative methods, including Focus Group Discussions (FGDs) with adolescents aged 12 to 19, contingent upon compliance with local regulations and ethics approvals. Key Informant Interviews (KIIs) were conducted with senior policymakers, ASRHR program managers, representatives from Civil Society Organizations (CSOs), and community leaders. The study framework included stakeholder mapping, a rapid systematic literature review, qualitative and quantitative data analyses and an analysis of ASRHR programs, policies, and interventions. The quantitative analysis employed descriptive and multivariate regression analyses and an Oaxaca-Blinder decomposition and cohort analysis of primarily Demographic and Health Surveys (DHS) data.

TRENDS IN ASRHR IN GHANA

Between 2000 and 2012, health expenditure per capita in Ghana increased significantly, primarily driven by GDP growth, with a dip observed between 2013 and 2016, also tied to fluctuations in GDP. Unlike other positive outliers, Ghana made minimal investments in family planning until the 2010s, with a concurrent rise in maternal health expenditure during that period. In 2022,

the pregnancy rate among adolescents aged 15-19 years in Ghana was 15%, with an adolescent fertility rate of 63 per 1,000.

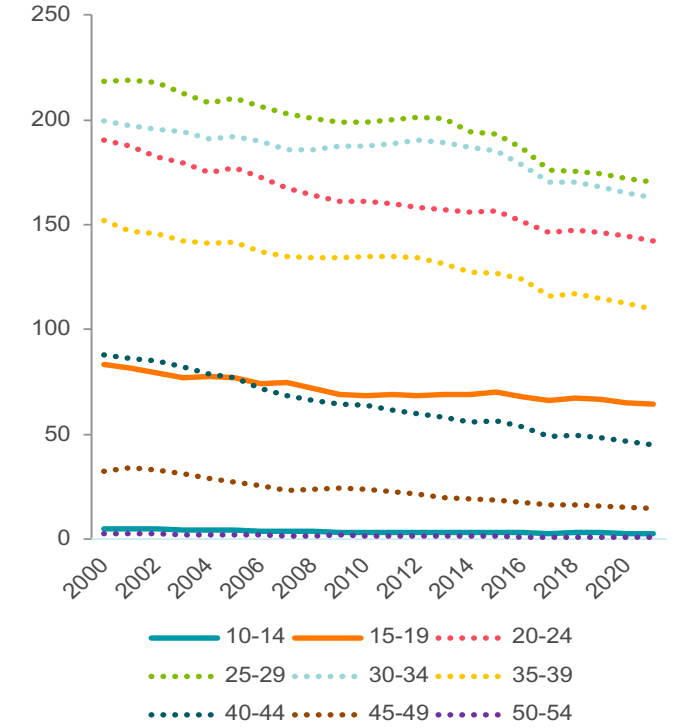

Figure 1: Births per 1,000 women, by age (UN Population Division)

Adolescents in Ghana also exhibited one of the lowest fertility rates across age groups, outpaced only by women aged 40-54. Approximately 67% of pregnancies among adolescents were unintended, with more than half ending in abortion, a reflection of the relatively few abortion restrictions in the country. The pregnancy-related mortality rate for adolescents aged 15-19 years was recorded at 0.12 per 1,000 in the Ghana Maternal Health Survey (GMHS) in 2017.

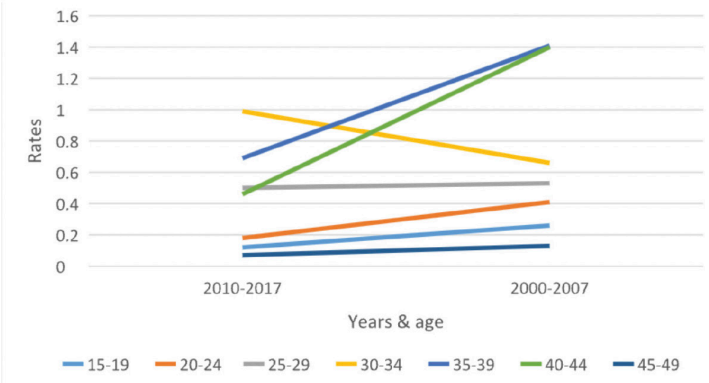

Figure 2: Pregnancy related mortality rate for adolescents ages 15 -19 years (GMHS)

Furthermore, the abortion rate among young people aged 15-24 was 30 per 1,000 in 2021. An examination of DHS data over the last three decades indicated that, while the median age at first sex has remained stable over the years, the median age at first birth and marriage increased. Despite a decline in adolescent fertility rates (ASFR 15-19), the share of adolescent girls who began childbearing increased, potentially due to a reduction in repeat adolescent births. Interestingly, the proportion of adolescents who began childbearing surpassed those who were married, indicating that early marriage was not a primary driver of adolescent fertility (figure 3).

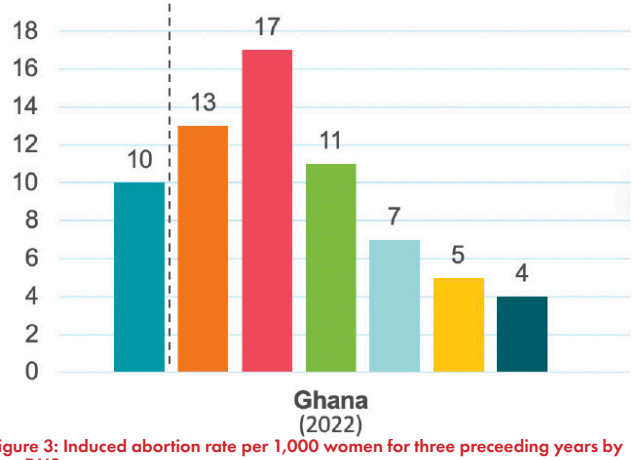

Figure 3: Induced abortion rate per 1,000 women for three preceeding years by age DHS

Between 2003 and 2022, the mix of contraceptive methods used by adolescents in Ghana shifted significantly, with declines in condom use and increases in the use of emergency contraception (EC), implants, injectables, and withdrawal.

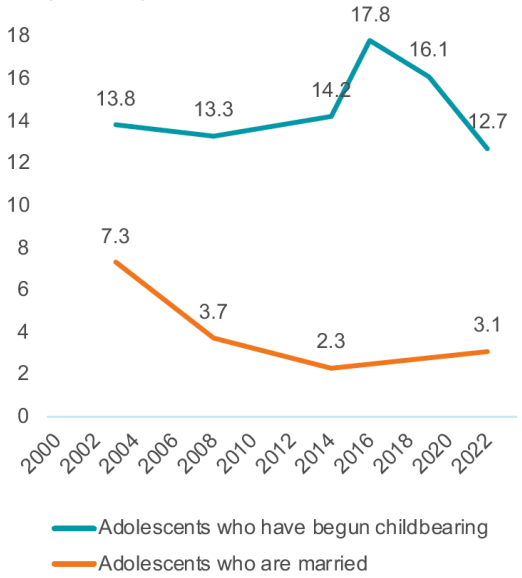

Figure 4: Marital and child bearing status, women ages 15 - 19 DHS

The modern contraceptive prevalence rate (mCPR) and unmet need for contraception remained relatively stable between 2003 and 2014, but both saw a significant rise by 2022. Modern contraceptive use among this age group reached 38%, while antenatal care coverage was at 74%, and skilled birth attendance stood at 82%. While HIV rates remained low for both men and women there was an increase in sexually transmitted infections (STIs) among both sexes. Gender equality improved; however, the share of women in the labor force declined, and the proportion of youth not engaged in education, training, or employment worsened. Although there were reductions in physical violence against adolescent girls, there was a slight increase in sexual violence.

Current use of contraception, ages 15-19 (DHS)	2003	2008	2014	2022
Condom	5.2	3.6	2.4	3.3
EC	0	0	0	2.9
Abstinence	1.6	2.1	1.2	2.5
Implants	0	0	1.1	2.4
Withdrawal	0.3	0.6	1	2.2
Injections	0.1	0.2	1.6	1.3
Pill	1	1.3	0.8	0.8
LAM	0	0	0	0.4
Other traditional	0.2	0.2	0.1	0.4
IUD	0	0	0.2	0

Figure 5: Current use of contraception ages 15 - 19 DHS

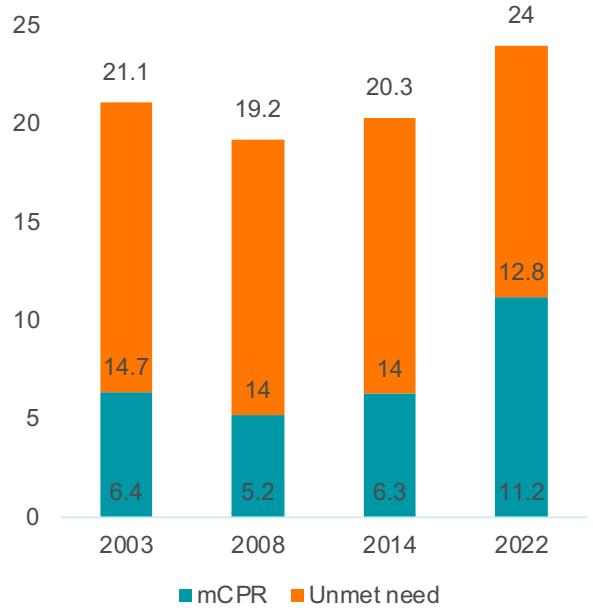

Figure 6: Total demand for modern methods of contarception, ages 15 - 19 DHS

KEY FINDINGS

Increase in Access to Family Planning

Ghana has made remarkable progress in family planning for adolescents, offering a wide range of contraceptive methods, including emergency contraception, condoms, injections, implants, and the utilization of abortion services. By 2022, both the mCPR and the unmet need for family planning saw significant improvements, with the percentage of adolescents aged 15-19 whose demand for family planning was satisfied by modern methods increasing from 36% in 2017 to 53%. This success is largely attributed to key initiatives such as the Adolescent Reproductive Health Policy and the Adolescent Health and Development (ADHD) program. These programs have been instrumental in enhancing access to reproductive health services through youth-friendly healthcare programs that provide care via static facilities, mobile outreach services, and virtual platforms. Complementary methods, including peer mentoring, adolescent clubs, the School Clinic Initiative, and annual medical screenings, have also played a critical role in broadening access to family planning services for adolescents.

Improvement In Educational Access

Ghana made significant progress in improving educational access and attainment, particularly among females aged 15-19. The median years of education for this group increased from 6.9 years in 2003 to 11.0 years by 2022. This progress was also reflected in the rise in gross secondary school attendance rates, which rose from 44.5% to 74.9% for females and from 46.8% to 71.2% for males during the same period. These educational improvements equipped adolescents with the knowledge and skills needed to make informed decisions about their sexual and reproductive health.

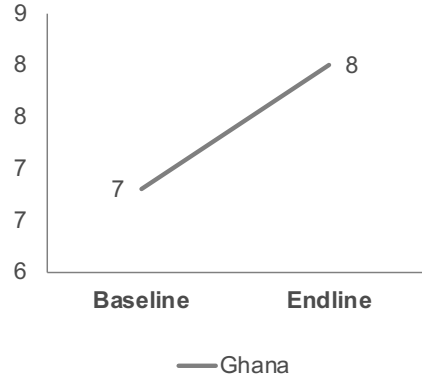

Figure 7: Mean years of education for women 15 -19 DHS

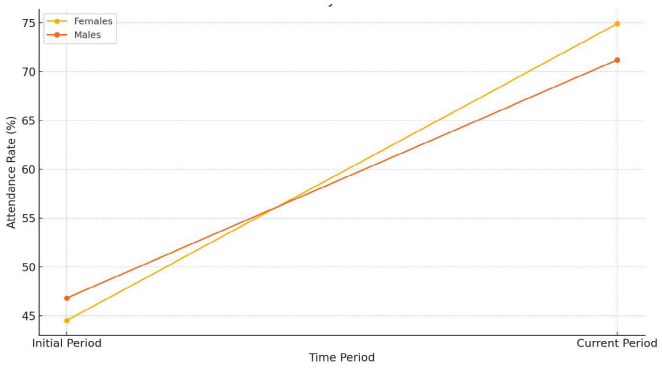

Figure 8: Rise in gross secondary school attendance rates DHS

Sexuality education was also integrated into the education system as a strategic measure to enhance ASRHR. Sexuality education was delivered through teachers and peer educators and incorporated across various subjects, ensuring widespread coverage and engagement. It became compulsory for specific age groups, guaranteeing that all adolescents received vital information on ASRHR. Specialised programs were also established to address the needs of out-of-school adolescents, recognizing the different ways young people sought information. Community-based interventions, such as "My Future's Sake" and "Safety Net," provided peer support services, while health clubs and ICT tools, including the YMK app, enhanced access to SRH information. Additionally, access to information about sexual and reproductive health and rights (SRHR), including safe abortion care, was bolstered through Youth-Friendly Health Services (YFHS) and Comprehensive Sexuality Education (CSE) and helped address cultural and social barriers, reducing stigma and misinformation surrounding abortion.

Legal Reforms that Supported ASRHR

Ghana's supportive political environment enabled the effective implementation of national policies at sub-national levels through tailored interpretations, which significantly contributed to sustained improvements in adolescent sexual and reproductive health and rights (ASRHR). Through collaborative efforts of government ministries, departments and agencies with support from multi-laterals such as the United Nations agencies and bi-lateral agencies ensured that key interventions that sustain the relatively low adolescent pregnancy rate are on track. Key legal reforms were enacted to enhance access to safe abortion services, including the development of comprehensive guidelines for healthcare providers to ensure standardized and high-quality care. These reforms were complemented by training programs for doctors, nurses, and other healthcare professionals, alongside improvements in the availability of medical equipment and essential supplies. Community engagement initiatives—such as educational workshops and peer educator programs— provided data that helped to refine practices and policies.

Social Protection Programs

Ghana made significant investments in social protection programs, which contributed to reaching the poorest adolescents and narrowing equity gaps. While substantial progress was achieved in addressing wealth and residence disparities, there was some regression in educational equity. Various poverty alleviation and social protection interventions were implemented to support households and ensure access to essential social services, including healthcare. Notable initiatives included the Growth and Poverty Reduction Strategy, the introduction of the National Health Insurance in 2003, the launch of the Livelihoods Empowerment Against Poverty program in 2008, and the initiation of the Integrated Social Services Initiative in 2020.

Recommendations

To sustain and further this progress, the Ghanaian government should adopt the following recommendations for the continued advancement of adolescent SRHR:

- **Sustain Political Will:** Place ASRHR services under the office of the President as a priority, and hold every District Chief Executive accountable for implementation at the district level. The focus should be on the removal of inequities, and the provision of high quality services.
- **Improve adolescent access to SRHR services:** Address the stigma associated with comprehensive abortion care and the inadequate knowledge of the abortion law by both clients and service providers. Improve adolescent contraceptive use by ensuring improved access, no contraceptive stockouts and improved counselling services by providers.
- **Implement CSE syllabus:** Implement the CSE age-appropriate syllabus that is currently awaiting ministerial approval. This will support adolescents with age-appropriate information and education to position them to make evidence-based free and informed choices about SRHR.
- **Leverage existing programs to provide SRHR interventions:** Ghana must develop and implement policies that use the School Health Education Programme (SHEP) and Safe Schools Program (SSP) as entry points to implement a mix of effective ASRHR interventions, including e-based to improve ASRHR indicators. Trained in-school adolescents will influence out-of-schools through peer-to-peer activities. NGOs/CSOs should be supported to complement in-school interventions through community-based interventions that target out-of-schools and disadvantaged/underserved sub-populations (LGBTQIA+, PWDs, hard-to-reach, NEET).

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