Health Care, Citizenship, and Policy Intervention in Ghana: An Agenda for Change

by

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ABSTRACT

HEALTH CARE, CITIZENSHIP, AND POLICY INTERVENTION IN GHANA:
AN AGENDA FOR CHANGE

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University of Guelph, 2019

Advisor:
Professor Candace Johnson

Recent research shows a growing interest in young people’s health. Yet there is relatively little empirical research on programs and health interventions for young people, particularly in developing countries. The present study contributes to filling this knowledge gap. Specifically, this dissertation comparatively examines Ghana’s prior Adolescent Health and Development Programme (ADHD), and a more recent health initiative – the Ghana Adolescent Reproductive Health Programme (GHARH). Situating the study within the broader context of new global paradigms – that is, the Sustainable Development Goals (SDGs), the Global Strategy, and the Global Accelerated Action for the Health of Adolescents (AA-HA!) – this research examines the impact of policy framing on citizenship and development outcomes for young people.

In light of the research objectives, this dissertation contributes broadly to the literature on health, citizenship, youth studies, globalization, and development studies. The study employs a qualitative case study method, which involves extensive document analysis, elite interviews, and focus group discussions. The
study involved sixty participants, and was conducted over a period of six months in Ghana in 2017.

Overall, three key findings emerge from the study. First, policy frames might or might not hold any potential for inclusive citizenship and change in health outcomes; contextual and institutional factors must be taken into careful account. Importantly, the analysis highlights how initiatives for young people’s health are shaped by the complex and dynamic interaction of the micro and macro political environment. In line with this understanding, the study establishes five key factors that shape adolescent and youth health outcomes: policy frames, political structure, economic framework, cultural discourse, and policy framework. Second, adolescent health programming must be understood within the broader context of participatory governance. As the analysis suggests, engaging young people in program interventions could potentially foster better policy outcomes. Third, health, as a social right of citizenship, is not a policy domain of state monopoly. Through collective action strategies, young people can reconfigure state-society relationship in ways that position them to better make claims on the state regarding their citizenship entitlements. As such, the substance of citizenship will likely be a function of both contestation and state-activated access.
“Any society that does not succeed in tapping into the energy and creativity of its youth will be left behind.”

Kofi Annan
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Pursuing a PhD can be lonely, expensive, and daunting. Against this backdrop, special thanks are in order for all those who have contributed in diverse respects to the successful completion of this dissertation, of which I am very much proud.

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all Forms of Discrimination against Women</td>
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<td>CHPS</td>
<td>Community-based Health Planning and Services</td>
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<td>CSOs</td>
<td>Civil Society Organizations</td>
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<tr>
<td>CSPOG</td>
<td>Civil Society Platform on Oil and Gas</td>
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<tr>
<td>DCE</td>
<td>District Chief Executive</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>FMC</td>
<td>Federation of Cuban Women</td>
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<td>GES</td>
<td>Ghana Education Service</td>
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<td>GHARH</td>
<td>Ghana Adolescent Reproductive Health</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<tr>
<td>GoG</td>
<td>Government of Ghana</td>
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<td>GPRS I</td>
<td>Ghana Poverty Reduction Strategy</td>
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<tr>
<td>GPRS II</td>
<td>Growth and Poverty Reduction Strategy</td>
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<tr>
<td>GSDGA</td>
<td>Ghana Shared Growth and Development Agenda</td>
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<td>GSFP</td>
<td>Ghana School Feeding Programme</td>
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<td>GSS</td>
<td>Ghana Statistical Service</td>
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<tr>
<td>GYEEDA</td>
<td>Ghana Youth Employment and Entrepreneurial Development Agency</td>
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<tr>
<td>HFFG</td>
<td>Hope for Future Generations</td>
</tr>
<tr>
<td>HIPC</td>
<td>Highly Indebted Poor Countries</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>ISRAD</td>
<td>Institute of Social Research and Development</td>
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<tr>
<td>LEAP</td>
<td>Livelihood Empowerment Against Poverty</td>
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<td>LFS</td>
<td>Labour Force Report</td>
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<tr>
<td>LMICs</td>
<td>Low-and Middle-Income Countries</td>
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<td>MDAs</td>
<td>Ministries, Departments and Agencies</td>
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<td>MDGs</td>
<td>Millenium Development Goals</td>
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<td>MMDAs</td>
<td>Metropolitan, Municipal and District Assemblies</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MOFEP</td>
<td>Ministry of Finance and Economic Planning</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MPSD</td>
<td>Ministry of Private Sector Development</td>
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<tr>
<td>NDA</td>
<td>Northern Development Authority</td>
</tr>
<tr>
<td>NDC</td>
<td>National Democratic Congress</td>
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<tr>
<td>NDPC</td>
<td>National Development Planning Commission</td>
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<tr>
<td>NGOs</td>
<td>Non-governmental Organizations</td>
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<tr>
<td>NPC</td>
<td>National Population Council</td>
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<td>NPP</td>
<td>New Patriotic Party</td>
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<td>NUGS</td>
<td>National Union of Ghana Students</td>
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<td>NYA</td>
<td>National Youth Authority</td>
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<td>NYEP</td>
<td>National Youth Employment Programme</td>
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<tr>
<td>PAMSCAD</td>
<td>Program of Action to Mitigate the Social Cost of Adjustment</td>
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<td>PIAC</td>
<td>Public Interest and Accountability Committee</td>
</tr>
<tr>
<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
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<td>PPPs</td>
<td>Public-Private Partnerships</td>
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<td>PRM</td>
<td>Petroleum Revenue Management</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<tr>
<td>RCA</td>
<td>Reality Check Approach</td>
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<td>RCC</td>
<td>Regional Coordinating Council</td>
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<td>SADA</td>
<td>Savannah Accelerated Development Agency</td>
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<td>SAP</td>
<td>Structural Adjustment programme</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>TEIN</td>
<td>Tertiary Institution Network</td>
</tr>
<tr>
<td>TESCON</td>
<td>Tertiary Education and Students’ Confederacy</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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WHO          World Health Organization
WILDAF      Women in Law for Development in Africa
Chapter One

Introduction

1.1. Background and Problem Definition

Young people constitute about one quarter of the world’s population (UNFPA, 2014). Yet research shows that the adolescent and youth cohort have suffered long-standing neglect and marginalization in health and social policies at the global and national level (Dehne & Riedner, 2001; Fatusi & Hindin, 2010; WHO, 2017). As noted by the World Health Organization (WHO), it has become increasingly clear that the global public health system has failed young people over time and consequently, the imperative for accelerated action to remedy the situation. For instance, adolescence has long been misconstrued as the healthiest period of life. Yet empirical evidence suggests that a significant proportion of adolescents die every day from largely preventable or treatable cause. Also, because they are generally perceived as a homogeneous group, interventions directed at them fail to take account of their specific cognitive, emotional, and unique developmental needs. Given the distorted conceptualization of adolescence, it is not surprising that young people remain largely invisible in national health statistics, and underserved by health care providers (WHO, 2017).

Existing studies on adolescent and youth health provide some levels of abstraction into why the area of young people’s health has received little to no attention over the years. Generally, the range of associated factors include poor
understanding of adolescent and youth health issues, fragmented nature of global governance, narrow focus of the Millennium Development Goals (MDGs), and the lack of appropriate techniques in data collection and analysis (Fatusi & Hindin, 2010; Goodburn & Ross, 2000; UNICEF, 2011; WHO, 2017). Perhaps the ambiguous status of a child in terms of citizenship offers a nuanced perspective to the issue. While children have their own human rights, they are dependents of their parents. Thus, they are considered unique moral agents who lack the capacity for fully informed decision-making and consent. As will be demonstrated in later sections of this study, a key factor that lends analytical currency to the apparent neglect of young people’s health concerns relates to social constructions that define their identity and entitlement within the broader health landscape.

Young people are generally considered to be a healthy class relative to other age groups. This erroneous assumption is rooted in the belief that they have lower mortality rate compared to children or elderly people (WHO, 2002). Indeed, the exigencies of the contemporary health environment suggest that young people have special health-related vulnerabilities and, therefore, require increased attention. To some scholars and health practitioners, this reality is as a result of major shifts in causes of morbidity and mortality among young people (Blum, 2009; Dehne & Riedner, 2001). It is estimated that the global adolescent death toll amounts to more than 3,000 per day, and as already noted, research has proven that most of these deaths resulting from diseases and injuries are largely preventable (WHO, 2017). Following from this same study, the evidence shows that the major causes of death among young people range from sexual and reproductive
health problems, unintentional injuries, communicable and non-communicable diseases, mental health problems, malnutrition, substance abuse and suicide.

While significant investments have been made in the area of reproductive health, evidence shows that adolescent pregnancy remains a public health issue that challenges development across the globe, particularly in developing countries. Globally, maternal mortality ranks second in terms of major causes of death among 15-19 year old girls (WHO, 2014). Despite recent declines, however, adolescent and youth pregnancy rates remain high in sub-Saharan Africa relative to other high-income countries (UNFPA, 2014). As lamented by Gyesaw and Ankomah (2013), the proportion of adolescent mothers in sub-Saharan African countries is disquieting. Given the physical demands of childbirth, vulnerability tends to be high among adolescent girls due to complications that often arise during pregnancy. While some adolescent girls hold up well, most face enormous difficulties that are exacerbated by unsafe abortion protocols, leading to possible death or disability. The issue of child marriage, for instance, contributes to this growing challenge, a phenomenon that has gained widespread attention over the years. As we will see, these developments significantly challenge the health and citizenship of young people.

In the context of Ghana, the dynamics of health politics bring into sharp focus the character of young people's neglect in the domain of health and institutional practices, which essentially generate difficult questions surrounding policy and youth-related health issues. This is especially true when we take into consideration the scale and trend of adolescent pregnancy at the subnational level.
In 2013, for instance, records at the Ghana Health Service (GHS) indicated that thirty-nine percent of a total of 971,269 pregnancies were registered to young women aged 10-24 years (GHS, 2014). The report also suggests that the proportion of youth pregnancy-related deaths was higher than the national average. It is also reported that the Eastern region of Ghana recorded 25,285 teenage pregnancies within a span of two years (Joyonline, 2016a), whereas the Greater Accra region recorded a total of 10,000 teenage pregnancy cases in 2015 (Joyonline, 2016b).

In 2017, it is estimated that 986 adolescent abortion cases were recorded in the various health centres in the Greater Accra region, characterized by complications that put the lives of adolescent girls at risk (Joyonline, 2018c). The Central region, in 2016, also recorded 12,048 cases of adolescent pregnancies, which is apparently an improvement over the previous year, reflected by 14,000 cases (Joyonline, 2017c). The objective here is not to provide a comprehensive or perhaps dull list of adolescent pregnancy rates across the various regions in Ghana, rather than to simply acknowledge that the aforementioned figures are significant. Put together, this grim picture brings into perspective the central questions underpinning this thesis, and its implications for policy development and health programming.

Paradigmatic shifts in global thinking have propelled adolescent and youth health issues into agenda prominence and, in effect, radically altered young peoples’ political and social identity within the broader context of global and national health. Indeed, current global commitments towards young people’s health and well-being obviously raise fundamental questions relating to policy and
politics, and their implications for citizenship and entitlement. Will the changes in
the global context transform the realities of health policy delivery? What challenges
and opportunities do these global paradigms present in the context of adolescent
and youth health development? Importantly, these issues bring into perspective
the link between identity construction and policy feedback. Central to the concept
of policy feedback is the idea that the framing of issues through policies influences
subsequent policy debates, institutions, political action, and participation patterns
(Béland, Foli, & Kpessa-Whyte, 2018; Mettler & Sorelle, 2014; Schneider, Ingram, &
Deleon, 2014).

In September 2015, the Sustainable Development Goals (SDGs) were
adopted by the global community to build on the earlier accomplishments attained
in the MDGs. The cardinal principle underpinning the SDGs – leave no one behind –
set the stage for a revolutionized global health system that positioned women,
children and young people at the forefront of the development agenda. In light of
this understanding, two core initiatives have been developed to advance young
peoples’ health and well-being – The Global Strategy for Women’s, Children’s and
Adolescents’ health (hereinafter, “The Global Strategy”), and the Global Accelerated
Action for the Health of Adolescents (AA-HA!).

Despite the expanding demand for reproductive health programming, there
is relatively little empirical research on adolescent and youth-targeted health
interventions. Indeed, the literature clearly shows that the research knowledge
base concerning these interventions, particularly for developing countries, is weak
and consequently, fails to provide adequate guidance about program effectiveness
(Fatusi, 2016; Hughes & McCauley, 1998; Lancet, 2016; Speizer, Magnani, & Colvin, 2003). In the Ghanaian context, the literature emphasizes the paucity of published work regarding the implementation of interventions aimed at improving young people’s health and well-being (Awusabo-Asare, Abane, & Kumi-Kyereme, 2004). Of particular importance to the present study is the idea that equity, service and access to health care relates to the implementation level (Ridde, 2009). As noted, adolescent pregnancy poses a major health and social issue across the global world, particularly in low-and middle-income countries (LMICs). And considering the momentum created by the new global paradigm, the present study is timely.

1.2. Research Question and Objectives of Study

In spite of the growing interest in young people’s health and well-being, the emerging body of literature appears to focus more on the substantive outcome of adolescent and youth-targeted health interventions rather than the procedural dynamics. In other words, the relationship between the what, when, who, and most importantly, why and how of the analysis is important; yet scholars have mostly overlooked its relevance. Strangely enough, most studies that have been conducted on young people’s health in developing countries tend to focus preponderantly on micro-level factors such as cultural, social, and individual-based economic considerations. As a result, there has not been in-depth attention to the broader

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1 Historically, the concept of developing country has been defined by international organizations such as the World Bank and International Monetary Fund (IMF) based on indicators such as income. The present study, however, adopts the United Nation’s classification of developing countries based on the Human Development Index (HDI). This classification will suffice as it moves beyond merely economic indicators to include literacy, standard of living, life expectancy, among others.
policy and institutional processes that shape adolescent and youth health outcomes, a gap this study attempts to fill.

Indeed, policy implementation cannot be fully understood without reference to the discourse and discursive processes that define, validate, and establish the institutional framework for policy action. Against this backdrop, this study is driven and guided by the following research question:

- What factors define the nature of interventions aimed at improving adolescent and youth health development?

The study is also directed by the following sub-questions:

- In what ways has the issue of adolescent and youth health been portrayed, and to what extent do global policy frames affect citizenship and development outcomes for young people in developing countries?

- How do adolescent-focused health programmes interact with the experiences and circumstances of young people on the ground, and what are its implications for policy practice and health sector governance?

These questions are important, as they direct attention to the importance of responsive and effective health care for citizenship. Good health, as commonly noted by the World Health Organization (WHO), is intrinsic to human happiness and well-being. Given the contemporary challenges faced by young people, particularly in relation to health, it makes little sense to adopt reactive strategies. First, responsive and effective youth health interventions safeguard young people's
human rights in accordance with the Convention on the Rights of the Child (CRC) – that is, the right to “the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” (p.7) (OHCHR). Second, good health care is intrinsically tied to overall productivity – today and tomorrow – and holds significant implications for socio-economic progress. Third and most important, effective and equitable health care is central to the construction of citizenship, which consequently promotes a political culture conducive to state-building (i.e., nurturing positive behavioural patterns and social cohesion). Of course, this is not an exhaustive list of benefits to be derived from effective health care and programming, but it offers a starting point for meaningful adolescent and youth health interventions.

1.3. Conceptual Clarification: Adolescence and Youth

In Ghana, like most developing countries, adolescent and youth health development is in its embryonic phase. It is, therefore, not surprising that the understanding of health and development issues of young people still remains relatively poor (Fatusi & Hindin, 2010). This challenge is based on the premise that the concept of adolescence, until recently, has either been non-existent or relatively new (Dehne & Riedner, 2001). Before examining the key issues in this study, it is important to first lay out the controversial concepts of adolescence and youth.

The concept of adolescence and youth defies a single universally accepted definition. Terms such as adolescence, youth, young people, and young adult are often used interchangeably or invoked to capture varied experiences of individuals
who fall within these age classifications. While this contemporary usage may appear somewhat confusing, it is also important to appreciate that these concepts are dynamic and derive meaning based on context, time, and interpretation (Dehne & Riedner, 2001; UN, 2017). As Ferguson (1993) puts it succinctly, “adolescence is a social construct used to understand part of the human experience” (p. 638).

The United Nations (UN) Secretariat defines youth and young people as individuals aged 15-24 years. The United Nations Children’s Fund (UNICEF), World Health Organization (WHO), and United Nations Population Fund (UNFPA) employ the following age categorizations – adolescents (10-19 yrs), young people (10-24 yrs), youth (15-24 yrs) (UN, 2017). The present study aggregates adolescents and youth, which is consistent with the UN classification of young people (i.e., 10-24 yrs.). It is important to highlight that this categorization aligns with the Ghanaian context, as reflected by both the ADHD and GHARH programmes, which focus on young people aged 10-24 years.

In light of the age demarcation described above, the terms – adolescents, youth, and young people – would be used interchangeably in this study. This consideration is premised on the understanding that there are definitional overlaps across the age groups (i.e., 10-24 yrs.). Indeed, the definition of adolescence and youth is a highly contested concept, and it is beyond the scope of this study to resolve this definitional debate. As some scholars and practitioners suggest, there are definitional difficulties involved regarding the specific time order for adolescence, as well as the point at which youthfulness commences (Ghana Statistical Service, 2013).
1.3.1. Context and Background: Adolescent and Youth Health

While the present study recognizes that each age group has varied developmental challenges and may require different set of interventions, the definitional terms (i.e., adolescents, youth and young people) are used interchangeably for analytical and policy purposes. Given the marked variations among these age groups, it would be crude to base the transition from childhood to adulthood solely on a person’s age, considering that some individuals mature earlier or later in comparison to others regardless of age difference. In light of the increasing maturation rate of young people, particularly in the context of globalization, appreciating the definitional overlap would, therefore, help to capture the nuances across the age bracket being considered in this study. Focusing on this age group is not only important because it fits with the global agenda in the context of young people’s health, but also because it aligns with the Government of Ghana’s key strategic priorities for young people (MOH, 2015).

Generally, the transition from childhood to adulthood is considered as a critical, risk-prone, and vulnerable period in the lives of young people (UNFPA, 2014; UNICEF, 2011). It is recognized that this phase of life is characterized by complex physical, emotional, physiological, and psychological changes, which, in turn, shapes the social worldview of young people. Such rapid development not only impacts their decision-making capabilities, but also their general sense of self and identity within the broader socio-political and economic context. Indeed, young people face enormous challenges during this explorative juncture in life, and
these difficulties range from the threat of child marriage, lack of educational opportunities, HIV/AIDS, unsafe abortions and unintended pregnancies.

In effect, the equity, availability and accessibility of health services for young people, therefore, continues to remain a central concern for policy makers, health activists, and other relevant stakeholders (Hampshire, Porter, Owusu, Tanle, & Abane, 2011; Tylee, Haller, Graham, Churchill, & Sanci, 2007; WHO, 2002, 2017). As some scholars have noted, it is estimated that almost half of girls in some parts of sub-Saharan Africa are pregnant by the age of nineteen, characterized by difficulties in accessing health services (Tylee et al., 2007; WHO, 2002). For instance, privacy and confidentiality in health facilities are key issues that have been raised as serious impediments to appropriate and effective health services for young people. Against this backdrop, there has been increasing calls across the international arena for increased attention and protection for young people. Particularly, the WHO-led call for global investments in youth-friendly services, as well as the Global Strategy, is reflective of these social and health concerns (WHO, 2002, 2017).

1.4. Summary of Findings and Argument

This study is based on extensive field research on two salient adolescent and youth focused health initiatives in Ghana – that is, the Adolescent Health and Development Programme (ADHD), and the Ghana Adolescent Reproductive Health Programme (GHARH). A review of primary and secondary documents provided a strong knowledge base for the project. Based on a thorough examination of the
aforementioned programmes, this thesis argues that the complex and dynamic interaction of the micro and broader macro political environment shapes the outcome of adolescent and youth-targeted health initiatives. In other words, young people’s citizenship and development outcomes is a function of global and domestic factors. To this effect, an enabling or open, as opposed to a closed policy environment (global and national), is critical to the success of health interventions.

The study reveals that various factors impinge on young people's health and development, but it is also worth focusing on health programming as a structural determinant of health, a dimension that has received little scholarly attention over the years. Against this backdrop, the case of the ADHD programme shows that the lack of adequate financial resources and support posed a challenge to program delivery. On the other hand, the GHARH programme (January 2014 – March 2017) received generous funding from the Department for International Development (UK aid), and with the advantage of paradigm shifts in the global policy environment, executed a far-reaching project across the Brong Ahafo region of Ghana. However, consolidating the gains achieved beyond the program's funding period remains a central concern among major stakeholders, a consideration that underscores the critical relationship between economic resources and program intervention.

In terms of program interaction, the study shows that when young people are effectively and meaningfully engaged, they respond positively to health interventions targeted at them. The GHARH intervention reached over 500,000

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2 Ghana is a unitary state that is comprised of ten administrative regions.
young people in terms of services and awareness creation. High patronage of these services and involvement in the programme by young people, therefore, challenges the preexisting notion that adolescents and youth are indifferent to interventions aimed at their health and well-being.

Generally, this finding overlaps with how young people are targeted for health programmes by the government and non-state actors. Given that adolescent and youth health intersect with various policy sectors and institutions outside of the health ministry, the evidence suggests that the structure, character, and depth of partnership holds significant implications for program quality and success. The multi-sectoral approach adopted for implementing the GHARH programme involved four key national agencies – National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA) – as well as five selected non-governmental organizations (NGOs). This strategy of complex multi-level engagement is not without challenges, but could certainly be considered a virtue in terms of policy implementation and program sustainability. In line with this policy direction, I argue that partnership must be understood within the broader context of strategic engagement. In relation to the present study, this implies that collaborative arrangements must move beyond mere engagement of policy actors, to identifying principal players relevant to youth health, while adapting to the realities of the external environment.

Paradoxically, despite the institutional and ideational changes that have redefined the socio-political identity of the adolescent and youth population, the study reveals that young people still risk being left behind in the new development
agenda; they are subsumed under maternal and child health. This interesting revelation raises important questions regarding the framing of adolescent health within the global policy discourse, and its implications for health and development in the context of national politics. Also, resistance to change and gender empowerment, as reflected by cultural norms in the Ghanaian society, brings into context the power of social construction for health and social transformation.

Overall, these findings call the role of the state in health governance into question, and demonstrate how the various forces that undermine young people’s health and well-being can be tempered. In order to generate momentum and harness the power of intra-collaborative and inter-collaborative efforts, the central government must be seen to be playing a crucial role as a primary actor in relation to policies and governance arrangements that promote and enrich national commitments towards a transformed lived experience for young people. However, as the study suggests, health care (as a social right of citizenship), cannot be left in the hands of the state alone. With support from more powerful and influential groups, young people can better advance their citizenship claims in relation to health and overall well-being.

In sum, this study identifies five key factors that shape citizenship and development outcomes for young people within the ever-changing context of globalization – policy frames, political structure, economic framework, cultural discourse, and policy framework. Suffice it to say that an integrated ideational policy discourse that considers the unique properties of individual frames holds
much promise for policy change and action within the broader context of adolescent and youth health development.

1.5. Contribution of the Thesis

This study makes significant contributions to the broader literature on health, youth studies, globalization, citizenship, and development studies. First, the study generates new empirical insights that contribute to and extend the existing literature. As already indicated, a notable gap in the literature speaks to the lack of adequate research knowledge regarding adolescent and youth-targeted health interventions. Therefore, empirical insights drawn from the ADHD and GHARH programmes in Ghana help to address this lacuna.

Second, the study makes three important theoretical contributions: (a) the study advances further theoretical understanding on the broader institutional and policy processes that shape adolescent and youth-targeted health initiatives. As noted above, the aim is not to delegitimize the influence of micro-level factors but, rather, to broaden the analytical discussion to include macro-level considerations; (b) the study also fills an ideational gap in the implementation literature. While the implementation studies literature captures the structural dimensions of policy implementation, it does not adequately account for the role of ideas. As suggested by Schofield (2001), scholars should also concern themselves with “a processural view of implementation” – a perspective that takes the role of ideas and interpretative dynamics into account (p. 254). By employing an integrated analytical framework that combines the analytical strengths of the framing and
implementation literature, the present study provides rich theoretical insights that further our understanding on adolescent and youth health development.

(c) The literature also shows that the theoretical underpinning of most scholarly work on adolescent health fall under the discipline of psychology, specifically within the cluster of health-risk-behavior theories (Hughes & McCauley, 1998). Against this backdrop, a multidisciplinary lens for appreciating the broader issues is, therefore, in order. Building on studies in sociology, anthropology, public health, political science and public policy help to address the theoretical limitation in the literature, and allows for more diverse perspectives on adolescent-related health issues. Thus, the study will be of interest to researchers in multiple disciplines.

Third, the practical contributions of this study, including insight into policy processes, as well as recommendations, also offer new pathways that could be embraced by policy makers, health practitioners, and other stakeholders to better tailor health interventions to meet the specific needs of young people not only in Ghana, but also other parts of the globe. In this regard, although the study speaks to the Ghanaian context, the findings are relevant to, and hold significant implications for other countries that have taken the initiative to adopt comprehensive adolescent and youth health programmes or are brainstorming ideas to do so.

1.6. Structure of the Dissertation

The structure and organization of the dissertation is as follows. Following this introductory chapter, chapter 2 presents the methodological framework employed
for the study. The research design, data collection methods, data analysis and limitations of the study will be discussed. The rationale for selecting Ghana as the focus of this study will also be explained. Chapter 3 provides broad insight into the historical and institutional considerations for the study. The discussion revolves around different threads such as existing policies and programs on reproductive health, gender, transnationalism, citizenship and participatory governance in Ghana. These multiple dimensions provide a fitting context for the study.

Chapter 4 provides an extensive review of the literature on adolescent and youth health. The primary objective in the chapter is to examine existing perspectives on adolescent sexual and reproductive health. This undertaking will shed insight on the context and gaps in the literature, as well as demonstrate why the current study is important. Chapter 5 presents the theoretical framework for the study. The literature on framing and implementation studies will be examined, and the rationale for employing an integrated analytical framework for the study will be discussed.

The discussion in chapter 6, 7, 8 and 9 speaks to the empirical findings of the study. Chapter 6 provides an overview of the ADHD and GHARH Programmes in Ghana. Drawing comparative insights from these two adolescent-focused programmes, the discussion throws light on four key factors that shape young people’s citizenship and health outcomes – political structure, economic framework, cultural discourse, and policy framework. The intersection of the micro and macro elements that inform adolescent health and well-being will be made evident throughout the discussion. Also, the political and social dimensions of
adolescent and youth pregnancy will be discussed to showcase the various ways in which politics and policy reinforce the health “problem.”

Chapter 7 builds on the previous discussion in chapter 6. It focuses on policy frames as ideational instruments for shaping adolescent health outcomes. More specifically, it deconstructs the core policy frames embedded in the SDGs, Global Strategy, and the AA-HA! Framework. The analysis will demonstrate the utility of an integrated ideational policy discourse, which, in turn, provides some insight into why the ADHD programme suffered implementation stasis, and why the GHARH programme offers a more fruitful pathway for adolescent and youth-focused interventions. Chapter 8 delves into the substance of citizenship and its implications for policy, health programming, and social development. It examines the citizenship discourse, with particular attention to adolescent health, youth empowerment and participation in the policy process. Contextual insights will be drawn from Palladium’s Reality Check Approach (RCA) study, as well as focus group discussions that I conducted with young people (10-24 years) in the Brong Ahafo region.

Chapter 9 situates the discussion within the global understanding of civil society as a vehicle for social change. The analysis draws on the constructivist literature to showcase how the youth can meaningfully make claims on the state, especially given their limited power resources. Chapter 10 concludes the study. It weaves together theoretical lessons, relevance and policy implications of the study.
Chapter Two

Research Methodology

This chapter discusses the broad framework that guides the collection and analysis of data for the present study. In this respect, the subsequent discussion will provide insight into the methods of data collection, research design, data analysis, as well as the limitations associated with the study.

2.1. Data Collection

This study adopts a qualitative interpretivist paradigm as an appropriate approach for appreciating the broader issues relating to the subject matter under consideration. The study is rooted in the understanding that knowledge about the nature of the social world is subjectively created. In other words, ‘what is’, or the substance of social reality is fundamentally different from the natural world; the world does not exist independent of thought, values, perception, or interpretation (Halperin & Heath, 2012). Given the ontological position adopted in the study, the research was conducted based on the epistemological premise of understanding and interpreting social phenomena. In other words, the study is driven by a ‘meaning and meaning-making’ approach that appreciates the dynamics of discourse and discursive constructions – the mechanism through which social reality is created (Halperin & Heath, 2012). Indeed, the findings of this study suggest that it is important to recognize that policy implementation is driven by the dynamics of language and discourse.
While the interpretivist approach has attracted criticism, particularly from scholars that privilege the positivist paradigm, its utility cannot be overemphasized. From the standpoint of classic positivists, the qualitative approach is perceived as subjective and contaminated, thus offering little analytical leverage to advancing the scientific discipline. As Palys and Atchison (2008) bluntly put it, scholars in the qualitative stream are often viewed as operating with a myopic and misguided lens. While qualitative research has now been endorsed as a legitimate and appropriate methodological tool in social science, a key concern with this approach has been the seeming lack of rigour, validity, and reliability (Halperin & Heath, 2012; Liamputtong, 2013).

These critiques notwithstanding, the qualitative methodology offers an appropriate toolbox to effectively deal with the social and political complexities associated with the present study. As Liamputtong (2013) notes, qualitative research is not without limitations, but adhering to the norms of good social science could help minimize, if not eliminate completely the problems associated with the qualitative approach. To be sure, the issue of validity and credibility is not unique to qualitative research; quantitative researchers also risk validity problems if they fail to properly design and conduct their research. It is within this broader understanding that the current study aims to provide transparency on the techniques and methods employed in the research in order to address potential validity and reliability concerns.

At the most basic level, the qualitative approach is particularly fitting for a single case study. However, the case study method is often viewed as a weak
approach to research particularly by scholars who view it with the lens of positivist science. For instance, it is viewed as bounded by context (thus prone to limited generalization), as well as open to large and diverse data sets that pose challenges to its efficient management (Liamputtong, 2013). However, like all research designs, the case study method has its merits and drawbacks, and as a number of scholars have rightly noted, the perceived hostility against this research approach is largely unwarranted (George & Bennett, 2005; Gerring, 2004; Liamputtong, 2013).

Rather than privilege breadth over depth, which is narrowly construed as a virtue of positivist science (i.e., statistical methods), the case study method allows for detailed and in-depth examination of contextual variables and processes relevant to understanding the political phenomena under investigation. Also, contrary to debates that seem to privilege the statistical method, a number of studies show that research that employs the case study approach have wide applicability and may be generalizable to other contexts (Bryman & Bell, 2016; Halperin & Heath, 2012). The case study method is particularly useful for the present study based on its ability to, as George and Bennett (2005) put it, accommodate “complex causal relations” and “interaction effects” (p. 22).

The fieldwork for this project covered a period of six months (January – June, 2017). For the purpose of the study, elite interviews, focus groups, and extensive document analysis served as the main research instruments for collecting data. In this regard, semi-structured interviews were conducted with individuals centrally involved in the GHARH programme at multiple levels of
intervention (i.e., national, regional, and district levels). The interviewees recruited include leading officials of the Palladium Group (formerly Futures Group Europe), an international NGO largely responsible for developing and implementing the GHARH programme. Also, officials at the National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA) were interviewed as part of the study. In addition, interviews were conducted with non-governmental organizations (NGOs) involved with the program such as MAP International and Planned Parenthood Association of Ghana (PPAG). Furthermore, focus group discussions were held with young people aged 10-24 years.

The open-ended interviews were conducted as a means to generate rich data by drawing on respondents’ perspectives, expertise, and experiences regarding the GHARH intervention. Different sets of interview protocol were designed for the various categories of respondents aforementioned. The variation in interview questions aimed to capture the varied understandings and experiences of respondents, while identifying the common themes that emerged from the data. Also, the study was supported with information garnered from primary and secondary materials such as health policy documents, published books, journal articles, local newspapers, and relevant health reports of international organizations such as the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA) etc. The use of multiple data collection instruments not only helped to build a robust knowledge base, but also served the purpose of triangulation to verify the information
obtained from various sources. Methodological triangulation, as noted by Liamputtong (2013), helps to strengthen the validity of information gathered.

The interviews conducted with officials of the Palladium Group aimed at tracing the origin and rationale behind the GHARH initiative, as well as obtaining updates about the organization’s outreach in terms of improving adolescent reproductive health in Ghana. These interviews were, therefore, useful in terms of providing understanding about the objectives of the organization, implementation of the GHARH programme, achievements and challenges associated with promoting the health and well-being of young people in Ghana. Interviews with the NPC, GHS, GES, NYA, and NGOs also provided useful insights into the collaborative framework adopted for implementing the GHARH programme. These interviews not only provided first-hand information regarding the challenges faced by the prior interventionist programme (i.e., the Adolescent Health and Development Programme), but also helped to situate the study within the broader framework of global and national health.

The interviews with NGOs were particularly useful in shedding light on the bottom-up approaches adopted in implementing the GHARH intervention. These interviews revealed the nature of partnerships and investments at the district and local level aimed at advancing young people’s health and development. Through these interviews, the study also uncovered some of the challenges faced by NGOs regarding their operation at the local level. Lastly, the focus group discussions with adolescents and youth sought to explore young people’s knowledge about sexual and reproductive health interventions in the region of focus, as well as their
experiences regarding the GHARH intervention. Overall, the interviews, focus groups, and document analysis proved particularly suited for the study as it provided comprehensive understanding of the political and social dimension of the health issues and challenges confronting young people, as well as knowledge of the factors essential for successful targeted interventions.

Prior to conducting the research, ethical clearance was obtained from the University of Guelph Research Ethics Board (Canada), as well as the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (Ghana). This undertaking was to ensure the overall integrity of the research in relation to the protection of participants’ rights and confidentiality. Consent/assent forms were given to respondents to complete prior to the interview, and they were also informed of their right to decline or withdraw from the study at any point in time without any penalty whatsoever. All the elite officials interviewed were contacted via email with an attached invitation letter and a copy of the consent form to complete. Through email correspondence, interviewees indicated interview dates and times that worked best for them. All the interviews conducted with the officials were held in their private office or private space.

The focus group discussions were also conducted in a private space that I booked for the purpose of the study. For practical reasons, adolescents and youth who participated in the interviews could not be reached by email or phone. Nonetheless, through face-to-face interactions, the consent/assent forms were given to them to complete prior to the interview. Their rights as participants were also emphasized at the outset, and opportunity was given for respondents to ask
questions pertaining to the study. Obtaining informed consent from participants served a dual purpose of disclosure about my identity and ensuring that interviewees were comfortable participating in the research.

All interviews conducted were audio recorded with the permission of respondents for the purpose of transcription. However, one official declined being recorded, which necessitated the use of extensive hand-written notes. As noted by Bryman and Bell (2016), qualitative researchers are “interested not only in what people say but also in the way they say it” (p. 205). In line with this understanding, the audio recordings, therefore, proved useful in capturing the complete series of exchanges in the interviews, while allowing for undivided attention and simultaneous reflection on the conversational exchanges with respondents. In total, sixty participants were involved in the interviews that were conducted (i.e., elite interviews and focus groups).

Four sets of focus group discussions were held, and each set comprised ten youth participants. The first set consisted of only males, whereas the second set was exclusive to females. The third and fourth sets constituted a mixed gender in terms of orientation. The rationale behind these variegated sets of interviews was to allow for a representative sample of the youth population in terms of gender and age, as well as control for the challenge of ‘group effect’, which is commonly associated with focus groups. As several scholars have noted, ‘group effect’ could potentially distort or undermine the quality and validity of a study, particularly due to the tendency for some participants to express ‘socially acceptable’ or ‘politically correct’ views in a group setting (Bryman & Bell, 2016; Halperin & Heath, 2012;
Liamputtong, 2013). In this regard, some participants could be influenced or conform to the responses given by other group members even though they may have different thoughts or perspectives on the issue being discussed. In the context of my study, setting up different sets of focus groups allowed room for better comparison and assessment of ideas and patterns across the interviews conducted.

In relation to interviews conducted with elites at the NPC, questions that were asked include the following: the role played by the NPC in devising the new health service policy and strategy; whether the new service policy was compact enough to meet the challenge of sexual and reproductive health in Ghana; the factors that account for poor maternal health outcomes across the various regions, and more particularly the Brong Ahafo region; and, the challenges that affect NPC initiatives and implementation of programmes aimed at improving young people’s health in the region, and more broadly at the national level.

Regarding officials of the Palladium Group, the interview questions were directed at obtaining knowledge about the groups or institutions that were engaged in meeting the organization’s primary goals. These questions were asked in light of my preliminary understanding of the broad nature and scope of the health intervention. I was also interested in knowing the various ways in which the GHARH programme had substantively impacted young people’s health and well-being, especially given my knowledge of the limited impact of the prior ADHD programme. Moreover, the questions aimed at exploring the challenges faced by the organization in undertaking the project in order to gain a broader and better
understanding of the mechanisms, processes, and relationship between policy intent and outcomes.

Furthermore, I sought to understand how young people were targeted in terms of outreach programmes. This was aimed at exploring the approaches used to target young people, and to examine whether the methods used could help assess the future success or otherwise of adolescent health interventions in the region, and elsewhere. Importantly, the interviews were designed to capture how the SDG’s, Global Strategy, and the AA-HA! Framework shaped the organization’s operations. This dimension was crucial in terms of examining the interrelationship between domestic policy making and transnationalism. Overall, the interviews were useful in gaining understanding on why and how the GHARH programme was implemented, the various institutional forces that shaped the formulation and implementation process, as well as the preliminary impact and challenges associated with the implementation of the project.

In relation to the remaining elite interviews, the interview questions were slightly modified to fit with the scope and mandate of the government agencies and NGOs. For the focus group discussions, questions relating to general knowledge about family planning, sources of knowledge and information about sexual and reproductive health in the district, familiarity with sexual and reproductive health interventions in the region, particularly the GHARH programme, experiences regarding the GHARH intervention, and awareness about the programme in the region, among other related questions, helped to gain insight into young people’s perspectives and experiences with the GHARH project.
All the interviews conducted lasted between forty-five minutes to one hour. In some cases, the interview time was reduced to half an hour to accommodate the pressing time demands on officials, as interviews were held during regular work hours. The interviews were conducted in English, with the exception of the focus group discussions where the local language (Akan) had to be used in some instances for clarity purposes. Overall, all respondents exuded enthusiasm about the research and gave generously of their time as their circumstances could permit. No respondent declined or withdrew from the study.

2.2. Research Design

The study utilizes a case study design and aims towards an in-depth understanding of contextual factors that will help situate and structure the project. Epistemologically, the study sought to uncover the inter-subjective meanings underlying health interventions targeted at young people in Ghana. An inductive approach thus proved appropriate for the study, as it allowed for a deeper appreciation of the contextual factors essential for successful adolescent and youth targeted health interventions. While the case study approach is not without limitations, its virtues are worth emphasizing. Unlike the statistical method, the case study approach not only offers a platform for detailed consideration of contextual factors, but also proves useful in testing hypotheses that emerge out of the data (George & Bennett, 2005). Ghana’s experience with the ADHD and GHARH programmes provide useful insights, and thus findings from the study could be extrapolated to other contexts to test their applicability.
Another striking feature of the case study method is the capacity to accommodate complex interaction effects (George & Bennett, 2005). As indicated at the outset, the present study is situated within the complex nexus of global-domestic arrangements aimed at improving the health and development outcomes of young people. The case study approach would, therefore, be useful in analyzing the discursive mechanisms and complex governance framework that shape the influence of global policy frames on the substance of citizenship and health entitlement in the new era of identity rights and global commitments. Rather than sacrificing depth for breadth, which is a salient feature of the statistical method, the case study method helps in identifying the intervening variables associated with the intersectionality of policy arrangements and health care politics. As already noted, while the case study design is appropriate for the purpose of this study, it is not without limitations. The downside to using the case study method will be discussed in the section on validity threats associated with the study.

The appropriateness of Ghana as a case study is based on a number of considerations. First, Ghana has responded quite well to the global call for comprehensive adolescent health programmes (WHO, 2017). Second, the nation has a historical record of leadership in reproductive health and family planning across Africa (MOH, 2015). Third, the implementation period for the GHARH intervention had almost expired at the time of the field research. This coincidence provided a timely opportunity to explore the initiatives, activities, and preliminary impact of the programme over the three-year funded period (Jan 2014 – March 2017).
It should, however, be emphasized at this point that this thesis is not a formal evaluation of the GHARH programme, but rather a general assessment of how the programme was implemented, the actors involved, the frames deployed, and whether the intervention had any tangible outcomes. Lastly, the GHARH intervention merits attention because it draws significantly on global protocols such as the recently adopted SDGs, which fits with the objectives of the present study in terms of advancing understanding on the dynamics and intersectionality of global policy frames and national politics. Indeed, Ghana’s rapid response to the global development agenda on young people’s health and well-being is intriguing.

2.2.1. Sampling

Research respondents, specifically elite officials, were identified and selected based on the purposive and snowball sampling approach. Due to my initial limited knowledge of actors specifically involved in the GHARH programme, this research approach proved appropriate for the study. Prior to conducting the study, I contacted my institution of affiliation (Department of Population, Family and Reproductive Health, University of Ghana), and this interaction set the stage for effective planning and conduct of the research. The expertise and experience of faculty members proved invaluable to the study. The department was particularly helpful in establishing contact with various senior officials involved with the ADHD and GHARH programmes, as well as the processing of the local ethics clearance required for conducting the research. In line with support received from the
department, the interview protocol was revised to include varied and specific age classifications of young people.

Based on ethical considerations associated with the present study, the study locations will remain confidential. This is not only to protect the identities of the youth participants and surrounding communities, but also the health staff who were engaged for the purpose of this study. Nonetheless, two districts in Sunyani were selected for the study due to time and resource constraints.\(^3\) Given the implementation trajectory of the GHARH programme, these two districts were good places to begin the study. It should be pointed out that all research participants identified in this dissertation provided explicit consent for their full name to be used for the purpose of this study.

Due to limited online information regarding the ADHD and GHARH programmes, the initial phase of my field visit, therefore, served as an opportunity to obtain real time updates on both interventions, as well as establish contact with the relevant institutions and individuals related to my research. The purposive sampling method, as noted by Liamputtong (2013), is particularly useful in selecting participants who are considered relevant to the study and hold the potential to “provide the best information” (p. 84). Based on earlier interviews conducted with elite officials, the snowball approach was used to generate further contacts for the study. Surprisingly, at the end of the interviews, most officials willingly provided the names of other contacts that could enrich my study with their perspectives and experiences. In situations where this was not the case,

\(^3\) Sunyani is the administrative capital of the Brong Ahafo Region.
officials were asked if they could suggest others who could speak to the substantive content of the study.

Given that officials of the Palladium Group were directly responsible for the disbursement of grants and implementation of the GHARH intervention, their contact network proved very useful for the study. My earlier contact with the organization in the Greater Accra Region of Ghana helped to supplement and map out strategies for contacting senior officials at the national, regional and district levels. The main research was conducted in the Brong Ahafo region of Ghana, which was the focal belt of the GHARH intervention.

The focus groups were selected using quota sampling. The aim of this sampling technique was to generate a sample that best reflected the population of young people in the region in terms of gender and age. Due to time and resource constraint, the study was limited to two geographical areas with close proximity to each other. The categories of young people recruited for the study fall under the broad umbrella of out-of-school youth, and a diverse range of students in basic school, junior high school, and senior high school. Given the challenge in recruiting students during school hours, participants were engaged after school hours. It was observed that most students from different schools walked home in pairs or groups after school and usually constituted varied age groups and gender. Based on my intuitive sense regarding the potential age range of adolescents, participants were approached to solicit their voluntary participation in the study.

All the young people recruited for the study were compensated with soft drinks as promised in the consent forms. Most of the elite respondents refused
compensation for their time as they considered themselves contributing to a broader cause of knowledge sharing and improving policy practice. It should be noted that while the strategy for recruiting young people is not without problems, quota sampling and focus group discussions are considered legitimate and suitable research instruments for conducting studies of such nature (Halperin & Heath, 2012; Liamputtong, 2013; Bryman & Bell, 2016).

At this juncture, it would also be useful to detail the population distribution in the region. The two districts under study form part of the twenty-seven districts in the Brong Ahafo region. Both districts are in close proximity and share similar geographical, cultural, and socio-economic features. The districts are also predominantly urban in character, and most dwelling units are constructed with cement or concrete, as well as roofed with corrugated metal sheets. Although it would have been useful to conduct the study in both the urban and rural setting, this approach was not possible due to time and resource constraints. However, useful information about other districts (rural) was gleaned from the interviews conducted, as well as other secondary materials. The issue of rural-urban divide will be addressed in further detail in the empirical chapters. To compensate for the jurisdictional limitation, it should also be noted that youth participants had different family, geographic, and socio-economic backgrounds, and this dynamic allowed for variation across the interviewees.

Despite the increasing growth in the service sector, agriculture, fishery, retail trade, transport equipment, among others, remain a major source of livelihood for some households. Generally, Sunyani, together with two other major
districts of Berekum and Techiman, are considered the most urbanized districts compared to the regional distribution. In the rural areas, dwelling units are mostly constructed with materials such as wood, thatch, palm leaf, and mud bricks. I did not have difficulties conducting interviews in English, except in a few instances where certain words and phrases had to be translated to the local language in the focus group discussions. Although illiteracy remains a major developmental challenge in the region, a number of educational facilities were observed, which may have stemmed the problem of language barrier.

2.3. Data Analysis

Following from the study's interpretivist orientation, discourse analysis and process tracing were utilized as the main tools for data analysis. As indicated earlier, the study takes particular interest in not only what participants said, but also how they conveyed the information. Language and meaning-making are thus central to the objectives of the present study. Discourse analysis, as noted by Halperin & Heath (2012), “explores the ways in which discourses give legitimacy and meaning to social practices and institutions” (p. 309). The concept of ideas, as will be discussed in the theoretical chapter, is central to understanding the various ways or discursive mechanisms through which meaning is produced and reproduced (Halperin & Heath, 2012).

Most importantly, discourse analysis is sensitive not only to the time and context in which the text is produced, but also the broader structural factors that shape that context, and consequently political behaviour and policy outcomes.
Simply put, discourse constructs social reality and, in turn, is shaped by the broader relations of power and authority (Halperin & Heath, 2012). In keeping with the primary research question guiding the present study, which is to better understand the factors that shape the nature of interventions aimed at improving young people’s health and well-being, a post-positivist approach is most suitable.

Analyzing both the manifest and latent content of communication provided space to identify and develop themes that emerged out of the data, as well as examine the underlying meanings embedded within the text. In this regard, the recorded interviews were completely transcribed and reviewed multiple times. Following this step, a thematic analysis approach was used to organize the data into meaningful themes using Microsoft Excel. This method of categorization not only allowed for the simplification of data, but also helped in identifying and analyzing patterns from the data. Thereafter, a deeper reflection on the themes helped in establishing appropriate and internal connections between the data and theoretical concepts used in the study.

Document analysis followed in a similar mode. Although several primary and secondary documents were analyzed, local health policy documents and reports (e.g., the GHARH project Team’s Demographic and Health Survey analysis, National Health Policy, Adolescent Reproductive Health Policy), as well as relevant global health documents such as those relating to the SDGs, Global Strategy and AA-HA! received prominent attention. Overall, the main themes that were analyzed from the interviews and documents include, but are not limited to the following: “adolescent health,” “global development agenda,” “poverty,” “gender inequality,”
“multisectoral implementation,” “ideational resistance and adaptation,” “culture and migration.”

Case study designs are often complemented by process tracing (George & Bennett, 2005). As noted by scholars, process tracing could be used to test claims made in relation to how causal mechanisms account for certain political or social outcomes (George & Bennett, 2005; Liamputtong, 2013). In a similar vein, Campbell (2002) also posits that careful process tracing could be used to examine “how specific actors carried certain ideas into the policy-making fray and used them effectively” (p. 29). Within this framework of understanding, process tracing helped in exploring the series of events leading to the adoption of the Global Strategy and AA-HA! and, consequently, how the frames embedded in these global protocols shaped the implementation of the GHARH intervention.

2.4. Methodological Limitations and Validity Threats

As with all research, this study is not without limitations. For the purpose of transparency and credibility, it is important to highlight the validity threats associated with this research. First, I have no prior experience working in the field of adolescent and youth health, which is a specialized area that requires a certain degree of training and understanding. Nonetheless, I engaged with leading officials and professionals who had expertise in the subject area, and the research was also conducted in line with the broader ethical expectations for the study.

Second, the implementation period for the GHARH intervention had almost expired at the time of the field research. While this coincidence constitutes a virtue
in itself, it also poses difficulties in terms of providing an extensive analysis of the programme's impact, especially considering its short duration (i.e., 3 years). For instance, it could not be clearly determined whether the GHARH programme had achieved its intended objective of reducing the adolescent pregnancy burden in the Brong Ahafo region; a longitudinal study might be more suited for research aimed in this direction. However, as earlier indicated, this study is not a formal evaluation of the programme, but rather aimed to get a general sense of how the program was implemented, the actors involved, and the preliminary impact of the intervention.

Third, the sample used for the study may not be representative, and cannot be generalized to the whole population. It would have been ideal to extend the study to other districts in the Brong Ahafo region but due to time and resource constraints, this was not possible. This limitation notwithstanding, useful lessons could be drawn from the study to test their applicability in other political and social contexts. Fourth, following from the sample limitation, the research also faces the challenge of selection bias in relation to the cases selected for the study, particularly considering that other districts could have been selected. However, given the trajectory of the GHARH programme, the selected districts proved a good place to begin with the research.

Fifth, as pointed out earlier in this chapter, it is widely acknowledged that focus group discussions pose particular difficulties in terms of eliciting what is popularly known as the ‘group effect’ or ‘social desirability bias’ (Halperin & Heath, 2012; Liamputtong, 2013; Bryman & Bell, 2016). Considering this challenge, flexibility and further probing helped to address inconsistencies in answers.
provided by interviewees, thus reducing the social desirability bias to a large extent.

In relation to the above point, it has also been noted that interviewer characteristics could potentially affect the responses given by respondents. Although all respondents seemed comfortable with the study and the line of questioning, it cannot be stated with absolute certainty that all responses given were devoid of biases and prejudices. For instance, being a male researcher interviewing young women, the tendency to exaggerate or withhold truth on the part of respondents cannot be completely discounted.

Despite the subjective and interpretive nature of the study, methodological triangulation helped to enrich, minimize or eliminate some of the problems associated with the study. The use of multiple sources of information, including a series of semi-structured interviews and document analysis to corroborate the data obtained serves to strengthen the credibility of this study. Also, the study was conducted based on a reflexive approach. As a Ghanaian, my own position and personal perspectives were inevitably part of the research process. However, I was careful not to foist my knowledge and thoughts on respondents, but rather sought to learn from them. Through critical self-reflection, objectivity remained a central keystone of the study.
Chapter Three

Historical and Institutional Considerations: Context and Background

This chapter provides a broad overview of the historical and institutional elements relevant to understanding the politics and dynamics of youth health, policy processes, and health development in Ghana. In this regard, attention is focused on the historical trajectory and institutional dynamics that define the present socio-political landscape. Against this backdrop, issues pertaining to women and gender, transnational policymaking, citizenship and participatory governance will be discussed. Overall, these varied dimensions set the context for the present study.

3.1. Country Profile

This section begins with a brief background information on Ghana, its socio-political characteristics, as well as health and demographic context. Ghana is an ethnically diverse African nation located on West Africa’s Gulf of Guinea. Geographically, the country shares territorial borders with Burkina Faso (North), Togo (East), and Côte d’Ivoire (West). The country is governed along the tenets of constitutional democracy, and is often touted as a shining star on the African continent based on its democratic credentials.

Undoubtedly, the current socio-political realities in Ghana cannot be fully understood without recourse to the impact of colonialism and colonial legacies on political development and state building in Africa. As several scholars have noted, colonialism disempowered African societies by undermining indigenous forms of
political organization and social arrangements central to identity formation and state building (Béland et al., 2018; Gilley, 2016; Rodney, 1997). As the literature suggests, social services such as hospitals, housing, schools, and railroads were exploitative, and served primarily in the interest of the metropoles. Importantly, the structures inherited from the colonial system institutionalized division and heightened ethnic consciousness. In the context of Ghana, this is particularly reflected in the rural-urban divide and developmental disparities between northern and southern regions. Also, the literature points to the deterioration in the status of women, especially in relation to education and political emancipation (Rodney, 1997). Aside from the legacies of social exclusion, colonialism also undermined state capacity and encouraged a vicious cycle of dependency, a development that is currently reflected in the persistent reliance on donor funding by most African states.

Despite historical lapses in developmental trajectories, the state has gradually evolved into an entity that champions social policy as a critical element of nation-building and social citizenship (Béland et al., 2018). As such, social programs such as education, health care, and welfare arrangements remain central to the national development agenda. In the mid-2000s for instance, the national social protection policy was developed as part of strategies aimed at strengthening social programs in the country, while addressing the economic and social disparities between the well-off and the poor (MMYE, 2007). To be sure, this transition comes on the back of widespread criticism against the state’s reduced
role in social provisioning, an idea that is developed more forcefully in the discussion on youth activism in this chapter.

Ghana has a youthful population, and as will be seen, this has significant implications for the country’s development, especially considering the rapid growth of the population and high dependency ratio of the adolescent and youth population. The current population of Ghana is estimated to be 29.46 million, which is at significant variance with figures recorded at independence in 1957 (i.e., less than six million) (Citifmonline, 2018; Joyonline, 2018b). Given the current annual growth rate of 2.5 per cent and the quest to control population growth, drastic measures (albeit controversial) have been proposed by the National Population Council (NPC), which essentially reflects the push for a mandatory policy that limits couples to a maximum of three babies (Joyonline, 2018a).

The country has a high fertility rate, and it goes without saying that young people contribute to this situation. As can be seen in table 1 below, early marriage is an intriguing feature of the demographic landscape. Despite the universal trend of marriage in Ghana, significant differences have been observed across the urban and rural areas. Research shows that the proportion of young people who are married in the rural areas are higher than in the urban parts, characterized by visible gender differences that raise fundamental questions about the high rates of married females compared to their male counterparts (Ghana Statistical Service, 2013).
Table 1: Distribution of Population of Young Persons by Marital Status, Age and Sex

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>12-14 Male</th>
<th>12-14 Female</th>
<th>15-19 Male</th>
<th>15-19 Female</th>
<th>20-24 Male</th>
<th>20-24 Female</th>
<th>25-35 Male</th>
<th>25-35 Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>93.9</td>
<td>94.2</td>
<td>94.2</td>
<td>86.8</td>
<td>84.3</td>
<td>54.7</td>
<td>41.2</td>
<td>19.7</td>
</tr>
<tr>
<td>Living together</td>
<td>0.5</td>
<td>0.6</td>
<td>0.7</td>
<td>3.2</td>
<td>3.9</td>
<td>10.0</td>
<td>8.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Married</td>
<td>5.6</td>
<td>5.2</td>
<td>4.8</td>
<td>9.2</td>
<td>11.0</td>
<td>32.5</td>
<td>46.8</td>
<td>64.2</td>
</tr>
<tr>
<td>Separated</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.4</td>
<td>0.4</td>
<td>1.4</td>
<td>1.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.2</td>
<td>0.3</td>
<td>1.1</td>
<td>1.4</td>
<td>3.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.4</td>
<td>0.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Total %</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Number</td>
<td>846,580</td>
<td>831,301</td>
<td>1,311,112</td>
<td>1,298,877</td>
<td>1,100,727</td>
<td>1,222,764</td>
<td>1,951,869</td>
<td>2,238,078</td>
</tr>
</tbody>
</table>

Source: Ghana Statistical Service, 2010 Population and Housing Census

As will be further discussed in subsequent chapters, abortion rates and consequent complications or deaths across the youth population are significantly high, which obviously cannot be overlooked considering the potential demographic, health, and socio-economic costs.

3.2. Policies and Programs: Politics of Reproductive Health in Ghana

The issue of reproductive health has received considerable attention from various Ghanaian governments. The first Population Policy dates back to 1969, and focused on key areas such as education, productivity, gainful employment, and a more broader approach to, and strengthening support for women in the formal economy (Odoi-Agyarko, 2003). However, due to the poor performance of the 1969 Policy, a revised Population Policy was formulated in 1994. As the evidence suggests, the
1969 Policy was designed with the long-term objective of reducing the population growth from around 3 per cent in 1969 to 1.7 per cent by the year 2000. However, the population growth rate still hovered around 3 per cent in 1993, suggesting a moderate decline of the total fertility rate (TFR) (National Population Policy, 1994). As noted in the Revised Population Policy (1994), the failure of the 1969 Policy was attributable to the “absence of a well-articulated and co-ordinated institutional machinery to translate policy objectives into programmable action plans . . .” (p. 25). Other significant causal factors include inadequate funding, lack of community participation and grassroots support, as well as inadequate knowledge about the dynamics of population development.

Notably, the adoption of the Revised Population Policy coincided with the 1994 Cairo International Conference on Population and Development (ICPD). This conference was particularly significant, as it created a platform for the international recognition of reproductive rights. In this regard, the ICPD established the right of men and women to have unhindered access to reproductive information and services relevant to the pursuit of good health and well-being. More importantly, the ICPD marked a paradigm shift from ‘Maternal and Child Health and Family Planning’ (MCH/FP) to ‘Reproductive Health’ (RH), with a broader focus on women, men, young people, as well as expansive coverage of reproductive health services such as sexual health, female genital mutilation, gender-based violence, and infertility, among others (Awusabo-Asare et al., 2004; Odoi-Agyarko, 2003).
In relation to the Ghanaian context, the ICPD Programme of Action coincided with the revision of the 1969 Population Policy, and was instrumental in shaping the definition of reproductive health. The policy shift points to an important observation related to young people’s reproductive health. As noted by Awusabo-Asare et al. (2004), the provision of family planning services and information was targeted exclusively at married couples prior to 1994. In other words, young people were generally excluded from family planning services until the Population Policy was revised. That said, the outbreak of the HIV/AIDS pandemic and the emergence of new concerns such as teenage pregnancy also contributed to shaping the policy agenda in terms of young people’s inclusion into family planning services (National Population Policy, 1994). Generally, the country’s high rate of population growth was viewed as an impediment to poverty eradication, dependency burden, economic modernization, and sustainable development, which largely informed the adoption of the Revised Population Policy (1994). This period, therefore, marked a watershed in Ghana’s socio-political history regarding the prioritization of adolescent health.

The Government of Ghana’s commitment to reproductive health is also reflected by the Reproductive Health Service Policy and Standards, which was developed in 1996 (later to be revised in 2003). Here, the aim was to establish an overarching framework for governing reproductive health services and training, as well as performance evaluation of service providers at the various points of service delivery (Odoi-Agyarko, 2003). Although Ghana’s policy environment and historical trajectory suggest significant advances in the area of reproductive health, it was not
until the year 2000 that the health sector witnessed a more explicit adolescent reproductive health policy that speaks broadly to adolescent health issues and reproductive health programmes for young people – that is, the Adolescent Reproductive Health Policy.

To be sure, some adolescent health initiatives were undertaken prior to the 2000s, and significant among these is the West African Youth Initiative (WAYI). This program was developed and implemented between 1994 and 1997 to improve knowledge of sexuality and reproductive health, as well as promote safer sex behaviours among adolescents in Ghana and Nigeria (Brieger, Delano, Lane, Oladepo, & Oyediran, 2001). In 2000, the African Youth Alliance (AYA) program was also established by the Bill and Melinda Gates Foundation to improve adolescent sexual and reproductive health, and to stem the transmission of HIV/AIDS in Botswana, Ghana, Tanzania, and Uganda (Williams, Mullen, Karim, & Posner, 2007). While both programs reflect significant efforts in the adolescent health domain and constituted more broadly, they focus largely on HIV/AIDS prevention. Importantly, they are not domestic initiatives, and the role of the state is largely negligible in the program interventions. This is in direct contrast with the ADHD and GHARH Programmes, which are both locally driven, and reflect varied degrees of state involvement (although primarily reliant on external funding).

3.3. Women, Gender and Power in Ghana

This section provides insight on the gendered dimension of Ghana’s socio-political landscape, with the view to laying the proper foundation for appreciating
discourses and issues surrounding adolescent and youth health development. Gender is one of the recurrent theoretical constructs that has generated a wide body of scholarship on the nature of politics in countries across the globe. This is particularly so in the context of gender as a structural determinant of political and socio-economic inequality between men and women.

Given the centrality of gender to understanding the character of power relations in society, a gendered analysis helps us better understand how political and socio-economic inequalities are constructed by the state and society. As most scholars have noted, gender is socially constructed, and a function of the interactions among human actors and institutions (Adomako Ampofo, 2001; Beckwith, 2010; Waylen, 2012). In other words, masculine and feminine identities are dictated by the socially constructed roles assigned to the biological characteristics of males and females (Inglehart & Norris, 2003). But it is important that we appreciate context and the nuanced manifestation of gender, particularly in relation to women’s issues.

Ghana, like other polities elsewhere (both developed and developing nations), still grapples with gender inequality, characterized by institutionalized practices and power dynamics that broadly work against women (Adomako Ampofo, 2001; Bawa, 2012; Sossou, 2006). Despite the progress made in terms of addressing these gender-based inequalities in Ghana, the problem still persists both at the national and sub-national levels, thus generating a sense of powerlessness, inferiority, and exclusion among women. Of course, some women may have willingly accepted their traditional position and domestic roles as wives.
and homemakers due to the element of social conditioning (Inglehart & Norris, 2003), but it would certainly be naïve to make such sweeping generalizations.

As Bawa (2012) notes, women in Ghana have increasingly become critical of the use of gender as a legitimizing paradigm for gender inequality. Yet the fact still remains – women remain politically and socio-economically vulnerable relative to their male counterparts. Gender-related violence such as rape, sexual abuse and harassment continue to impede efforts towards social change. Women’s reproductive and sexual rights are sharply curtailed, partly due to patriarchal norms that limit women’s right and control over their bodies, thus exposing them to unwanted pregnancies and sexually transmitted infections (STIs) (Adomako Ampofo, 2006a; MOH, 2009; Sossou, 2006). In other words, men dominate decisions over reproductive health, particularly in relation to contraceptive use and issues surrounding family planning.

In her seminal work on gender socialization, for instance, Adomako Ampofo (2001) clearly captures how culture produces and reproduces gender inequalities and inequities. According to her, the socialization of young people has significant implications for their future sexual relationships and reproductive behaviour. As she explains, most Ghanaian societies train adolescent girls for domestic roles, whereas boys are groomed for leadership and privileged positions of power. By imbibing these gendered norms from early childhood, boys are encouraged to lead and control women, which ultimately leads to “dominance over, and exploitation of, females” (Adomako Ampofo, 2001, p. 200). Fundamentally, this argument is consistent with theorists who view gender inequalities as a function of social
construction – a dynamic that embodies the traditional division of sex roles and appropriate behaviours expected of men and women (Beckwith, 2010; Inglehart & Norris, 2003; Waylen, 2012).4

The political exclusion of women is reflected by their lack of voice in the political arena. The underrepresentation of women in politics, as some scholars have argued, could be linked to colonialism, poverty and illiteracy (Rodney, 1997; Senadza, 2012; Sossou, 2006). As Senadza (2012) explains, the Ghanaian society privileges the education of boys over girls, particularly because of the gendered expectations of girls’ traditional care giving role in the domestic sphere. This trend is pronounced in resource-poor settings. As such, it is not uncommon for girls enrolled in school to be withdrawn to support household chores and family businesses in poorer households (Senadza, 2012). Although most men and women in Ghana have completed some level of formal education, men are generally more educated than women, with significant disparities across urban and rural settlements (Ghana Statistical Service, 2014). Tables 2 and 3 below provide a clearer picture of gender inequality in relation to educational attainment between men and women in Ghana.

---

Table 2: Educational Attainment: Women

<table>
<thead>
<tr>
<th>Background characteristic</th>
<th>No education</th>
<th>Some primary</th>
<th>Completed primary&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Some secondary</th>
<th>Completed secondary&lt;sup&gt;2&lt;/sup&gt;</th>
<th>More than secondary</th>
<th>Total</th>
<th>Median years completed</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>8.1</td>
<td>12.0</td>
<td>6.4</td>
<td>53.8</td>
<td>15.7</td>
<td>4.0</td>
<td>100.0</td>
<td>7.9</td>
<td>3,238</td>
</tr>
<tr>
<td>15-19</td>
<td>4.3</td>
<td>14.5</td>
<td>8.1</td>
<td>67.0</td>
<td>6.1</td>
<td>0.1</td>
<td>100.0</td>
<td>7.2</td>
<td>1,625</td>
</tr>
<tr>
<td>20-24</td>
<td>11.9</td>
<td>9.5</td>
<td>4.6</td>
<td>40.6</td>
<td>25.4</td>
<td>8.0</td>
<td>100.0</td>
<td>8.5</td>
<td>1,613</td>
</tr>
<tr>
<td>25-29</td>
<td>17.2</td>
<td>10.2</td>
<td>3.8</td>
<td>39.0</td>
<td>15.4</td>
<td>14.3</td>
<td>100.0</td>
<td>8.3</td>
<td>1,604</td>
</tr>
<tr>
<td>30-34</td>
<td>21.3</td>
<td>12.6</td>
<td>5.2</td>
<td>43.4</td>
<td>9.5</td>
<td>7.9</td>
<td>100.0</td>
<td>8.1</td>
<td>1,372</td>
</tr>
<tr>
<td>35-39</td>
<td>25.4</td>
<td>12.9</td>
<td>4.3</td>
<td>42.6</td>
<td>9.4</td>
<td>5.5</td>
<td>100.0</td>
<td>7.8</td>
<td>1,295</td>
</tr>
<tr>
<td>40-44</td>
<td>31.6</td>
<td>15.8</td>
<td>5.7</td>
<td>41.9</td>
<td>2.1</td>
<td>2.9</td>
<td>100.0</td>
<td>5.4</td>
<td>1,030</td>
</tr>
<tr>
<td>45-49</td>
<td>35.7</td>
<td>14.5</td>
<td>4.5</td>
<td>41.7</td>
<td>0.3</td>
<td>3.3</td>
<td>100.0</td>
<td>4.9</td>
<td>857</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>11.0</td>
<td>9.9</td>
<td>4.0</td>
<td>49.8</td>
<td>15.7</td>
<td>9.7</td>
<td>100.0</td>
<td>8.5</td>
<td>5,051</td>
</tr>
<tr>
<td>Rural</td>
<td>28.5</td>
<td>15.7</td>
<td>6.7</td>
<td>41.1</td>
<td>5.5</td>
<td>2.5</td>
<td>100.0</td>
<td>5.7</td>
<td>4,345</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western</td>
<td>14.2</td>
<td>14.1</td>
<td>5.8</td>
<td>51.3</td>
<td>11.0</td>
<td>3.6</td>
<td>100.0</td>
<td>8.1</td>
<td>1,038</td>
</tr>
<tr>
<td>Central</td>
<td>15.1</td>
<td>10.6</td>
<td>7.3</td>
<td>50.0</td>
<td>10.6</td>
<td>6.3</td>
<td>100.0</td>
<td>8.0</td>
<td>937</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>8.3</td>
<td>10.5</td>
<td>3.7</td>
<td>46.3</td>
<td>17.5</td>
<td>13.7</td>
<td>100.0</td>
<td>8.7</td>
<td>1,898</td>
</tr>
<tr>
<td>Volta</td>
<td>19.1</td>
<td>16.2</td>
<td>6.0</td>
<td>46.0</td>
<td>8.4</td>
<td>4.2</td>
<td>100.0</td>
<td>7.0</td>
<td>720</td>
</tr>
<tr>
<td>Eastern</td>
<td>10.4</td>
<td>13.5</td>
<td>8.1</td>
<td>52.4</td>
<td>10.3</td>
<td>5.4</td>
<td>100.0</td>
<td>8.0</td>
<td>878</td>
</tr>
<tr>
<td>Ashanti</td>
<td>10.8</td>
<td>11.3</td>
<td>4.2</td>
<td>56.4</td>
<td>11.5</td>
<td>5.8</td>
<td>100.0</td>
<td>8.4</td>
<td>1,798</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>20.5</td>
<td>16.4</td>
<td>6.1</td>
<td>45.2</td>
<td>8.5</td>
<td>3.2</td>
<td>100.0</td>
<td>6.5</td>
<td>769</td>
</tr>
<tr>
<td>Northern</td>
<td>65.8</td>
<td>8.6</td>
<td>2.6</td>
<td>17.0</td>
<td>4.4</td>
<td>1.7</td>
<td>100.0</td>
<td>0.0</td>
<td>786</td>
</tr>
<tr>
<td>Upper East</td>
<td>40.0</td>
<td>19.7</td>
<td>7.4</td>
<td>24.8</td>
<td>5.9</td>
<td>2.3</td>
<td>100.0</td>
<td>2.9</td>
<td>358</td>
</tr>
<tr>
<td>Upper West</td>
<td>48.7</td>
<td>15.4</td>
<td>4.6</td>
<td>23.1</td>
<td>3.6</td>
<td>4.6</td>
<td>100.0</td>
<td>1.0</td>
<td>215</td>
</tr>
<tr>
<td>Wealth quintile</td>
<td></td>
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<tr>
<td>Lowest</td>
<td>51.7</td>
<td>16.9</td>
<td>5.7</td>
<td>24.0</td>
<td>1.6</td>
<td>0.1</td>
<td>100.0</td>
<td>0.0</td>
<td>1,511</td>
</tr>
<tr>
<td>Second</td>
<td>27.4</td>
<td>20.0</td>
<td>7.4</td>
<td>42.0</td>
<td>3.0</td>
<td>0.3</td>
<td>100.0</td>
<td>5.3</td>
<td>1,636</td>
</tr>
<tr>
<td>Middle</td>
<td>15.0</td>
<td>14.7</td>
<td>7.8</td>
<td>52.4</td>
<td>8.0</td>
<td>2.1</td>
<td>100.0</td>
<td>7.3</td>
<td>1,938</td>
</tr>
<tr>
<td>Fourth</td>
<td>9.0</td>
<td>9.1</td>
<td>4.2</td>
<td>56.4</td>
<td>15.6</td>
<td>5.7</td>
<td>100.0</td>
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<tr>
<td>Highest</td>
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<td>5.5</td>
<td>2.0</td>
<td>47.6</td>
<td>21.5</td>
<td>19.5</td>
<td>100.0</td>
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</tr>
<tr>
<td>Total</td>
<td>19.1</td>
<td>12.6</td>
<td>5.2</td>
<td>45.8</td>
<td>11.0</td>
<td>6.3</td>
<td>100.0</td>
<td>7.8</td>
<td>9,396</td>
</tr>
</tbody>
</table>

Source: Ghana Demographic and Health Survey (2014)
In her study on gender equality and poverty in Ghana, Awumbila (2006) notes that a significant number of Ghanaians depend on agriculture in meeting their livelihood needs. However, women have less access to land and tend to be more concentrated in the informal economy, characterized by low productivity, income...
irregularities, and economic isolation. Against the backdrop of poverty and inequality, concerns about the gendered nature of access to quality and equitable health care, as well as reproductive well-being remain central to discussions in both policy and social circles (MOH, 2009). Simply put, women face significant structural barriers to effective health care, political and socio-economic empowerment.

The issue of abortion is also noteworthy, especially given the controversial nature of abortion worldwide, including Ghana. As scholars have noted, although safe abortion services (albeit limited) are legally permissible in Ghana, a number of barriers exist that help to explain why women and young girls undertake abortion in unsafe settings (Ahiadeke, 2001; Lithur, 2004; Payne et al., 2013). First, the legality of abortion is shrouded in ambiguous language, which makes it difficult to distinguish between legal and illegal abortion. As a result of this confusion, Payne et al. (2013) note that some physicians and women are wary of the potential ramifications associated with abortion – including fines or imprisonment – for even abortions that may be considered legal under the criminal code. Given that both parties to an abortion procedure could be liable for prosecution, some physicians are reluctant to provide such services due to fear of attracting a criminal record, thus encouraging some women and young girls to resort to dangerous methods of dealing with unwanted pregnancies (i.e., self-induced abortion). As noted by Lithur (2004), the maximum penalty for illegal abortion is five years imprisonment.

Hitherto, abortion was considered a criminal offence in all circumstances, subject to a maximum sentence of ten years imprisonment (Lithur, 2004). Under
the revised criminal law, which occurred in 2003, there are three instances under which abortion could be considered legal – “if the pregnancy was as a result of rape, defilement or incest; would pose a risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that if the child were born may suffer from a serious abnormality or disease” (Lithur, 2004), and where abortion is “caused by a medical practitioner specializing in gynecology or other registered practitioner in a government hospital or registered private hospital or clinic” (as quoted in Ahiadeke, 2001). Given the broad and interpretative nature of the abortion law, Payne et al. (2013) note that a physician’s judgment on the legality of an abortion could be challenged. It is, therefore, not surprising that medical records surrounding abortion services are underreported or difficult to obtain, especially among private practitioners (Ahiadeke, 2001; Payne et al., 2013; Rominski & Lori, 2014).

Second, traditional and cultural values, coupled with negative social perceptions and religious teachings have further contributed to the stigmatization of abortion (Lithur, 2004; Morhee & Morhee, 2006). Fertility and childbearing are highly cherished in the Ghanaian society, although efforts are being made to reduce the fertility rate across the broader population. Given this cultural value, women or young girls who have abortions are socially constructed in negative ways. For example, in the Ga traditional community in Ghana, a woman who performs or self-induces an abortion is perceived as having brought shame upon the family and, therefore, may be branded as “the family where its womenfolk remove pregnancies” (Lithur, 2004, p. 72).
Of course, this simple, yet powerful construction has significant implications, as potential marriage suitors might steer clear of such families. As Lithur (2004) explains, certain societies, in the attempt to avoid such social embarrassment and stigmatization, encourage or coerce young girls who become pregnant to use unorthodox procedures to terminate the pregnancy to avoid disclosure. In fact, these social values not only affect women and young girls, but also health practitioners. Given the premium placed on motherhood, coupled with cultural and religious factors, it has been observed that some physicians refuse to provide abortion services, or may provide such services in obscure places. Payne et al. (2013), for instance, in their study note that “nobody wants to be labeled an abortionist, and healthcare professionals generally don’t want to be associated with abortion” (p. 122).

Third, abortion services are expensive, which drives young girls and women to adopt or seek unsafe abortion alternatives. As Morhee and Morhee (2006) point out, most government hospitals are reluctant to perform abortions, thus leaving the service in the hands of a few private practitioners incentivized mostly by financial considerations. Suffice it to say that complications arising from unsafe abortion are considered a leading cause of maternal mortality and morbidity in Ghana (Morhee & Morhee, 2006; Rominski & Lori, 2014), which suggests the need for greater attention to, and commitment to young people’s health and well-being. All in all, a ‘gender lens’ is helpful in terms of appreciating some of the key issues surrounding the politics of adolescent and youth health in Ghana.
3.4. Transnationalism and Global Health Policymaking

This section seeks to map out and explain the global terrain, with particular interest in the complex relationships between international institutions (e.g., UN and WHO) and transnational actors (bilateral, multilateral and civil society) on the one hand, and between national governmental and non-governmental actors on the other. This overview is important as it broadens our conceptual understanding of the complex dynamics of global health governance and its implications for domestic politics. The increasing role of transnational actors in policy diffusion and implementation processes has not escaped the attention of policy scholars, and considering the rapid pace of globalization, it is unlikely that debates over frames, ideational exchange, and paradigm shifts will abate.

International institutions such as the United Nations (UN) and World Health Organization (WHO) have featured as prominent actors in global health governance in the past several decades, developing and shaping policies that have significantly influenced the priorities of national governments and transnational actors (Johnson, 2010; Labonté, 2008; Shiffman & Smith, 2007). More recently, their various roles in structuring the international and domestic policy agenda [both visible and invisible] has attained new heights, thus prompting comparative and policy scholars to take curious interest in how these dynamics play out in the international and national arena (Skogstad, 2011). In the contemporary era, the policies articulated by these international institutions are broadly conceived in global terms, a departure from previous practice where developing countries largely appeared to be the ‘target subjects’ (albeit some qualifications remain). This
is particularly true in the case of the Sustainable Development Goals (SDGs), which is largely conceived as a significant improvement over the Millennium Development Goals (MDGs) in terms of scope and reach (Global Strategy, 2015).

The role of actors and ideas in the policy arena is essential to understanding political behavior and outcomes. Given the fluidity of the political environment, most ideational scholars have underscored the need to pay critical attention to how and when ideas matter (Campbell, 2002; Mehta, 2011; Schmidt, 2008). In pursuing this line of inquiry, the literature places significant emphasis on the nature of the political landscape. Generally, scholarship on ideas and politics acknowledge that different types of ideas yield different outcomes based on the prevailing conditions. It is, therefore, apparent that policy discourses do not operate in a vacuum. In order for policy frames and ideas to be activated, there is the crucial need for what has been popularly referred to as ‘political opportunity structures’ (Benford & Snow, 2000; Tarrow, 2011) or ‘policy windows’ (Kingdon, 2011). In other words, an open or enabling political structure, as opposed to a closed political system, can facilitate institutional change, and ultimately engender policy success.

Undoubtedly, globalization has created significant opportunities for attention to, and investment in adolescent and youth health development. As noted in chapter one, a range of explanatory factors have been proffered to explain the neglect and marginalization of young people, and this includes poor understanding of adolescent health issues, narrow focus of the MDGs, poor research methodology, among others. Of interest to this study is the bounded character of the MDGs. While the MDGs placed emphasis on maternal health issues more broadly, it failed to
specifically carve out the youth population as deserving of attention. This lapse perhaps explains the limited scope of the preceding Global Strategy launched in 2010, which focused solely on maternal and child health.

But as suggested by Baumgartner, Jones, and Mortensen (2014), new policy images could attract new participants and engender collective decision-making. While the MDGs have generally been praised for success in the area of poverty reduction and socioeconomic improvement, empirical evidence suggests that the benefits were unevenly distributed across the global community (UN, 2015). As noted in the United Nations (UN) report (2015), the prevalence of inequalities, disparities, disadvantage, and vulnerability, which somewhat diminished the achievements attained in the MDGs, underscored the need for a comprehensive and more inclusive global discourse aimed at sustainable development across the world. In line with this reasoning, global leaders adopted the SDGs in 2015, with the ultimate goal of promoting healthy lives and well-being for all at all ages.

Perhaps a striking feature of the new global protocol is the strategic positioning of women, children, and adolescents at the forefront of the development agenda. In keeping with the broad vision of the SDGs, the updated Global Strategy, which specifically provides a framework for adolescent and youth health development, was launched at the 68th World Health Assembly (WHA), resulting in the subsequent adoption of the Global Accelerated Action for the Health of Adolescents (AA-HA!).

Policy diffusion occurs through various mechanisms – learning, imitation, normative pressure, competition, and coercion (Berry & Berry, 2014). As Berry and
Berry (2014) note, multiple mechanisms may dictate a policy’s diffusion, and most importantly, these mechanisms are fluid, dependent on context (i.e., characteristics of a state), as well as the nature of the policy. Of particular interest to the present study is the normative ideas that underlie the diffusion of global protocols such as the MDGs and SDGs. In this context, governments may follow the policy directives of the UN and WHO, for instance, primarily because of the power and credibility of these global institutions, as well as shared norms about the conception of “good policy” and “best practices” (Berry & Berry, 2014).

In fact, policy diffusion does not occur in a vacuum. Given the globalized context in which global protocols are forged, the impact of international issue framing on the domestic policy landscape is also influenced by the interrelations among bilateral, multilateral and non-governmental actors. This dynamic is important, particularly in the context of shifts in global funding arrangements towards NGOs rather than state actors. Notably, shifts in the structure of international funding or development assistance to developing countries are largely in response to corruption, fraud and misappropriation at the state level, a development that further reveals the complexities of the issues involved.

But a more interesting debate that has preoccupied development scholars and foreign donors more recently speaks to the question of whether NGOs apply funding secured from development partners in line with their established mandate, or serve as institutional avenues for the pursuit and nurturing of patrimonial relations. As Chabal and Daloz (1999) put it, where foreign aid is available, it tends to serve the interests of those who know how to play that system. In many ways,
the intersection of transnational and domestic politics has put the spotlight on the activities of NGOs, and this dynamic certainly captures the growing importance of accountability mechanisms within the context of transnational policymaking. In short, the aforementioned actors are important and should not be ignored – because the nature of their relationship is key to understanding the ideational mechanisms and processes that underpin global and domestic policy change and reform.

Generally, public-private partnerships (PPPs) are widely recognized as strategic approaches to dealing with the complex and increasing demands of modern governance. Today, the private sector is viewed as a promising alternative mechanism to effective, competitive, innovative, and efficient program delivery (Kernaghan, Marson, & Borins, 2000). It is argued that the private sector brings a wealth of resources including ideas, expertise, and much-needed funding to the decision-making table, and therefore, shared resources could reduce the financial and logistical burden of the government. Given the benefits that flow from partnership arrangements, the Global Strategy and AA-HAI emphasize the need for aggressive pursuit and maximization of such opportunities.

In the context of Ghana, PPPs have often been touted as the engine of growth and development, and as such, have been used in various policy sectors including transport, sanitation, agriculture, telecommunication, among others. However, a historical trajectory of the use of PPPs in the country holds significant implications if such partnership arrangements are to form a centerpiece of the adolescent health development agenda. While the PPP ideology is not new, it was
not until the early 1990s that the private sector received serious attention in policy circles – a watershed that marked the shift away from state-centric development to market-based mechanisms as vehicles for economic growth (and the realization of citizenship bargains). But this new path has been characterized by a fuzzy and unstable relationship between various governments and the private sector over the years. Arguably, the concept of partnership has been taken for granted.

As noted by Ackah, Aryeeetey, Ayee, and Clotey (2010), the political ideologies of the incumbent political leadership often dictate the nature of the relationship between the state and the private sector. Nonetheless, it is worth noting that the key political parties in Ghana (i.e., the National Democratic Congress (NDC) and the New Patriotic Party (NPP)) have promoted the private sector in various ways and to varying degrees. The NDC, for instance, championed economic stabilization and liberalization as a pathway to development, while the NPP also pushed this agenda further through its popular mantra, the ‘Golden Age of Business’ (Ackah et al., 2010; Arthur, 2006).

In line with this wave of business thinking, Ghana developed PPP policy guidelines in 2004, but they were not operationalized. However, a new national PPP policy framework was developed in June 2011 to provide an official platform to effectively engage the private sector in the provision of public infrastructure and services (MOFEP, 2011). As noted by Zaato and Ohemeng (2016), it is the first national policy designed “to regulate the interface between the public and private sectors in the PPP form” (p. 327). The central objectives of the new PPP policy are to:
• Accelerate investments in infrastructure and services by leveraging public assets and funds with private sector resources from local and international markets;

• Ensure value for money by creating an enabling environment for PPPs;

• Protect the interest of all stakeholders, while respecting local and international social and environmental standards;

• Ensure efficient and transparent institutional arrangements for the identification, structuring and competitive tendering of PPP projects;

• Improve service quality and efficiency of projects through effective risk sharing mechanisms; and

• Encourage and promote local Ghanaian private sector participation in the delivery of public infrastructure and services (MOFEP, 2011).

This brief overview provides context and a yardstick against which PPPs can be measured to inform the present analysis. Central to the discussion is the fact that despite these policy commitments and grand political speeches, private sector development in the country remains relatively weak. As Zaato and Ohemeng (2016) note, the PPP policy is hollow due to the lack of institutionalized structures and substantive governance arrangements that give force and meaning to the policy document. Beyond this issue, scholars have highlighted the lack of trust between successive governments and the private sector, which is obviously a crucial ingredient for successful partnerships (Aryeetey & Owoo, 2015; Osei-Kyei, Chan, & Dansoh, 2017).
A cursory look at Ghana’s history suggests that the private sector is often viewed as a complex mechanism through which corruption is produced, legitimized, and sustained. During Ghana’s military regime, for instance, various private companies had their assets confiscated due to the belief that their corrupt activities had engendered a vicious cycle of poverty and economic hardship (Aryeetey & Owoo, 2015; Danso, 1992). In a similar vein, Zaato and Ohemeng (2016) note that upon assuming office in 2009, the NDC government abolished the Ministry of Private Sector Development (MPSD) established by the NPP administration based on the rationale that the ministry was being used as a conduit for corruption and cronyism. While significant strides have been made in terms of PPPs, rent seeking and corruption are still endemic to the country (Aryeetey & Owoo, 2015). The increasing rise of abrogated contracts and subsequent judgment debts shed further insight on the nature of PPP operations in the country (Osei-Kyei et al., 2017).

Another worrying concern is the lack of specialized knowledge and experience in managing PPP operations (Osei-Kyei et al., 2017; Zaato & Ohemeng, 2016). In their study on public-private partnership in Ghana, for instance, Osei-Kyei et al. (2017) note that misallocation and questionable risk sharing arrangements, as well as poorly managed contract agreements have been typical of the PPP landscape. Given these challenges, the failure of waste disposal PPPs to effectively and efficiently deliver expected social services is not surprising (Awortwi, 2004). Put together, most scholars have also noted that unfavorable tax policies, coupled
with the harsh realities of the PPP environment have seriously undermined private sector development in Ghana (Arthur, 2006; Aryeetey & Owuo, 2015).

It is clear from the above discussion that if the private sector is to be meaningfully engaged in advancing adolescent health, some considerations have to be taken into account. Partnerships are complex relationships that could be mutually beneficial for the parties involved, but things could go awry if careful thought is not given to the mechanisms that define such arrangements. As Kernaghan et al. (2000) note, there are various forms and types of partnerships characterized by varying degrees of power, influence, risk sharing, and so forth. In Ghana’s effort to partner with the private sector, it is, therefore, imperative that such partnerships are contextualized to the local environment and deeply informed by past experiences, mistakes, and a better understanding of the complexities and nuances of the PPP milieu.

3.5. Youth and Citizenship

The concept of citizenship has been part of centuries-long political discourse and has increasingly gained political currency in contemporary politics. The concept in itself defies a universally accepted definition given its ambiguous properties. As noted by Wallace (2001), it is essentially politically contested due to its normative character. In addressing the issue, this study conceptualizes citizenship as a process that evolves over time rather than an end in itself. For the purpose of this dissertation, citizenship is defined as the substance of the relationship among individual citizens, community, and the state.
Over the past few years, T. H. Marshall’s (1950) conceptualization of citizenship has been challenged and broadened by several scholars due to its narrow focus (Helve & Wallace, 2001a; Isin & Turner, 2007; Johnson Redden, 2002b). At its most fundamental level, however, Marshall’s conception of citizenship captures three important interrelated rights – that is, civil rights, political rights, and social rights. The present study builds on the emerging scholarship on citizenship, with particular focus on how young people are incorporated into decision-making structures and its implications for health sector governance and social development.

As already pointed out, young people have consistently faced neglect and marginalization to a degree that challenges their citizenship in terms of access to socio-economic and political rights. Paradoxically, even though the youth possess citizenship rights, they cannot fully access them. Thus, it is not surprising that some scholars describe the youth of today as ‘partial citizens’ reinventing themselves as active rather than passive recipients of rights (Helve & Wallace, 2001b). But citizenship, as described by Kymlicka and Norman (1994), cannot merely be reduced to status, defined by a myriad of rights and responsibilities. Rather, it is an identity and a function of one’s membership in a political community.

As argued by Béland et al. (2018), state programs like education and health care fundamentally boil down to citizenship, in light of the understanding that they are “instrumental in the construction and reconstruction of national identities and solidarities, at both the ideational and institutional levels” (p. 2). In a similar vein, Johnson Redden (2002a) notes that health care, broadly conceived, is an
embodiment of citizenship that encompasses distribution, redistribution, inclusion, provision, service and access. In the context of the present study, the concept of citizenship brings into perspective the state’s responsibilities to young people, and how that translates in the national agenda in terms of policies and practices that pertain to their identity rights.

In Ghana, the provision of health care has traditionally been conceived as the responsibility of the State (Mills, Bennett, & Russell, 2001). The National Health Insurance Scheme (NHIS), for instance, is a social intervention program that was instituted in response to broader calls for the state to demonstrate its commitment towards prevailing barriers to health care and health inequities faced by the citizenry (Agyepong & Adjei, 2008). The premium exemptions provided for young people (i.e., children below eighteen years) under the NHIS scheme, as well as free maternal health care, for example, clearly reflects the underlying values of the social rights of citizenship, broadly understood within the larger context of democratic citizenship.

In short, the renewed emphasis on young people’s citizenship in the global arena is laudable and might contribute to addressing the historical deficit of youth inclusion in the public policy process. Addressing the issue of young people’s health development within this context could, therefore, not be more relevant in contemporary politics as citizenship takes on new meanings and political space. This process, however, would require a restructuring of the relations between the state and society, with particular emphasis on socio-economic and political inclusion of young people. For the purpose of clarity, the aim of this dissertation is
not to suggest that maternal and child health are less deserving of attention or inclusion, nor is it designed to foster competition that could potentially result in a race to the bottom. Rather, the analysis is rooted in a social justice framework that seeks to bring to the fore the historical and contemporary limitations of citizenship as it pertains to young people, and to explore opportunities that advance a new culture of inclusivity.

3.5.1. Participation as Citizenship

Political participation is a central pillar of citizenship (Sloam, 2012), and has become a pertinent theme in citizenship studies in recent times. Within this broader understanding, there have been several calls for the need to engage young people in decisions that affect them (Ginwright & Taj, 2002; Levac, 2013b; MacDonald et al., 2011b). Indeed, the literature shows that the historical trend of political apathy, particularly in relation to the current cohort of young people, has given way to a new political direction where young people are consistently pushing to be recognized and included in the public policy process. Perhaps this dynamic of youth politics is informed by the dramatic changes in youths’ expectations about their intrinsic entitlements and inclusion within the citizenship discourse (i.e., the right to be recognized as full citizens). This phenomenon obviously resonates with Inglehart and Welzel’s (2005) theory of emerging self-expression values, which encourages individual autonomy and agency.

Notably, the past few years have also witnessed significant emphasis on ‘citizen engagement’, as part of the broader discourse on good governance. It would
be useful to situate the present discussion within this overarching deliberative framework. The logic of citizen participation in the policy process, otherwise known as participatory democracy, is grounded in the fundamental understanding that the mechanism of consultation could make government more responsive, accountable, efficient, and effective in policy delivery (Kernaghan et al., 2000). In other words, the content of policies and programs could be positively impacted if citizens were engaged in the decision-making process.

Since the 1990s, policymaking in Ghana and some other African countries has witnessed a progressive shift from the traditional state-centric approach to a communicative mechanism that engages the citizenry through legitimized channels of deliberative participation (Kpessa, 2011; Oduro, 2009; Ohemeng, 2005). Similar to other countries in the developed and developing world, Ghana’s policymaking arena was hitherto considered a privileged space for politicians and bureaucrats. As aptly described by Ohemeng (2005), the policymaking environment approximated a “closed circuit network” characterized by secrecy (p. 450). This non-participatory regime, however, witnessed an evolutionary transformation as Ghana liberalized its political and economic environment through the transition to democratic rule in 1992, alongside pressure from the Bretton Woods institutions (i.e., The World Bank and IMF). As Kpessa (2011) succinctly puts it, the new political landscape, characterized by a participatory ideology, encourages citizens to express their voice while the state is entreated to listen.

The changes in the policymaking environment are largely rooted in what has been popularly referred to as New Public Governance (NPG), which essentially
captures the complex interplay between politics and governance. At the heart of NPG are the emerging governing pressures that have been brought to bear on the state by a constellation of social and institutional forces, and responses to those pressures, which ultimately have implications for policy outcomes (Jarvis & Bakvis, 2012). Due to the departure from the state-centric approach to governance, new terms such as ‘horizontal government’, ‘joined-up government’, and ‘network governance’ have become important vocabularies in political discourse. Given the shift in expectations, the public now seems less willing to accept political decisions that are in line with the command-and-control style of governing (Peters & Savoie, 2012). Fundamentally, the public generally perceives policy making as a collective expression of mediated values, of which they legitimately constitute vested stakeholders.

An intriguing component of the NPG movement is the rise of the private market and nonprofit sectors in the policy arena, which also lay claims to ownership of the public good (Bao, Wang, Larsen, & Morgan, 2012; Hajer & Wagenaar, 2003; O’Toole, 2010; Skogstad, 2011). The paradox of the NPG paradigm, then, is that although the political space has been broadened to include a multiplicity of actors, it has also created tensions to the extent that concerns have been raised about the apparent dispersal of decision-making away from the centre (Peters & Savoie, 2012). In other words, the power of governments to deliver policy outcomes has been constrained, deceptively pushing non-state actors into the ‘driving seat’.
These concerns certainly touch on long-drawn debates in the policy literature – Who governs? Who should govern? (Skogstad, 2003). As Skogstad (2003) argues, the seemingly competing sources of political authority have implications for effective and legitimate governance. While there is some truth to this argument, it loudly calls for critical reflection on the frightening dominance of the political executive in the decision-making process. In fact, the so-called ‘governance crisis’ begs the question – to what extent are stakeholders involved in the decision-making process, and is this sufficient to affect policy outcomes?

3.5.2. Youth Participation and Citizenship

As noted, participatory governance is an essential component of citizenship. However, as Percy-Smith (2010) suggests, the façade of active citizenship has become a dominant discourse in policy circles due to the general assumption that young people are now ‘included’ in the policy process. But as most scholars have noted, many young people who have been engaged in consultation have not only become disillusioned due to the lack of feedback on the consultative process, but also the limited impact of their opinions on policy outcomes (Malcolm Hill, Davis, Prout, & Tisdall, 2004; Matthews, Limb, & Taylor, 1999).

In her gradated analysis of the various types of citizen participation, Arnstein (1969) presents an eight-rung typology that distinguishes ‘genuine’ from ‘rhetorical’ participation – manipulation, therapy, informing, consultation, placation, partnership, delegated power, and citizen control. This analytical ladder is useful in the context of examining the Reality Check Approach (RCA) employed
by Palladium in engaging young people as part of the GHARH intervention. According to Arnstein (1969), manipulation and therapy are often confused with participation, but in reality, it only enables policymakers or the political elite to “educate” or “cure” the participants. Informing and consultation, on the other hand, allow citizens to have a voice in the policy process. However, information flow may be limited with no opportunities for feedback or negotiation. Thus, the power to affect the status quo is undermined. While placation allows citizens some degree of influence, the ultimate power of decision-making rests with policymakers and the political elite. At the level of partnership, delegated power, and citizen control, power is redistributed among citizens and the political establishment to the extent that negotiation, joint decision-making, and collective stake in policy outcomes become the norm, reflecting a significant shift away from the “window dressing ritual” to a culture of genuine participation.

The issue of young people’s age vis-à-vis adults has received wide attention from scholars over the years. In Africa and most Western contexts, the literature shows that young people do not feel valued in the society due to their age. As most scholars posit, young people are perceived to be incompetent, unreliable, undeveloped, and untrustworthy (Cockburn, 2005; Kleinert, 2007; Weller, 2003). As Levac (2013a) notes, they are, therefore, regarded as unworthy of participation until they become adults. In the Ghanaian context, the recognition of youth voices is particularly challenged by socio-cultural mores. Young people are typically expected to acquiesce to the elderly, as their authority is bestowed upon them by divine right. As Porter and Abane (2008) note, young people are socialized from
childhood to know and accept their place within the hierarchical order of family and community structures – they should be seen and not heard. Challenging authority is thus considered alien and a matter of gross insubordination, a grave offense that should not go unpunished.

Aside the issue of age, young people are often judged as less worthy of full citizenship due to little economic investments put into the state. Unlike advantaged groups such as the elderly, entrepreneurs, and small businesses (who are considered worthy and deserving), young people are viewed as a burden because they are on the receiving end of the economic spectrum rather than contributing to society through taxes (Schneider et al., 2014). But how do the youth contribute to national wealth in the face of high unemployment levels? Should citizenship be constructed based on an economic calculus?

High youth unemployment is a global problem, but the challenge is particularly evident across developing countries. In the case of Ghana, data from 2015 shows that the general unemployment rate was relatively high (Ghana Statistical Service, 2016). For those employed, most were either self-employed, worked in the informal sector or private sector. However, as noted in the 2015 Labour Force Report (LFS) produced by the Ghana Statistical Service (Ghana Statistical Service, 2016), majority of those in the employed bracket face precarious employment conditions. Apparently, a historical trajectory of unemployment in Ghana shows that a significant proportion of the unemployed fall within the youth category (Amankrah, 2012). While a relatively small proportion of youth are
engaged in professional occupations, others have been absorbed into the agriculture, forestry, and fishing industries (Ghana Statistical Service, 2013).

Various factors account for youth unemployment in Ghana, and key among these factors include poor macroeconomic performance and inability to generate adequate employment outlets (Amankrah, 2012). Recently, Ghana attained a new development status as a middle-income country. Yet poverty and unemployment remain endemic across the nation. As part of measures towards poverty alleviation and unemployment, various governments have undertaken several initiatives over the years. These include: Livelihood Empowerment Against Poverty (LEAP), Ghana Poverty Reduction Strategy (GPRS), Ghana Shared Growth and Development Agenda (GSDGA), National Youth Employment programme (NYEP), among others. The current political administration has prioritized job creation as paramount to addressing youth vulnerability, inequality, and exclusion within the broader governance and development framework.

The SDGs and other related protocols establish a clear relationship between citizenship and youth employment. If young people are considered assets in the broader development agenda, then the issue of high unemployment rates among the youth necessitates critical attention. Table 4 below provides a contextual overview of youth unemployment in Ghana.
According to Table 4, the data shows that the youth score high on the unemployment index (25.9%) relative to the rest of the population. Also, the unemployment rate is higher for females compared to their male counterparts. Constitutionally, the State is enjoined to provide adequate means of livelihood and productive employment for all citizens (Article 36. (1)). In addition, equality of employment opportunity is guaranteed under the Directive Principles of State
Policy, with particular attention to women. From a critical standpoint, it is clear that the economic premise upon which citizenship is defined is not only weak and misguided, but also violates the inherent citizenship rights of young people. Of course, the youth are encouraged to be innovative and not wait on the state to provide jobs. Fundamentally, however, the role of the state is central to the conversation, so it is more fruitful to take this into account in discussions surrounding youth citizenship.

If the youth are to enjoy optimum health in accordance with their social rights while fulfilling their expected role as change agents in the development discourse, then rethinking youth citizenship cannot be overemphasized. Rather than perceiving young people as undeveloped and a burden to society, attention should be shifted towards nurturing their citizenship claims on agency, confidence, leadership, and better integration into their communities and governance chain. Viewed from this angle, youth citizenship is not predicated on economic productivity nor seen as an end in itself, but rather, as a dynamic process rooted in normative values of socio-economic and political rights.

As argued by most scholars, it is imperative to include young people in the decision-making process because they hold the key to policy solutions (DiCenso, Guyatt, Willan, & Griffith, 2002; Levac, 2013b; MacDonald et al., 2011b). Against this backdrop, it is important to note that the concept of youth citizenship, particularly in relation to participatory governance, is reflected by the GHARH programme through the use of the RCA (Palladium, 2015a). This approach entailed the use of informal channels to engage young people in their normal social settings.
From a methodological standpoint, the merits associated with researchers embedding themselves in a social setting over extended periods of time are widely acknowledged (Bryman & Bell, 2016). The issue of reactivity is, of course, a major challenge associated with this research method, and this was captured in the RCA report. In the broader context of the citizenship discourse, Halperin and Heath (2012) suggest that participant observation not only allows for “thick description,” but could also “give voice to people who otherwise would not be heard ...” (p. 290). The informal nature of the RCA resonates with the argument advanced by Percy-Smith (2010) on the need to shift attention away from institutionalized public decision-making processes by engaging young people in everyday life contexts.

However, as the discussion in chapter eight suggests, formal (structured participatory spaces) and informal approaches (unstructured participatory arrangements) to inclusive citizenship need not be at odds with each other. On the contrary, these approaches should be used as complementary strategies to effective and meaningful youth engagement, while ensuring that the contextual environment is taken into account. It is, however, imperative to ensure that the youth are not pushed to the margins in the use of these approaches. Indeed, such citizenship discourse is central to advancing development within the broader context of nation building.

3.5.3. Youth, Politics and Policy: Participatory Governance in Ghana

As already noted, the youth possess enormous potential that remain untapped due to institutional barriers that restrict their citizenship rights. In light of this
understanding, this thesis places emphasis on the need to shift attention towards innovative mechanisms through which the youth can effectively challenge the power imbalance that structure the political process, particularly their role in shaping policy outcomes. To address this issue, the structural deficit of participatory governance needs to be recognized and understood. Indeed, the so-called ‘governance crisis’ thesis, where state-centred political authority is viewed as largely usurped by popular authority (i.e., citizenry participation in governance), needs to be critically examined, especially in light of the contextual political realities in Ghana.

The following discussion provides a deeper contextualized understanding of the participatory landscape in terms of youth engagement in decision-making, which also brings into sharp focus the ‘real’ character of civil society-state relationship in Ghana. The analysis will inform youth strategies that may perhaps be useful in making effective claims on the state. The discussion is relevant, especially in the context of global calls for civil society engagement in advancing adolescent health and well-being (WHO, 2017).

Youth participation in Ghana, although new, is something old that dates back to the country’s pre-independence era. Through a historical account, Datta and Porter (1971) note that the asafo (organized military bands), which is a traditional social institution among the coastal Akan, emerged around the middle of the 17th century.5 This institution, which comprises mostly youth (young men) operated in various capacities such as providing security, keeping the society clean,

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5 The Akan constitute the largest ethnic group in Ghana. These groups of people reside mostly in Southern Ghana.
governing the community and shaping political events. While the power sharing arrangement is not entirely clear, the historical account suggests that their position in the state was well recognized. However, with the onset of colonial rule and the emergence of the indirect rule system, the asafo lost its influence in state affairs, as they were socially constructed as anti-state elements that possessed the power to destabilize the state and thwart the colonizer's vision of indirect rule (Shaloff, 1974).

After independence, however, the asafo, together with other youth groups became the youth wing of the Convention People's Party (CPP). Although the youth were engaged for development purposes, they served mainly as a politicized vehicle for advancing Nkrumah’s socialist ideology and repressing political dissent (Goody, 1968). It is, therefore, not surprising that these groups were disbanded after Nkrumah was ousted from office through a military coup in 1966. A notable youth group that has lost much of its political clout in contemporary Ghanaian politics is the National Union of Ghana Students (NUGS). Apparently, this group played a key role in the overthrow of the Supreme Military Council (SMC) (I) through collective protests and criticism of the military’s dictatorship, economic hardship, unemployment, poverty, and rampant corruption among the elite (Shillington, 1992).  

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6 The Convention People’s Party (CPP) was established by Kwame Nkrumah. He became the first prime minister and president of Ghana after the country attained independence from colonial rule in 1957.
7 The period between 1966 and 1992 constitutes a dark period in Ghana’s political history, characterized by military coups and counter coup d’états.
Youth activism has, therefore, contributed significantly to the quality of
democratic politics in Ghana. Since the return to democratic rule in 1992, students
have been given prominence in the campaign strategies of political parties and
political aspirants to maximize their electoral calculus (Asante, 2012). In fact, the
two main political parties in Ghana, knowing the worth of youth support, have
established student wings across the various tertiary institutions to further their
agenda. The Tertiary Education and Students’ Confederacy (TESCON) and The
Tertiary Institution Network (TEIN), for instance, are the student wings of the New
Patriotic Party (NPP) and the National Democratic Congress (NDC) respectively.

Through protests and confrontation with various governments, youth
activism has been central to shaping broader national issues and policies. But at the
same time, this seemingly radical posture has often been met with brutal
suppression from the state, thus alienating the youth from national politics.
Although student activism is still operative in the current democratic dispensation,
the student front has somewhat been rendered ineffective over time. According to
Gyampo (2013), political leaders have surreptitiously corrupted and infiltrated the
student body, thus weakening the leverage and legitimacy of youth groups across
time and space, particularly NUGS.

As pointed out earlier, the youth are generally perceived to be immature,
clueless and unworthy of participation. However, the historical trajectory of youth
activism in Ghana suggests otherwise. In her study of political culture and
socialization, for instance, Chazan (1978) uncovers “an extremely sophisticated
awareness of politics” among Ghanaian youth aged between 15 and over 26 years
old (p. 4). Her research showed that the youth had strong interest in national affairs but felt disillusioned about their lack of voice on policy decisions. Also, the youth felt that the policies developed and implemented by the government had no direct benefit or bearing on their lived realities. In short, the youth had demonstrable capacity to appraise the government’s performance and relevance of its policies.

Chazan’s (1978) study is particularly striking, especially considering the time period in which the research was conducted – an era characterized by fear, uncertainty, and widespread illiteracy. Arguably, in the current democratic dispensation, characterized by relatively higher levels of educational attainment, technological sophistication, and open political space, the persistent marginalization of the youth in the policy arena is unwarranted. Indeed, it raises critical questions not only about the so-called ‘good governance’ ideology often touted in policy circles, but also points to deeper fractures in the democratic system.

According to Gyampo and Obeng-Odoom (2013), attempts to engage the youth in policy implementation are “purely accidental and unintended” (p. 131). Their argument is based on the premise that policy formulation and implementation in Ghana are still characterized by the vestiges of the state-centric model of governance. As they note, policy decisions are primarily shaped by, and implemented by government Ministries, Departments and Agencies (MDAs), as well as Metropolitan, Municipal and District Assemblies (MMDAs). To some extent,
the private sector, development partners, and civil society are also engaged in the implementation process.

In their study on youth participation in local and national development in Ghana, Gyampo and Obeng-Odoom (2013) present a depressing picture regarding the nature of development activities under the National Development Planning Commission (NDPC). According to them, although Ghana boasts of about 4,000 registered youth groups, none of these groups is represented on the lead implementing agencies of the NDPC. Ironically, the National Youth Employment Policy (NYEP), which promised to integrate the youth in national development, proved to be deficient. In contradiction to the NYEP Implementation Guidelines (2006), which positions the youth at the forefront of the implementation process, it was observed that other institutions performed the formulation and implementation role designated for the youth (Gyampo & Obeng-Odoom, 2013).

One might be tempted to think that having more youth elected into parliament could help address the deficit of youth representation in national decision-making. But the issue is not as straightforward as it seems. In his study on youth representation in parliament, Gyampo (2015) observes that a higher number of young parliamentarians does not necessarily translate into representation of youth interest, but rather encourages “tokenism, exclusivity and co-optation of the youth into decision-making structures of state” (pg. 69). As his research suggests, the 2012 Parliamentary Elections, which resulted in the election of about 44 young

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8 The National Youth Employment Policy (NYEP) was a programme established under the New Patriotic Party’s (NPP) administration to address the issue of rising unemployment and underemployment among the youth in Ghana.
people (between the ages of 21 and 40) was greeted with a sense of optimism, especially considering the unprecedented outcome of the elections. However, the study revealed that the young parliamentarians perceived their respective party affiliation and loyalty, as well as personal political ambitions as an overriding consideration to the representation of youth interests. Ironically, their campaign messages, which served as the platform and basis for their election, revolved around the challenges faced by the youth.

The issues discussed so far raise two important questions relating to youth citizenship: (1) Given the realities of the participatory landscape, how can the youth make effective claims on the state? (2) To what extent can the youth make these claims? To answer these intriguing questions, the analysis will benefit by exploring the nature and dynamics of civil society in Ghana. This brief overview will provide context to the discussion, especially given that youth associations are grouped under the broad umbrella of civil society organizations (CSOs).

3.6. Civil Society in Theoretical Perspective

Ghana’s political environment has witnessed a shift from state-centric decision making towards a more participatory arrangement rooted in the ideology of inclusive citizenship. But so far, the discussion suggests that although this may be the case, this value shift cannot be taken at face value. As the following discussion shows, the deficit of youth engagement in the policy process cuts across the broader civil society landscape. This intriguing, yet troubling development raises

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9 Per the 1992 Constitution of Ghana, the minimum age for election to Parliament is 21 years.
concerns about strategies that can be embraced to effectively participate in the decision-making process in ways that substantively affect policy outcomes. Before discussing these strategies, it is essential to examine the nature and dynamics of civil society in Ghana, especially considering the relationship between the concept of CSOs and youth citizenship.

In recent years, there has been a proliferation of CSOs across the global and domestic landscape, which, of course, is largely due to globalization and response to the increasing demands and influence of the ‘good governance’ mantra (Atibil, 2012; Kpessa, 2011; Ohemeng, 2015; Scholte, 2002). As a result of changes in the political environment, civil society groups have increasingly sought to shape national policies and development as part of their political rights and entitlements. Consequently, they are now recognized as important actors in the policy arena. As noted by Ohemeng (2015), these organizations play a dual role as repositories of ideas, as well as vehicles of political action within the broader agenda of nation building and development. It is important to note that the idea of civil society is not only based on groups’ self-initiative to engage the government. On the contrary, most developing countries have recognized the weak administrative capacity of the state for data collection and processing, thus compelling governments to seek assistance and input from civil society groups (Ohemeng, 2005).

The concept of civil society, as scholars have noted, is quite contentious, diverse, and ambiguous in meaning. To some scholars, civil society is a relatively autonomous entity characterized by complex associational interactions, governed by shared values, beliefs and common interests (Hutchful, 1996; Kligman, 1990).
Others view it as specific kinds of state and non-state funded organizations that help to strengthen the key tenets of democracy, including transparency and accountability in public policy (Kpessa, 2011; Ohemeng, 2015). For Abdulai and Quantson (2008), the concept captures all voluntary associations engaged in the business of active participation in the policy process, without attempting to usurp the power and authority of the state. In other respects, the concept of civil society is associated with the distribution of power and representation of marginalized communities in society (Post, 1991).

From a broader perspective, civil society employs a universalistic criteria (Carroll & Carroll, 2004), which encompass the entire gamut of organizations and associations that exist outside of the state, and this includes youth groups, political parties, business community, interest groups, informal community groups, and more (Carothers & Barndt, 1999). Fundamentally, civil society is a central element of citizenship, which has been defined in this dissertation as the substance of the relationship among individual citizens, community, and the state. In contemporary politics, civil society plays various important roles in society including, promoting political, civil and social rights, infrastructural development, offering assistance programmes, all of which center on some of the core issues of citizenship – inclusion, distribution, provision, and access. As Scholte (2002) argues, civil society embodies a political space that structures the social order, a process that affects policy, norms, and deeper social structures. In other words, it involves the deliberate attempt to shape the rules that govern society or engages with broader questions of national governance.
Whitfield (2003) provides a useful conceptualization of the concept of civil society, which is helpful for the purpose of the present analysis. For analytic purposes, she deconstructs civil society as idea and civil society as process. On the one hand, the former speaks to the civility and autonomy of civil society from the state, and its primary goal of promoting democracy and supporting government policy vis-à-vis national development. On the other, the latter captures civil society as an arena of discursive struggle in which organizations challenge government decisions and policy, particularly relating to the distribution of state resources. However, in the context of Ghana, she also identifies a dialectical relationship between the two aforementioned theoretical constructs, where “civil society” is defined by the context in which it is used, thus leading to manipulation, control, and exclusion of some groups in national decision-making.

In a similar vein, Scholte (2002) also engages with the concept of civil society in ways that resonate with the present study. Although his work focuses largely on transnational civil society, it also speaks to civil society activity in local and national arenas in contemporary politics. As he argues, the search for alternative means of political action (away from, or supplementary to, traditional party structures) has created strong incentives for civil society mobilization. Of particular interest is his focus on the impact and legitimacy of civil society. The impact of civil society, as discussed in his work, reflects in the key areas of discourse, institutional processes, policy content, and social structure. In relation to discourse, civil society plays a significant role in shaping ideas that affect policy outcomes though the medium of language. From an institutional perspective, many
civil society actors have become key players in relation to governance and decision-making, thus affecting the structural procedures and implementation of policy. Given these structural shifts in the political system, the substantive content of policies has increasingly become amenable to value orientations within civil society, thus reflecting a fundamental shift away from statist governance and, consequently, a reconfiguration of the socio-political order.

3.6.1. Civil Society and Policy Making in Ghana

Civil society groups have played a key role in Ghana's political environment, and continue to impact the policy process through various mechanisms. This section provides insight into a few case studies to illustrate the character of state-civil society relationship in Ghana. We shall see that although civil society has attained greater visibility over the years, their impact has been very modest, and the reasons are not far-fetched. What does this mean, then, for adolescent health and citizenship?

Civil society has a long history in Ghana, and to better assess the civil society landscape, a key program worthy of attention is the Program of Action to Mitigate the Social Cost of Adjustment (PAMSCAD). This program was a policy response to the Structural Adjustment Programme (SAP), which was adopted in the mid 1980s with the ultimate goal of stabilizing and stimulating economic growth. Given the
devastating impact of the SAP, PAMSCAD was initiated to alleviate poverty and provide some relief to the poor.  

Central to the present discussion is the fact that PAMSCAD was one of the earliest opportunities for formalized relations between the state and civil society organizations (Abdulai & Quants, 2008). However, as noted by Darkwa, Amponsah, and Gyampoh (2006), the driving force for engaging civil society in the development discourse came from donors rather than the government. In their assessment, they observed that a key deficiency of the institutional arrangement was the dominance of the World Bank, bilateral donors, and state officials, which left little room for civil society involvement. In short, CSOs merely played a consultative role without any substantive influence in the PAMSCAD program.

Another case study that invites exploration is Ghana’s Poverty Reduction Strategy Paper (PRSP). The PRSP is also a Bretton Woods initiative that was launched in 1999 as a conditionality for continued access to concessional lending from the World Bank and IMF (Whitfield, 2005). In line with the Heavily Indebted Poor Countries (HIPC) initiative, low-income countries could qualify for debt relief by completing a PRSP. A key aspect of the PRSP was its focus on broader stakeholder participation where citizens could have the opportunity to shape their country’s development agenda. As such, the National Development Planning Commission (NDPC) instituted a Task Force that engaged in a participatory exercise in line with the stipulation for broader citizen engagement.

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But as noted by Whitfield (2005), the teams comprised of a few representatives of civil society who played a casual role in the formulation process. Although workshops were organized for CSOs, Whitfield (2005) suggests that they were primarily informative and devoid of any substantive discussions. Corroborating this finding, Godfrey and Sheehy (2000) point out the frustration expressed by civil society groups about the Government’s appalling commitment to involving CSOs in the decision-making structure. Notably, government officials and the Bretton Woods institutions dominated the entire participatory process, controlling decision-making and the formulation of policy choices. Put simply, the ‘consultative process’ has facilitated the opening up of the Ghanaian policy space, but the technocratic approach to policymaking is still prevalent. Not surprisingly, Whitfield (2005) describes the labels of ‘participation’ and ‘consultation’ as a masquerade for validating decisions already taken to create a semblance of inclusion in policymaking processes.

Two other cases worth examining are the Ghana Poverty Reduction Strategy I (GPRS I) and the Growth and Poverty Reduction Strategy II (GPRS II). The GPRS is a series of development plans that builds on the PRSP discussed above, with the ultimate aim of enhancing economic growth and improving the welfare of the poor. GPRS I (2003-2005) was an anti-poverty initiative that sought to alleviate poverty and restore macroeconomic stability. As such, it focused on five priority action areas: infrastructure, rural development based on modernized agriculture, enhanced social services, good governance, and private sector development (IMF, 2012). GPRS II, on the other hand, focused on sustainable economic growth, with
the overarching goal of pushing Ghana from a low-income to middle-income status. As part of strategies to achieve this goal, core thematic areas were prioritized: private sector growth, human resource development, and good governance and civic responsibility (IMF, 2012).

Importantly, both GPRS I and GPRS II emphasize the need for comprehensive stakeholder engagement that reflects the ethos of democratic governance and the much-idealized participatory philosophy. Research, however, shows that a significant number of CSOs were excluded from the policy formulation stage, and to compound the problem, there was also the challenge of access to information necessary for informed deliberation (Mohammed, 2013). In short, CSO impact on policy was negligible. In dealing with the challenges identified in GPRS I, the consultative framework for GPRS II was broadened to include a diverse range of stakeholders.

In contrast to GPRS I, GPRS II appeared more credible due to the availability of information and interactive nature of consensus building among stakeholders and the NDPC. However, it has also been noted that although CSOs were extensively engaged in virtually all stages of the GPRS II operation, policymakers still had a tight rein on the policymaking process. It is, therefore, not surprising that some CSOs and other stakeholders expressed misgivings about their impact on policy (Abdulai & Quantson, 2008; Mohammed, 2013). Aside from the issue of policy impact, it was also noted that all consultations and public debates regarding the GPRS were geographically limited to the country’s capital, thus leading to the marginalization of rural communities (Killick & Abugre, 2001; Mohammed, 2013).
In his study on recent social security reforms, Kpessa (2011) captures a nuanced participatory dynamic regarding the structure of old age income arrangement in Ghana. These reforms were necessitated by the historical challenges that had bedeviled the social security system over time, which include: political manipulation and abuse of pension funds; systemic exclusion of the informal sector; paltry retirement benefits; discriminatory work practices, among others. In light of these challenges, workers and civil society groups engaged in street protests in order to push the government to remedy the situation. In a striking fashion, their demands were taken into consideration by the NPP administration, which established a commission with the mandate to engage a broader spectrum of stakeholders in resolving the dilemma.

As Kpessa (2011) notes, a wide range of media tools, including radio, television, newspapers, and the internet, were used to sensitize and invite paper submissions, petitions, and memorandums – an exercise that received a high response rate from civil society groups and a broad section of the general public. As a departure from the two cases discussed above, the interim report from the commission, which contained options for pension reform, was subjected to public debate after thorough deliberations among the commission, civil society groups, media, and individuals who participated in the reform exercise (Government of Ghana, 2006, as quoted in Kpessa, 2011).

Despite the positive outlook of this case study, Kpessa (2011) highlights two important points that are worthy of consideration. First, he notes that about eighty percent of informal sector dwellers were excluded from the participatory exercise.
Thus, their ideas and interests were not considered in the design of the pension reforms. Second, some elected officials, and particularly political parties deliberately abstained from the reform deliberations, thus creating opportunity structures for them to “free ride” and avoid blame for policy outcomes. Overall, it is not far-fetched to say that this case study approximates the earlier two cases discussed in terms of the deficit of CSO involvement in the policymaking process.

A final interesting case study that will be examined relates to the role of CSOs in Ghana’s oil and gas sector. Since Ghana struck oil in 2007, and subsequent commercial production of oil began in 2011, concerns have been raised by civil society groups, social policy commentators, and policy makers regarding its proper management and use. Such concerns are premised on the idea that oil-backed states or regimes are often plagued by unbridled corruption, political instability, and what has popularly been diagnosed as “Dutch Disease” or the “resource curse” (Friedman, 2006). In response to these concerns, a broad array of over 110 civil society groups coalesced with local oil-policy experts into a formidable force known as the Civil Society Platform on Oil and Gas (CSPOG), with the ultimate aim of promoting transparency, accountability, and social justice in the extraction and management of oil wealth (Debrah & Graham, 2015; Gyimah-Boadi & Prempeh, 2012).

Studies show that CSPOG has played a significant role in safeguarding the national interest through engagement with the government and key stakeholders. For instance, through its watchdog role, the Petroleum Revenue Management (PRM) Bill was promulgated, which defined the regulatory and legal framework for
oil governance (Gyimah-Boadi & Prempeh, 2012). Through its activities, the coalition was also able to persuade parliament to establish an independent commission to exercise oversight responsibility over the management of Ghana’s hydrocarbons (Debrah & Graham, 2015). In addition to these achievements, CSPOG was also instrumental in the establishment of the Public Interest and Accountability Committee (PIAC), with the mandate to monitor and ensure government’s compliance with the stewardship and investments of oil revenue. To some extent, the coalition has also been successful in challenging the government to disclose oil and gas contracts through demonstration (Debrah & Graham, 2015).

Despite these positive reflections, it has been noted that the financial landscape is still characterized by secrecy, engendered by deliberate calculated complexities that undermine access to information on oil inflows (Debrah & Graham, 2015; Gyimah-Boadi & Prempeh, 2012). This situation has often compelled most CSOs to obtain information via alternative means rather than through official protocol. In fact, this challenge has given many CSOs reason to question government’s commitment to engaging them in the policy process, especially in light of the fact that certain major decisions and actions regarding oil production and revenue transfers were taken without the involvement of civil society groups (Debrah & Graham, 2015).

Based on the case studies discussed above, it is clear that Ghana’s policy space has gradually encouraged CSO engagement in the policy process but at the same time, promotes a restrictive environment that works against inclusive participation. Apparently, successive governments have largely contributed to the
fascinating paradox. But as the literature shows, most CSOs also suffer from a 
number of structural deficiencies that have undermined their effective 
participation in the policy arena. (Darkwa et al., 2006; Oppong, Oduro, Awal, & 
Debrah, 2013). First, it has been noted that most CSOs lack the requisite financial 
resources, thus making them dependent on donor funding. Thus, rather than 
focusing on the issues, attention is paid to competition for external funding. To 
some extent, this challenge has undermined the sustainability of their watchdog 
roles over the public interest.

Second, it is also argued that most CSOs have inadequate knowledge of 
policy issues and the general workings of government, an issue that is quite 
problematic not only in Ghana but across Africa. Of course, weak capacity of civil 
society contributes to the problem, but it is also fair to acknowledge that 
governments have monopoly over information and often manipulate this resource 
to their advantage. Third, some CSOs have been perceived as politically biased, 
advocating for issues along partisan lines. This phenomenon is believed to affect 
credibility, engender suspicion and marginalization of some CSOs from the policy 
process. Lastly, scholars have also pointed out institutional fragmentation as the 
bane of CSOs, which impedes them from presenting a common voice on issues.

It is certainly difficult to draw unconditional inspiration from the realities of 
Ghana’s civil society landscape. However, it is clear that some CSOs have carved a 
niche for themselves as potent transformative vehicles for social change within 
Ghana’s policy landscape (Gyimah-Boadi & Prempeh, 2012; Ohemeng, 2005). 
Indeed, some CSOs have been able to navigate the structural impediments that
plague the policy arena in ways that situate them in a position of strength to define and re-define the contours of policy making in various policy sectors. Therefore, the citizenship discourse stands to benefit from the available opportunities that provide substance to participatory policymaking in Ghana. Indeed, the CSO landscape in Ghana resonates with Scholte's (2002) work on civil society. As he notes, the effectiveness and authoritative influence of civil society in the political realm is predicated on legitimacy, which broadly encompasses issues of morality, competence, contributions to democracy and representation, as well as social cohesion (i.e., human security and collective solidarity). In sum, a critical assessment of Ghana’s CSO landscape allows for better appreciation of political strategies and institutional levers relevant to navigating the complex terrain of adolescent and youth health.

### 3.7. Chapter Summary

The objective of this chapter was to provide a historical and institutional overview, and particularly to set the broader context for the present study. As the analysis shows, the gendered character of Ghana’s socio-political landscape provides insight into institutionalized norms and practices that reinforce gender-based inequalities – a phenomenon that holds significant implications for adolescent health outcomes and reproductive behavior. Indeed, the gendered social realities focus attention on the challenge of advancing reproductive health interventions in the Ghanaian context.
Undoubtedly, the dynamics of global health governance has significantly altered the policy landscape in relation to young people's identity, health and well-being. In contrast to the MDGs, the SDGs strategically positions women, children, and adolescents at the forefront of the development agenda, which certainly draws attention to how global policy frames affect citizenship and structural priorities accorded to young people. This development brings to the fore the complex interplay of global institutions, state and non-state actors, and their impact on the domestic policy agenda. In the face of new global protocols and restructuring of the global policy agenda, it would be useful to examine the impact of global policy frames on adolescent health within the context of transnational policymaking. Given the limitations associated with the MDGs, the positionality of the SDGs as a broad conceptualization of development offers interesting insights into the role of ideas in the policy process.

Inclusive citizenship is a challenge worldwide, especially as individuals, groups and communities seek out opportunities through which their needs can be better addressed by the state. An analysis of Ghana's policymaking landscape provides a contextualized understanding of possible avenues through which young people can effectively make claims on the state pertaining to their health and citizenship entitlements. Situating the analysis within the broader context of limited power resources available to young people, it appears the youth can form constructive alliances with more powerful civil society groups in order to take advantage of political opportunity structures in global and domestic political
spaces. Through a brief discussion of six related contextualized case studies, the analysis, however, calls attention to the limited impact of CSOs in policy making.

Nonetheless, the discussion also suggests that some CSOs have consistently proved themselves as potent vehicles for social change. In light of this understanding, the central question remains – can the youth can use this opportunity as a leverage to press the state on their citizenship claims? The challenge, of course, is ensuring that such collective action is informed by reasoned, innovative, and legitimate strategies. Be that as it may, navigating the complex terrain of civil society-government arrangements will not be easy, but through sustained commitment and advocacy, it seems policy change can be affected not only in discourse, but also in practice.
Chapter Four

Literature Review

This chapter reviews the literature on adolescent and youth-related research (psychology, sociology, anthropology, public health, international development, and population studies), with particular focus on health as a central component of citizenship and development. Given the current discourse on adolescent pregnancy as a public health issue, four dominant perspectives on adolescent and youth pregnancy will be examined, with the ultimate goal of shedding light on the gap in the literature and potential areas of inquiry.

4.1. Perspectives on Youth Health through Adolescent Pregnancy

Over the past two decades, the literature on adolescent and youth health has been primarily rooted in micro-level analysis, focusing mostly on individual-based material factors. However, the increasing body of scholarly work on young people’s health shows that the literature has broadened from the dominant focus on the individual to an ecological framework that encompasses the role of political, social, cultural and economic forces (Blum & Mmari, 2009; Lancet, 2016; WHO, 2008a). As indicated earlier in chapter one, the paucity of empirical knowledge from the developing country context warrants careful attention to the dimensions and intersectionality of structural and micro-level factors, and the implication of this nexus for young people’s health development, particularly in the contemporary context of the global development agenda. Considering the penetrative influence of
globalization in the contemporary era, it is apparent that a deeper understanding of adolescent and youth health issues cannot be fully achieved without reference to these global protocols.

By situating the study within the broader scholarly work on adolescent and youth health, the primary aim is to highlight the gap in the literature, while identifying avenues for a richer analysis of adolescent and youth health issues. The study, therefore, builds on the existing body of knowledge. This discussion will draw from the broader literature on adolescent and youth health, particularly as reflected by countries across the developing world. Examples and experiences from Ghana will also be incorporated into the discussion to provide a contextual base for analysis. Although the literature highlights varying perspectives to understanding adolescent pregnancy and reproductive health, the present study focuses on four dominant themes.

4.1.1. Economic Perspective

It is widely acknowledged that adolescent and youth pregnancy is a function of economic variables. In other words, poverty, or the material insecurity of young people account for their risky sexual behaviours, which consequently lead to unintended pregnancies, unsafe abortions, and poor health outcomes. While poverty is a challenge across the global world, it appears to be particularly dire in developing countries with serious ramifications for young people in such contexts. As noted by several scholars, poverty inhibits a number of young people from the poorest households from attaining basic primary or secondary education, which is
not only key to reducing the total fertility rate, but also equipping young people with the requisite skills, competence, and capacity to steer their life-course in a positive direction (Gakidou, Cowling, Lozano, & Murray, 2010; WorldBank, 2007).

In line with this thinking, it has also been established that poor, uneducated girls living in rural communities are at greater risk of becoming pregnant, relative to their wealthier, well-educated or urban counterparts (UNFPA, 2014). In a study by Kravdal (2002), it was observed that the length of an individual’s education had significant implications for birth rates. According to the study, a higher level of education encouraged nuclear families, less dependence on children as old-age security, as well as lower infant and child mortality rates. Another important point raised by Kravdal (2002) was that the average educational level in the community had implications for birth rates as well. The findings from the study, therefore, bring the influence of community-level factors into perspective.

Given that poverty at the individual and community level restricts choices or opportunities available to young people, it follows that they become more vulnerable to health risks that might hold negative implications for their sexual and reproductive health. Gold, Kawachi, Kennedy, Lynch, and Connell (2001) add to the discussion by suggesting that although the communal poverty argument holds true, greater emphasis should be placed on income and income inequality. Based on their study, communities with higher income inequality tend to exhibit higher adolescent birth rates and limited accessibility to health resources. In line with this understanding, it has also been suggested that higher income families tend to fare better relative to their counterparts in the low-income bracket. This argument is
based on the premise that well-to-do families have more resources that allow for better parental supervision (Lammers, Ireland, Resnick, & Blum, 2000). In contrast, impoverished families are often characterized by adolescent and youth neglect, thus resulting in premature adulthood and vulnerability. As the study points out, the challenge is further compounded in cases where adolescents come from single-parent families. It follows from this argument that dual-earning families often have a stronger financial base to support the growth and development of young people.

In a related study, Thornton and Camburn (1987) conclude that the experience of divorce seemed to offer permissive attitudes regarding non-marital sexual behavior among young people. As the study suggests, young people are believed to view parental premarital conception as a legitimate basis or justification for their own premarital sexual behaviour. In essence, parental premarital conception, often characterized by financial difficulties, is believed to have a negative effect on the quality of discipline and control, thus allowing young people more autonomy in their sexual behaviour. In short, weak parent-child relationships increase the likelihood of premarital sexuality among young people. As the discussion demonstrates below, social determinants at the family level have significant implications at the individual level.

Generally, it has been argued that economic viability constitutes the legitimate and proper basis for engaging in sexual activity (Asampong, Osafo, Bingenheimer, & Ahiadeke, 2013). In other words, young people should be gainfully employed, as this allows them the opportunity to successfully navigate the difficult terrain of parenthood. However, majority of young people in developing
countries are dependent on their parents or guardians who are themselves very poor (UNFPA, 2014). As a result, adolescents and youth are driven to engage in what has been popularly referred to in academic circles as ‘transactional sex’ in order to cater for their basic needs such as food, clothing, shelter, school fees, among others (Gyesaw & Ankomah, 2013). As Adomako Ampofo (2006b) notes, in situations where financial considerations dictate women’s partner choices, their ability to negotiate for safer sex could be undermined.

In some cases, poverty may be the driving factor behind a young girl's early marriage. It is well established that the issue of child marriage has gained notoriety across some developing countries. In order to make ends meet, a girl may be coerced into early marriage, or the girl’s parents may encourage an inappropriate relationship to continue – a situation that often results in complicated and unintended pregnancies (Asampong et al., 2013). This practice is often the case where it is believed that material benefits and gifts can be easily obtained from such marriage arrangements.

Another important and related study by Brook, Morojele, Zhang, and Brook (2006) speaks to how family-level factors contribute to the problem of adolescent and youth pregnancy. Findings from their study on South African adolescents suggest that poverty has a positive association with weak parent-child relationship. In their opinion, poverty alienates young people from their parents, which, in effect, engenders vulnerable personality and behavioural attributes. The lack of guidance and direction, which could have been sourced from parents, therefore, makes
young people prone to negative influences such as deviant peers, thus resulting in poor sexual and reproductive decisions.

Based on the economic deprivation theory, it is clear that the material explanation for poor adolescent reproductive health is a dominant account in the literature. However, although the level of impoverishment obviously impacts young people’s health, the literature does not adequately account for health programming or interventions, which is a critical structural factor that has broad implications for young people’s health and well-being. Why do young girls from economically endowed backgrounds also run the risk of adolescent pregnancy? Are young people from strict parental backgrounds immune from risky sexual behaviours? How do macroeconomic policies engender poverty, inequality, and marginalization at the individual, family, and community level? Why do economic investments in education fail to yield expected behavioural and attitudinal change among young people?

These fundamental questions are important. Yet they have not received much attention in the literature. As some scholars have noted, the lack of knowledge, or otherwise, may sometimes be irrelevant to the context of explaining young people’s risky sexual behaviours (Adomako Ampofo, 2006b; Sawyer et al., 2012). Theoretically speaking, contributions from psychology and other disciplines such as sociology, public health, and population studies advance further understanding in the area of adolescent sexual and reproductive health. However, the economic argument falls short of providing a holistic understanding of the ‘problem’.
4.1.2. Cultural and Social Perspective

The cultural and social perspective to young people’s health is also another important theme that has gained widespread attention, particularly in the psychology and sociology literatures. Scholars who subscribe to this theoretical explanation conceptualize adolescent and youth pregnancy as a function of cultural or social norms and values. In other words, young people are socialized by their immediate environment, which consequently affects their social identity and behaviour in society. Simply put, the norms of appropriateness or values imbibed from childhood define an individual’s developmental trajectory towards adulthood. There are varied streams of thinking within the cultural and social perspective, and these variants will be discussed in turn.

Research in Ghana demonstrates that, just like most developing countries, discussions surrounding sex and sexuality are considered alien to the socio-cultural fabric (Anarfi & Owusu, 2011; Geest, 2001; Speizer, Mullen, & Amegee, 2001). As a result, the general political landscape is somewhat characterized by a culture of silence and secrecy regarding issues about sexuality (Asampong et al., 2013; Kumi-Kyereme, Awusabo-Asare, & Darteh, 2014). For example, in the Ghanaian social context, sex is not only considered as a sensitive issue, but a taboo topic. As such, discussions or conversations interlaced with sexual elements may be met with some level of resistance or discomfort. This situation is true not only in the Ghanaian context but in other African countries as well. A comparative study of Nigeria and Kenya, for instance, revealed that until recently, unmarried youth were barred from access to contraceptives by the Kenyan government (Barker & Rich,
1992). Findings from the same study also capture the restrictive nature of the social environment. According to the authors, the young people interviewed in both jurisdictional contexts expressed great discomfort regarding discussions surrounding sexuality with their parents or family members.

In their study on sexual communications in the Eastern and Volta regions of Ghana, Asampong et al. (2013) note that sex is considered ‘bad language’ that is inconsistent with the Ghanaian culture. In a related study by Kumi-Kyereme et al. (2014), it was brought to bear that some parents resisted SRH services due to the general notion on sex. There are two notable points from this research that require attention. On the one hand, parents were shy to initiate conversations surrounding sex with their adolescent children. On the other, there was also the fear of encouraging their children to engage in premarital sex due to their enlightenment on the use of contraceptives. The study also revealed that community opinion leaders and health care providers disapproved of condom demonstration and provision in schools. As the literature suggests, sex education is generally viewed in some contexts as a corruptive force that has the potential to give rise to a generation of wayward young adults. It is believed that the culture of silence and secrecy, based on the cultural and social theorization, engenders ignorance on issues of sexuality, thus encouraging clandestine and risky sexual behaviours among young people, as well as increasing the risk of adolescent and youth pregnancy.

Another dimension within the socio-cultural school of thought relates to the influence of peers as a social determinant of health. As some scholars have noted,
young people are sometimes influenced by their peers to engage in inappropriate sexual relations, which holds implications for their reproductive health (Asampong et al., 2013; Kumi-Kyereme et al., 2014). Given the restrictive character of the social environment, fear and isolation often drives young people to resort to peer advice relating to issues surrounding their sexuality. In some cases, it has been proven that succumbing to peer influence provides a sense of belonging and identity, which helps young people overcome neglect, poverty, and embarrassment among their peers (Geugten, Meijel, Uyl, & Vries, 2013). Indeed, young people are particularly vulnerable to peer influence in situations of impoverishment, and this view intersects with the economic determinants of adolescent and youth health.

Following from the peer influence argument, some scholars maintain that religion also plays a significant social role in reducing adolescent pregnancy, particularly in developing countries. It is argued that when one associates with peers who have strong religious and moral principles, the tendency to focus on greater aspirations such as education and career remains very high (Geugten et al., 2013). In this regard, such individuals intuitively refuse to be distracted by premarital sex and its immediate promises of pleasure and material gain. Consistent with these findings is the evidence that peer norms that emphasized sexual restraint encouraged positive relations among young people, therefore, serving as a strong protective factor against sexual activity (Santelli et al., 2004). Findings from the study suggest that such norms influence young peoples’ personal values, which, in turn, shapes their development and behaviour. In a related study that sought to identify factors associated with compromising health behaviours
among young people in Caribbean countries, the evidence suggests that attendance at religious services minimized behaviours that increased health risk (Blum et al., 2003). In relation to adolescent and youth reproductive health, the study established that religion was associated with delay of sexual activity.

Indeed, religion is considered a powerful social force across most African countries, including Ghana, and is believed to be a potent vehicle for social transformation. It is, therefore, not surprising to see most social and political phenomena interpreted with a religious lens. As noted by Anarfi and Owusu (2011), the contextual religious setting allows issues pertaining to sexual behaviour to be viewed from a morality perspective. Findings from their study established a strong relationship between religion and sexual socialization in Ghana. According to them, adherents of the three main religious beliefs in Ghana – Christianity, Islam, and Traditional religion – emphasized zero-tolerance for pre-marital sex. Across the three religious traditions, sexual activity has been established to be the preserve of marriage.

In terms of religious demography in Ghana, the composition is as follows: Christian population (approximately 71 per cent), Muslim (18 per cent), Traditionalists (5 per cent), and non-religious and other religious groups (6 per cent) (US, 2015). Research in Ghana shows that some young people tend to abstain from pre-marital sex primarily due to religious considerations (Palladium, 2015a). From a religious perspective, particularly for those in the Christian tradition, it is generally believed that pre-marital sex is inappropriate, and carries future consequences such as barrenness or other forms of metaphysical punishment. But,
it should be pointed out that religion can be a positive or negative factor. On the one hand, given the potency of religion as a transformative social force, it will later become clear in the empirical analysis why religious leaders and organizations have recently been targeted as critical stakeholders in political and policy arrangements pertaining to adolescent and youth-oriented interventions. On the other, we will also see the tension between two cultures – that is, religion and modernization.

To further illustrate the dual character of religion, research has established the influential and regulatory role of religion in shaping adolescent and youth sexual behaviour (Agha, Hutchinson, & Kusanthan, 2006; Opayemi, 2011; Trinitapoli & Regnerus, 2006). For instance, Osafo, Asampong, Langmagne, and Ahiedeke (2014) note that religion serves two significant purposes. First, it plays an inhibitive role by restraining young people from certain immoral acts. For example, evidence shows that some religious denominations do not give a slap on the wrist for engaging in premarital sex, but proceed to withdraw the membership of those found guilty from the church records (Agha et al., 2006). In fact, the transgression is considered grave enough to proscribe participation in any religious activity organized by the church. Second, religion is also believed to play a facilitative role by inculcating religious values, ideals and principles into young people, thus empowering them to make good and responsible choices. However, the study also revealed that religion, particularly Christianity, was somewhat viewed as a destructive force that had undermined traditional systems of regulating sexual behaviour. As will be seen in the next section, this finding aligns
with the modernization perspective, which views globalization as a counterproductive force vis-à-vis young people’s reproductive health and development.

Overall, a key strength of the cultural and social perspective is the emphasis on social determinants that impact young people’s health at the individual, family and community level. Nonetheless, while culture is important, individual agency should also be accounted for. The literature points out that young people resist advice given by professional health workers. What explains such uncooperative attitude? What is the nature of the relationship between government agencies, ministries, institutions, and NGOs that deal with young people’s health at the national, regional, and district level? Do NGO and sector-wide health advertisements and messages resonate with the youth? Given the supposedly powerful social role of religion, what explains the high rates of adolescent pregnancies in the developing world? Considering these questions, it is clear that further research is needed to better understand the complex intersection of the macro and microenvironment.

4.1.3. Modernization Perspective

As the literature on population, public health, and international development demonstrate, the rapid onset of globalization, characterized by eroding borders and greater interconnectedness, has exacted a costly price for young people’s reproductive health. It is believed that young people have become increasingly modernized and sophisticated due to the technological revolution associated with
globalization. The central argument underpinning the so-called modernization perspective is that the increased exposure to technology has undermined parents’ capacity in raising responsible and productive young adults. This development is attributed to the difficulties associated with providing the needed sex education to young people (Asampong et al., 2013; Blum & Nelson-Mmari, 2004). With the invasive intrusion of globalization, young people are believed to have been prematurely oriented into adulthood. This façade, therefore, emboldens them to flout advice given to them by their elders. As pointed out in the study by Asampong et al. (2013), contemporary adolescents and youth are deemed to be stubborn and disrespectful due to the influence of modern norms.

Indeed, young people of today are considered to be a ‘spoilt’ generation due to the increased tendency to emulate Western standards. It is argued that the culture of sexual liberation associated with Western countries, coupled with the influence of foreign movies, have corrupted the youth. To some extent, it is argued that parents’ role of providing sex education to their children has been undermined to the point where some parents assume that young people already know much about issues pertaining to their sexuality. The fear of parental ignorance, as noted by Asampong et al. (2013), constitutes a major barrier to educating young people about sex. Therefore, to avoid the embarrassing possibility of exposing their own lack of knowledge, some parents avoid the sexual conversation altogether.

As some sociologists and ethnographers suggest, puberty rites, which used to be an effective system for regulating sexual behaviour in some ethnic communities, have been challenged as outmoded and inconsistent with modern
life. In the Ghanaian context for instance, a sacred ceremony was usually performed to initiate young people into adulthood in some communities. The ceremony signified maturity and the ability to assume responsibilities mostly associated with adulthood such as child rearing. This rite varies across societies, and was believed to encourage chaste living and socially acceptable sexual relationships (Anarfi & Owusu, 2011; Awusabo-Asare et al., 2004). A young man, for instance, may be symbolically presented with a shotgun by his father to conscientize him about his responsibilities as the breadwinner for the family. Girls were also oriented on domestic issues, including personal hygiene, child care, and the art of trading (Awusabo-Asare et al., 2004). In the event that a young woman got pregnant prior to the initiation ceremony, she was either punished alone or along with her partner to serve as a deterrent to other young people in the community. In some cases, they were publicly humiliated or banished from the town.

However, it is believed that these so-called rites of passage have gradually been displaced by modernity, urbanization, and formal education – a development that is popularly described by scholars as cultural disenfranchisement (Blum & Nelson-Mmari, 2004). In many ways, this perspective seems consistent with the argument advanced by Inglehart and Welzel (2005) – modernization engenders cultural change, which, in turn, nurtures individual autonomy and self-expression values. In light of this understanding, young people now question the wisdom of abstinence, and tend to view attempts at shaping their sexual behaviour as a violation of their inherent right over their individual bodies. Are young people
then, demanding greater openness with regard to information about sexual health and access to sexual health services?

On another spectrum, the impact of the Internet is deemed to have exacerbated the problem of adolescent and youth recalcitrance. It is believed that young people now have unlimited access to Western movies, and that the exposure to sexual content has a negative influence on young people’s reproductive health. As some scholars posit, the new medium is to be blamed for the moral degeneration of the youth, especially given that young people use the information obtained through the internet and media to guide their own interests, motivations, and actions (Anderson, Huston, Schmitt, Linebarger, & Wright, 2001).

Incidentally, young people’s high levels of interest in online health information further compounds this situation. According to Borzekowski, Fobil, and Asante (2006), the internet seems to offer a sense of privacy, as it allows young people to seek answers to personal, sensitive, and embarrassing questions relating to their health. In effect, technology has also aided in weakening parent-child relationships, thus encouraging social deviance among young people. This finding relates to other studies and debates on health-seeking behaviour that highlight the lack of privacy, friendliness, and confidentiality in public health care services (Kumi-Kyereme et al., 2014; Tylee et al., 2007). As pointed out in chapter one, privacy and confidentiality concerns have been raised as serious challenges to effective health services for young people. To avoid embarrassment arising from judgmental questions often posed by health care providers, young people resort to the use of other alternatives such as the Internet as the best avenue for
information. However, young people risk the possibility of misinformation and consequently, the potential to engage in risky sexual behaviour.

Although the modernization perspective introduces an insightful structural dimension to adolescent and youth health development, it is also important to note that globalization does not occur in a vacuum. What are the mechanisms linking the international and domestic health arena? How do health inequities translate to the national, regional, and district level? How do global health paradigms affect the realities of national policy delivery? Which set of actors influence adolescent and youth health development, and what mechanisms do they employ? As this study demonstrates in later chapters, governance and politics are critical to richer analyses and understanding of the broader institutional framework that structures young people’s health and development.

4.1.4. Physiological Perspective

The physiological perspective to adolescent and youth pregnancy has also gained widespread attention, particularly in the psychology literature. This perspective rests on the premise that the biological make-up of human beings accounts for most unintended pregnancies among young people (Asampong et al., 2013; Geugten et al., 2013). According to this view, the transition from adolescence to adulthood is marked by remarkable heightened sexual desires, which can be traced to increased hormonal influences. Therefore, given this physical and biological transformation, there is an increased predisposition to engage in sexual activity, which could potentially result in unplanned pregnancy.
In a similar but nuanced vein, Udry (1988) posits that the biological basis of sexual motivation is rooted in hormonal variation among young people. According to Udry, the maturity rate for adolescents varies across different age groups, thus making some adolescents more predisposed to sexual activity than others. Based on his study, the levels of testosterone determined sexual interest and behaviours. Another interesting finding from the study was that the hormonal effect also varied across gender. In their study of sexual behaviour of young people in Ghana, specifically the Bolgatanga municipality, Geugten et al. (2013) suggest that sexual tension and the irresistible impulse for sexual gratification was a major discourse that surrounded conceptions, motives, and practices regarding premarital sex. A related social phenomenon, as revealed by the study, suggests that the tendency to engage in sexual activity was also driven by provocative dressing by young girls, which ultimately tends to stimulate the sexual drive of young men. This complex physio-social relationship is further explained below.

In Ghana, just like other African countries where adolescent and youth pregnancy is largely frowned upon, the ‘scapegoating syndrome’ seems to be an informal approach to dealing with young women in skimpy outfits (Böhm, 2017; Kwenaithe & Heerden, 2011; Wipper, 1972). Although the practice has attracted widespread condemnation from government institutions and civil society, it has gained increased popularity over the years. It is, therefore, not surprising for young women in skimpy outfit to be subjected to mob action, stripped off their clothes, raped, or publicly humiliated by the young men in a community. In some instances, women are also seen partaking in such activities. Basically, the idea is that such
public assault and ridicule will encourage decency and chaste living, and most importantly, help the young men who are mostly prone to visual stimuli exercise control over their sexual desires. In fact, it is believed that the blatant provocative dressing by young girls robs young men of the capacity to control their sexual drive, thus encouraging the vicious cycle of illegitimate children.

It is also argued that the transition from adolescence to adulthood is a particularly vulnerable period characterized by heightened curiosity and desire by young people to experiment with sex in order to understand the physiological changes in their bodies (Asampong et al., 2013; Barker & Rich, 1992). As the psychology and sociology literatures point out, the problem is pronounced among impoverished youth. In such instances, young girls are easily swayed by trendy gadgets, dresses, jewelry, and other material gains. The urge to experiment or keep up with fashion trends or technological innovation encourages some young girls to seek out external financial outlets. However, by depending on boys or men for such material benefits, unsuspecting adolescents run the risk of sexual experimentation and early pregnancy (Blum & Nelson-Mmari, 2004). Also, by experimenting with clothing and make-up, young girls attract more attention, and may be immature to deal with that attention, thus making them vulnerable to early sex and unplanned pregnancies.

The physiological argument also aligns with the perspective that the challenge of peer influence is heightened during the transition to adulthood. In this regard, it is believed that most young people are blindly influenced by their peers to engage in inappropriate relations with the opposite sex. As some scholars have
pointed out, some adolescents are made to feel inferior by their peers due to their commitment to abstain from premarital sex. Geugten et al. (2013), for example, note that some young people view the transition stage as a natural period to engage in sexual activity. Therefore, a young person who refuses to have sex during the experimental stage of life is often tagged as being stubborn, immature, and primitive, among others. As their study further illustrates, some adolescent and youth groups may refuse to share their food and other gains with members who refuse to explore their sexuality and share their experiences. Such undue pressure, therefore, leads young people to experiment with sex in order to avoid embarrassment and loss of identity among their peers. All in all, the physiological outlook is rooted in the idea that sexuality is an innate component of human life, and for that matter, sexual expression cannot be denied or suppressed (Anarfi & Owusu, 2011).

While the biological theorization encourages thinking beyond structural factors to an organic understanding of adolescent reproductive health, it leaves little room for individual agency and learning. Indeed, the biological argument is also profoundly gendered. To be sure, hormonal changes are certainly natural occurrences associated with the transition from childhood to adulthood. Nonetheless, the physiological argument treats adolescent and youth pregnancy as a given without critical exploration of the options or choices available to young people. If adolescent and youth pregnancy is a function of biological determinism, what explains its diverse manifestations across different polities and contexts? Why are some states better suited to deal with the challenge of adolescent
pregnancy compared to other jurisdictions? What explains intra-regional differences in adolescent and youth pregnancy within the same jurisdictional boundary? In point of fact, the biological explanation is reductionist in orientation, if not misleading, and does not allow for a deeper appreciation of the broader dynamics and processes that inform adolescent and youth health development.

4.2. Chapter Summary

Based on the various discursive perspectives illuminated in this chapter, it is clear that there is no single factor or determinant that accounts for adolescent and youth reproductive health. On the contrary, existing research demonstrates that young peoples’ health and well-being are influenced by multiple elements operating at the individual, family, community, societal, national, and global levels. Given the intersection across the various schools of thought, it makes sense to view the analytical boundaries as interdependent.

While most studies underscore the critical need to focus on adolescent and youth health, there is undue silence on empirical interventionist programs aimed at improving young peoples’ health outcomes. More specifically, adolescent health programming appears to have been left out of the broader picture; yet it constitutes a fundamental structural determinant of health. Ultimately, the politics of adolescent and youth health cannot be fully understood without reference to the complex intersection and dynamics of micro and macro-level factors that dictate, and influence the direction and impact of adolescent focused health interventions.
Chapter Five

Theoretical Framework

This chapter situates the present study within a broader analytical framework that allows for a better appreciation of policy and governance processes relevant to understanding the contextual realities and discourse which define adolescent and youth health issues. In response to the analytical demands of this study, combined theoretical insights will be drawn from the framing literature and implementation studies, and the rationale for this approach will be discussed in light of the purpose of the present research.

The concept of issue framing and frame analysis has gained considerable attention in the policy literature over the past few decades. Incidentally, some scholars have long considered research on policy implementation as a ‘dead’ field since the mid 1980s (Barrett, 2004; Michael Hill, 1997). However, several studies that have reviewed the state of the field have underscored the exponential growth and relevance of implementation research, particularly within the growing context of contemporary challenges associated with translating policy intent into action (O'Toole, 2000; Saetren, 2005; Schofield, 2001). By examining the global development agenda and its intersection with domestic politics, the utility of an integrated analytical framework will be brought to bear. This framework is particularly useful in the context of examining the implementation of the ADHD and GHARH initiatives.
5.1. Theoretical Assumptions on Policy Framing

A growing body of scholarly work on issue framing and frame analysis has emerged in recent years largely in response to the rational or empiricist research approach to studying social and political phenomena. As opposed to an approach that privileges absolute truths or objective knowledge of the social world, the framing literature is rooted in the social constructivist philosophy that reality cannot be conceived independent of thought, values, perception, and interpretation (Benford & Snow, 2000; Fischer, 2003; Johnson, 2010; Schon & Rein, 1994; Stone, 2012). In other words, the world is socially or discursively constructed and based on subjective human experiences, beliefs, ideas, and meaning-making. As Stone (2012) has noted, humans are social creatures whose ideas are shaped by influence, persuasion, and socialization. To be sure, policy decisions and actions are based on facts. However, the strategic framing of information cannot be overemphasized. Indeed, politics and for that matter policy implementation, is driven by the dynamics of language and discourse. It is, therefore, germane to argue that the substance of policy vis-à-vis policy outcome is a function of ideas, strategic portrayals and discursive practices.

The concept of framing defies a single definition, and the utility of such varied understandings will be discussed to shed insight on existing frameworks that lend analytical currency to the present study. As Schon and Rein (1994) posit, a frame constitutes the “underlying structures of belief, perception, and appreciation” that define the policy positions of social actors or parties involved in the policy-making process (p. 23). Framing, as defined by Fischer (2003), is a
dynamic process by which actors (producers and receivers of messages) process and transform information or images into a meaningful whole by interpreting them through other available social, psychological, and cultural concepts, axioms, and principles (p.144).

Against this backdrop, Schon and Rein (1994) distinguish between several types (rhetorical and action frames) and levels of action frames (policy, institutional action, and metacultural frames). Although rhetorical and action frames are not mutually exclusive, the former embodies the persuasive use of story and argument in policy debate, whereas the latter speaks to policy practice. This perspective (i.e., rhetorical frame) resonates with what Fischer (2003) refers to as the ‘argumentative turn’, which essentially boils down to persuading an audience on the normative importance of an idea or solution to a problem. In a similar vein, Stone (2012) illustrates how political actors use frames to either challenge or defend an existing social order through strategic and symbolic problem definition. For example, issues could be pushed from the realm of accidental or natural cause to the realm of human control, thus shifting the burden of responsibility to human action.

In terms of the levels of action frames advanced by Schon and Rein (1994), institutional actors use policy frames to construct specific policy problems. On the other hand, institutional action frames, otherwise known as metacultural frames, are generic frames used to structure a broader range of problematic policy situations. Hence, a metacultural frame could house families of several related frames. Central to the conceptual understanding of a metacultural frame is the
possibility of fragmented ideas and policy practice at the global, national, regional, and district levels. In this regard, response, interpretation, and conformity to action frames may vary across different institutional levels. For instance, individuals operating at the street-level may, therefore, conceptualize problems and respond to them differently than expected of them by the political leadership or institutional heads.

Campbell (2002) conceptualizes frames in a related fashion. By reviewing the ideational literature, attention is brought to the various types of ideas that dictate or influence policy making. Significant to the discussion is the conceptualization of frames as ideas. In this regard, frames are ideas that affect not only the policy making process, but also the dynamics of policy outcomes. As Campbell (2002) puts it, the causal processes through which ideas exert effects are important to understanding the link between policy intent and policy outcomes. Such a scholarly enterprise would include identifying the relevant political actors, ascertaining the institutional settings that enable or constrain actors, as well as understanding how discourse affects political communication and the translation of policy ideas into practice. Based on this multi-dimensional understanding of framing, it makes sense to conceptualize frames as vehicles or ‘bubbles’ for conveying ideas. Simply put, frames are ‘idea carriers’. As will be seen in later chapters, the nature of ideas or the discursive process itself determines the prospects, or otherwise, of policy interventions targeted at young people's health development.
Policy controversies, often considered mundane in social and political life, are complex issues that shed insight into how the world works, particularly in the policy arena. As argued by Schon and Rein (1994), policymaking is a discursive practice in which policy makers engage in ‘design rationality’, a reflective process for dealing with controversies that arise in the policy arena. Intractable policy controversies, as noted by Schon and Rein (1994), arise due to conflicting frames or policy positions, which form the basis for reasoning among policy actors. In other words, the underlying beliefs and values of actors (advocates and opponents) structures the policy process in ways that engender varied perspectives and thinking on issues, thus setting the stage for contentious policymaking.

As Stone (2012) suggests, policy making in itself is a struggle over values and ideas (such as the policy debates on adolescent health vis-à-vis maternal and child health). While there is a thin line between policy disagreements (policy disputes) and policy controversies (frame conflicts), the latter is distinguished by their inherently stubborn resistance to resolution through the use of facts (Schon & Rein, 1994). As observed by Stone (2012) and Fischer (2003), ‘facts’ are symbolic devices, subject to strategic manipulation by political actors. Therefore, even when actors agree on the same facts, they may interpret them differently in terms of their relevance and appeal. The discussion of the GHARH programme, as detailed in chapter six, clearly brings this element into perspective.

Despite the practical difficulties associated with constructing and resolving frame conflicts, Schon and Rein (1994) note that political actors possess the capacity to reflect on the underlying factors that give rise to, or exacerbate the
intractability of policy controversies – a reflective practice known as frame reflection. In other words, they are able to empathize with other actors, isolate the factors that encourage contention or stalemate, thus leading to a constructive reflective discourse that moves beyond their own narrow action frames. The framing process essentially boils down to the construction of diagnostic (what is wrong and needs fixing) and prescriptive (how the problem can be fixed) stories (Schon & Rein, 1994). As will be seen, the framing of adolescent health revolves around this dialectic, which seems to project the global argumentation for attention to adolescent health issues in a more favorable light.

A closer look at the seminal work by Schon and Rein (1994) provides invaluable insights on the dynamics and complexities of policymaking. More specifically, their work speaks to the design and implementation of programs, a process that often gets entangled in stubborn controversies and stalemates. But as they argue, these difficulties can be managed through a reflective channel of frame reflection, otherwise known in metaphoric terms as ‘design rationality’. In this context, the designer (i.e., collection of actors) engages in “a process of seeing, making design moves, and seeing again” (p. 85). Given the multiple values (possibly divergent and incompatible) and constraints that may come into play regarding the project, the designer anticipates new dilemmas and constructs new possibilities for action (Schon & Rein, 1994). As Austin (2001) posits, “societies may interpret, prioritize and realize values differently, but it does seem possible to reach consensus on some universals” (p. 191). However, as several scholars have also
noted, reframing of policy issues may not necessarily resolve policy controversies (Harrison, 2001; Schon & Rein, 1994; Stone, 2012).

According to Fischer (2003), politics is rooted in arguments about the 'best story' or 'better argument', which essentially captures different ways in which the world is conceived. This is noteworthy because as he argues, it allows one to examine the varied understandings of social reality and in particular, how these meanings are manipulated as part of political strategy. Given that stories are central to political action, strategic problem definition has become part of the arsenal for policy warfare, with the ultimate goal of minimizing criticisms through persuasive emotive appeals. As Stone (2012) argues, strategic stories could alter power relations and provide leverage in terms of mobilizing support for a common cause or agenda. This strategy obviously provides a platform for broader legitimacy and justification for policy decisions. While political rhetoric has always been part of the policy discourse, uncovering the symbolic elements and hidden meanings in discursive constructions is not straightforward, especially considering the normative grounds upon which such discourses are based. It is, therefore, not surprising that Stone (2012) describes reasoned analysis as inherently embedded with political properties, an exercise that forms the basis for political argument.

The social constructivist analytical toolbox is also appropriate for the project, as the present study is situated within the broader domain of “target populations” – a concept that has gained considerable currency in the study of public policy. In their analysis, Schneider et al. (2014) contend that the manner in which targeted groups are socially constructed has significant implications. In this
regard, policies embedded with positive or negative social constructions define the
distribution of benefits or burdens across target populations. In other words, the
frames embedded in social constructions have the potential to reward certain
target groups while punishing others.

Paradoxically, Schneider et al. (2014) also note that although positively
constructed groups (e.g., young people) may be considered deserving and entitled
based on sympathy and pity, they only enjoy limited benefits due to their lack of
political power. Such categories of people include mothers, children, and students,
homeless, impoverished families, to name a few. In their theorization, Schneider et
al. (2014) present a fourfold typology of social constructions – Advantaged groups,
Contenders, Dependents, and Deviants. Advantaged groups such as middle class,
small businesses, and taxpayers enjoy a greater share of benefits relative to
burdens because they contribute significantly to national wealth and possess
immense political power. Hence, they are viewed in a more positive light.
Contenders such as big corporations, big banks, labor unions, and insurance
companies are negatively constructed but still enjoy disproportionate benefits due
to their power resources. Deviants such as criminals, terrorists, illegal immigrants,
and welfare cheats carry a greater share of burdens and punishments because they
are socially constructed as posing significant costs for society. Deviants, therefore,
fall into the categories of negative and underserving groups.

Of particular interest is the dependent group, which captures the subject of
interest in the present study (i.e., young people). While adolescents and youth
currently enjoy positive social constructions due to rapid policy changes at the
global and national level, their potential and real health benefits in public policy remains uncertain, especially considering their lack of political power. As Schneider et al. (2014) put it succinctly, “dependents are viewed as good people but considerably less deserving of actual investments than advantaged groups” (p. 112). An intriguing issue that arises from this analysis speaks to the question of why women and children have received much more policy attention relative to young people on the political agenda (despite their classification within the same constructivist matrix). This puzzle will be addressed as the discussion moves forward.

Again, the social constructivist framework helps in advancing understanding of such political dynamics. As discussed in chapter three, one could argue that the political power resources of young people relative to women and children explains their neglect over time, and could possibly account for their uncertain future within the broader development context. The framing literature has been used widely in the study of social movements, and drawing insights from the growing body of scholarly work within this field enriches the discussion on young people’s health and citizenship.

Despite the strengths associated with the social constructivist literature, scholars have also acknowledged the limitations of policy frames and discursive processes (Beland & Cox, 2011; Fischer, 2003; Schmidt, 2008; Stone, 2012; Yanow, 2003). As the literature points out, context matters, and to a large degree, determines the success or otherwise of policy ideas. According to Schmidt (2008), text (what is said), context (where, when, how, and why it was said), and agency
(who said what to whom) are equally important so far as framing and discourse are concerned. Schmidt (2008) draws our attention to two important spheres of discourse, which are relevant for the present study – that is, “coordinative discourse” and “communicative discourse” (p. 310). The coordinative discourse is primarily concerned with policy construction, and consists of individuals and groups at the center of policy making (e.g., civil servants, elected officials, activists, organized interests, experts, the media, community leaders, among others).

The communicative discourse, on the other hand, speaks more to the “presentation, deliberation, and legitimation of political ideas to the general public” (Schmidt, 2008, p. 310). In order for a policy frame to ‘catch on’, it must resonate with the prevailing discourses. Such consideration not only provides avenues for policy ideas to penetrate the policy-making process, but also establishes legitimacy and increases the chances of a successful outcome. As Fischer (2003) notes, ideas that fail to draw on, or interact with existing discourses face the possibility of being dismissed as irrelevant. Of course, policy frames that do not align with broader national values or traditions face the inherent risk of possible resistance and failure.

In short, policy frames are influenced by a broad range of social, political, and institutional forces: culture, political salience, history, religion, and media, to mention a few. Indeed, the political environment may present opportunities that enable policy ideas to diffuse and affect health outcomes. This, however, should be understood within the contextual settings that inform such processes – a complex
dynamic that holds significant implications and limitations for policy making and adolescent health intervention.

5.2. Theoretical Perspectives on Policy Implementation

Policy implementation is a critical aspect of the policy process, and has been the preoccupation of scholars since the 1970s and 1980s (Conteh, 2011; Exworthy & Powell, 2004). Arguably, it constitutes the most important stage of the policy cycle, especially given that policies are not self-implementing and require political direction (rather than simple bureaucratic processing). The present study on adolescent and youth health intervention falls within the domain of policy implementation, thus necessitating attention to the structural mechanism or framework by which policy translates into action.

Over the past few decades, policy implementation has been conceived as a simple and straightforward process. Based on conventional wisdom, it was believed that policy implementation followed a linear fashion: a policy gets on the government agenda, a decision is made, and the new policy gets implemented (Thomas & Grindle, 1990). However, research has proven that such assumptions or arguments are clearly untenable, and fail to account for the dynamics and complexities associated with implementing proposed policies or reform. As argued by O’Toole (2000), policy makers and practitioners are perpetually enmeshed in the vexing challenges of converting policy intent into desired outcomes – a process characterized by prominent policy failures. In essence, the linear model of reform
has been challenged as an overly simplistic representation of the policy process (Thomas & Grindle, 1990).

While some scholars have considered implementation studies to be ‘yesterday’s issue’ (Michael Hill, 1997), others also believe the contemporary world is in critical need of valid knowledge about policy implementation (O'Toole, 2000; Saetren, 2005). Indeed, a thorough understanding of the intricacies of policy implementation is worthwhile, especially considering the ever-changing and practical realities of governance and the policy environment under the pressures of globalization. As suggested by Brinkerhoff (1996), continued failure to effectively implement policy not only results in the waste of scarce resources, but also undermines opportunities for sustainable development, which consequently imperils the legitimacy of the state. In a similar vein, Thomas and Grindle (1990) contend that “reforms that fail can be worse than no reforms at all” (p. 1178).

The concept of implementation or ‘implementation deficit’ has long been a dominant theme in the implementation studies literature. Although the challenge of policy implementation appears to be a general problem across the global world, the difficulty of executing programmes seems particularly grave for countries in the developing world, partly due to poverty. In simple terms, implementation is defined as the execution of a project intended at achieving specific policy objectives (Cheema & Rondinelli, 1983). According to O'Toole (2000), implementation refers to an “apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action” (p. 266).
The seminal work by Pressman and Wildavsky (1973) generated scholarly interest in implementation studies and, over time, significant advances have been made within this field. Generally, scholarly reviews suggest that the literature has been characterized by three phases of development – first, second, and third generations (Conteh, 2011; Michael Hill & Hupe, 2003; Lindquist, 2006; Schofield, 2001). Understanding these trajectories is central to establishing the analytical framework for the present study. The first phase was underpinned by rational or technocratic and linear-oriented thinking, which privileged the dichotomy between politics and administration (Schofield, 2001). In essence, the first model of implementation studies was driven by positivist assumptions that focused largely on empiricism, systematic and cause-effect relationships. In the effort to achieve desired policy outcomes, this strand of writing aimed at policy predictability. However, as noted by Stone (2012), the “rationality project misses the point of politics” (p. 10).

The second phase of implementation studies thus emerged in response to the limitations identified in the first model. Scholars within this camp sought answers on how to anticipate and better address implementation challenges (Lindquist, 2006). A key characteristic of this model was the debate between the top-down and bottom-up approaches to policy implementation. Critics of the top-down approach believed that such an implementation model belonged to the first-generation thinkers – a framework based on assumptions of rationality and complete information. Indeed, the top-down approach (forward-mapping), unlike the bottom-up (backward-mapping) model, focused primarily on the role of the
central government and policymakers, while neglecting the complex interaction between street-level bureaucrats and organized societal interests (Elmore, 1979; Lindquist, 2006). As Conteh (2011) notes, the theoretical and empirical postulations of the top-down approach was perceived as excessively mechanistic and incompatible with the realities of policy delivery in democratic societies.

Although the second-generation model synthesized the top-down and bottom-up approaches, the third-generation researchers emerged with the goal of establishing grand theories in order to broaden the scope to research on policy implementation. Within the third-generation model, there has been a significant shift towards a multi-actor approach to policy implementation, which focuses on the interplay between a multiplicity of actors, institutions, and different levels of governance (Conteh, 2011; Lindquist, 2006; Peters & Savoie, 2012). In line with this focus, concepts such as partnerships, accountability, interdependence, collaboration, coordination, networking, decentralization, devolution, horizontal governance, joined-up government, among others, have increasingly become dominant themes in the literature (Kernaghan et al., 2000; Peters & Savoie, 2012; Skogstad, 2011). This is more in keeping with the policy literature, which has expanded in scope to address issues of transnational policymaking and implementation, with particular attention to shifting norms and governance structures, of which interactions between state and non-state actors remain prominent.

Considering the present study’s focus on the global-domestic nexus, it is apparent that the implementation literature offers significant insights into, and
understanding of adolescent and youth health development within the broader context of the global development agenda. Central to the present discussion is the shift from technocratic governance to an interactive model of decision-making and implementation (Thomas & Grindle, 1990). By viewing implementation from a process perspective, one is able to better come to terms with the dynamics and complexities of the policy environment, which policy makers and practitioners neglect at their own peril. As Brinkerhoff (1996) asserts, “policy implementation is as much process as it is content,” and hence the need for critical attention to both the direction and nature of investment that will yield the desired outcome (p. 1395).

Critical to implementation research is the need for policy legitimation (similar to the framing discourse), resource mobilization, ‘policy champions’, participation, and organizational arrangements, among several others. Given the expanding scope of governance and increasing complexity of policy issues, it is argued that managerial efficiency and effectiveness are imperative to successful policy delivery (Brinkerhoff, 1996). As argued by Brinkerhoff (1996), a managerial perspective takes into serious account the aforementioned components that shape the direction and ultimate outcome of proposed policies.

In their study on policy reforms in developing countries, for instance, Thomas and Grindle (1990) draw insight from four cases (Indonesia, Ghana, Jamaica, India) to illustrate a range of elements that mediate policy intent and policy action. According to their study, the void between policy decision and implementation could be overcome if decision makers and policy managers
critically analyze the policy environment, engage in capacity assessment to ensure that the requisite resources (political, financial, managerial, technical) are available. By analyzing the implementation of Ghana’s ADHD and GHARH programmes, the utility of these theoretical postulations will illustrate why the latter intervention holds much promise compared to the former.

5.3. Towards an Integrated Analytical Framework

As indicated, the present study employs an integrated analytical framework that combines the analytical strengths of the framing literature and implementation studies. While much has been written about framing and policy implementation, little attention has been given to the shared analytical conversation between these theoretical streams. A more fruitful approach would, therefore, ask how the two perspectives intersect. This is important, especially in terms of advancing the frontiers of knowledge about the institutional and governance processes that define the policy landscape.

A common ground shared by both perspectives is the simultaneous focus on structure and agency. It is also worthwhile to point out that both perspectives appreciate the need for a process-oriented understanding of social and political phenomenon. Schofield (2001), for instance, contends that a ‘processural’ view of implementation that takes into account the role of ideas is long overdue. In a similar vein, Campbell (2002) also reiterates the need for a better understanding on how ideas and discourse affect political communication, and consequently policy practice and outcomes. Likewise, in their study on health care reform in
Africa, Béland and Ridde (2016) suggest that an analytical perspective that takes into account the complementary properties of ideas and policy implementation may help explain policy success, resistance, and sustainability. Based on Schon and Rein’s (1994) analysis, there is good reason to appreciate the fact that ‘action frames’ speak directly to policy practice. Furthermore, the framing and implementation studies literatures both place heavy emphasis on context and the need for policy legitimation (Brinkerhoff, 1996; Conteh, 2011; Fischer, 2003; Stone, 2012).

Based on the analysis above, it is clear that that the framing and implementation literatures are intrinsically intertwined, and could be fruitfully combined without any loss in analytical usage. In fact, two interesting points are noteworthy; first, that there are ideational elements embedded in policy implementation; second, that policy framing is not limited to agenda setting but encompasses the sphere of implementation. Central to the discussion is that although policy formulation and implementation have distinct features, it is useful to consider how they impact each other. Grindle (1980) notes, “decisions made at the design or formulation stage have a considerable impact on how implementation proceeds” (p. 8).

Despite the common threads embedded in the framing and implementation literature, it is important to note that the two perspectives are not sufficient in themselves to advance comprehensive understanding on adolescent and youth health development. For the purpose of the present study, both perspectives are limited in their explanatory power, and should be combined as a fruitful pathway.
to understanding and appreciating the broader issues. For instance, while the framing literature encompasses the domain of policy implementation, it does not sufficiently address the complex technical and scientific details pertaining to health programming. On the other hand, the implementation studies literature provides a bird’s-eye view into the technicalities and bureaucratic dimensions of adolescent and youth health initiatives, but falls short of providing a full picture of the ideational and discursive mechanisms surrounding the implementation process.

Policy shapes politics and vice versa, both at the macro political system and micro level – an understanding shared by the framing and implementation literatures. Indeed, a significant point of convergence across the two literatures encompasses the ability to explain phenomena at the macro and micro levels, while appreciating the link between both spheres. The literatures on framing and implementation, therefore, help to unpack the complex multi-level relations among political actors, as well as socio-political and cultural matters at the heart of this thesis. Overall, by using an integrated analytical lens rooted in political science and policy studies theories, the study not only builds on the existing body of knowledge, but also more importantly, compensates particularly for the psychology-dominated theories on youth studies.

5.4. Chapter Summary

The aim of this chapter was to provide understanding on the theoretical framework guiding the study. By analyzing the framing and implementation studies literature, it becomes clear that combining analytical insights from both perspectives enrich
the discussion, and advance further theoretical understanding on global and national initiatives aimed at improving young people's health and well-being. The decision to employ an integrated analytical framework is based on the common threads that flow from the literature, as well as the inadequacy of a single theoretical framework to do justice to the analytical demands of the present study. By combining theoretical insights, the study not only fills an ideational gap in the implementation literature, but also captures the need for a multi-disciplinary appreciation of the broader issues and politics relating to adolescent health. The next chapter delves into the research findings and analysis pertaining to the present study.
RESEARCH FINDINGS & ANALYSIS
Chapter Six

Health and Policy Intervention: Prospects and Challenges

This chapter presents the research findings from the data collected in relation to the present study. In order to better appreciate the factors that structure adolescent and youth health outcomes, it would be useful to first provide some insight into the Adolescent Health and Development Programme (ADHD), which preceded the Ghana Adolescent Reproductive Health (GARH) intervention. While the GARH initiative is essentially a transformed version of the ADHD programme, a separate overview of both programmes will be presented for analytical purposes.

6.1. The Adolescent Health and Development Programme (ADHD)

Several initiatives have been undertaken across space and time to improve adolescent and youth health outcomes in Ghana, and notable among these initiatives is the national ADHD programme, which was established in 2001. It was established with the ultimate goal of achieving MDG 5 – that is, to reduce maternal mortality ratio, and to achieve universal access to reproductive health. In line with this international protocol, the programme was instituted as an integral component of the Reproductive and Child Health Programme, which falls under the purview of the GHS Family Health Division (GHS, 2014). The program sought to address a broad range of issues relating to the health of young people, including sexual and reproductive health, poor nutrition, violence and injuries, substance abuse, harmful practices and unhealthy lifestyle, as well as other endemic diseases.
Implementation of the programme commenced under the auspices of the Ghana Health Service (GHS), whereas coordination remained within the ambit of the National Population Council (NPC). The NPC is the highest statutory body that advises Government on population-related issues, and provides the relevant policy framework to guide and support programme planning and implementation. Given the broad focus of the programme, the objective was to integrate adolescent health and development into both public and private health facilities at the various levels of health policy delivery, including the community level (GHS, 2016). In 2009, a seven-year National ADHD Strategic Plan (2009-2015) was developed to provide multi-sectoral support to adolescent health delivery. Evidence suggests that some gains were made in relation to the ADHD programme, including utilization of health services by young people and reduction in HIV infections among 15-19 year adolescents (GHS, 2017).

Central to the present discussion are the problematic factors that crippled the ADHD programme from the outset, thereby resulting in implementation stasis. Based on a national and regional assessment of the programme, a number of concerns were brought to the fore (GHS, 2014). First, findings from the evaluation report underscored the lack of regional support for the programme across most of the regions. Second, it was noted that about ninety per cent of service providers lacked the requisite orientation and training in ADHD. Not surprisingly, these service providers exhibited judgmental and unfriendly attitudes that further alienated the youth upon their visits to the health facilities. Third, it was also observed that information, education, and communication (IEC) materials from the
GHS were severely lacking, thus affecting service provision for particularly out-of-school adolescents and young people in rural and hard-to-reach communities. Fourth, although a number of adolescent health corners had been established to specifically provide “safe spaces” or adolescent friendly services to young people, the evidence indicated that most of them had integrity and functionality problems. Lastly, the programme had no documentation or database from which services rendered could be consolidated, thus prompting concerns about transparency and accountability.

Further details on the ADHD program evaluation report is provided in the Ghana Health Service annual report (GHS, 2015). A summary of key findings from the evaluation included the following:

- Access to appropriate health information by adolescents and young people has not improved significantly over the period [of the review]
- Utilization of health services by adolescents and young people has remained poor even though there is improvement overall
- The political and legal environment has enhanced considerably but the same cannot be said of the social and cultural environment
- Community participation in ADHD has been weak; however, increasing numbers of adolescents and young people are getting more involved in health programme development and implementation
- The management and coordination of ADHD programmes has improved considerably though more needs to be done at the decentralized levels.
Funding for ADHD, especially from donor partners, has increased considerably.

- There is gradual improvement in most of the adolescent indicators over the period. However, at the current rate of impact, it will be impossible to achieve envisaged targets set for the new ADHD policy (GHS, 2015, p. 46).

As noted, the ADHD programme was established in 2001. However, it was not until almost a decade that gradual efforts were made to rebrand the programme to appeal to its target audience (i.e., young people). It would, therefore, make sense to attribute the modest gains achieved in the latter part of the programme partly to the rebranding efforts by GHS, NPC, PPAG, Futures Group, UNFPA, Marie Stopes International, and other stakeholders. And, it should also be pointed out that this period coincided with discourses surrounding the formulation of the SDGs. Based on the issues outlined above, an obvious concern that generates avenues for possible systematic inquiry speaks to the following question: why did a promising initiative with a clear focus and mandate yield such poor outcomes? It has been argued that weak and irregular supervision, particularly at the regional level, accounts for some of the aforementioned difficulties associated with the program (GHS, 2014). Generally, it has been suggested that several capacity-building activities were undertaken prior to, and after the establishment of the ADHD programme. But if this is the case, then what explains the gap in the training of service providers as captured in the ADHD assessment report and subsequent outcomes of the program?
Of course, given the myriad of challenges described earlier, it is apparent that a more careful and broader analysis would offer more fruitful insight into the dilemma. In other words, it is imperative to pay attention to the broader policy and institutional processes that shape the health outcomes of young people, and most importantly, how these mechanisms and policy arrangements intersect with health care politics. On the face of it, one could surmise that the ADHD programme was a novel idea, and perhaps overly ambitious, particularly considering its national scope. But clearly, such arguments are too simplistic and obfuscate the real issues, thus frustrating analytical efforts at gaining understanding of the complex institutional and socio-political forces that shape adolescent and youth health initiatives.

6.2. The Ghana Adolescent Reproductive Health Programme (GHARH)

The GHARH programme, on the other hand, is a three-year partnership-driven intervention (Jan 2014 – March 2017) implemented by an international non-governmental organization (NGO) known as Palladium (formerly Futures Group Europe), in collaboration with the Government of Ghana (GoG) and other key institutional partners. The programme is a DFID funded project (£11.3 million UK aid) awarded to Palladium on a competitive basis. It should, however, be noted that although Palladium served as the primary implementing actor, the organization operated mostly as a grant manager, facilitating the disbursement of funds to implementing partners, and directly overseeing the overall implementation of the programme. The NPC served as the coordinating body on the GHARH project.
The focal point of intervention for the GHARH programme was the Brong Ahafo region due to the high adolescent pregnancy burden uncovered geographically. Given its broad scope, the programme covered all the 27 districts in the region. As can be seen in figure 1 below, the Northern and Central regions reflect a slightly higher pregnancy burden in terms of rates of adolescent and youth pregnancy. However, the interviews conducted with Palladium officials revealed that the decision to focus on Brong Ahafo was based on consultation with the Ghana Government, Ministry of Health (MOH), and GHS. It was noted that due to donor presence (i.e., USAID projects) in some of the areas in the South, including Central and Western regions, Brong Ahafo appeared to have a significant service gap. Most importantly, Brong Ahafo was deemed a “transit zone” or “mid-point” that required urgent attention. Further insight on this transitory dynamic will be provided later on in this chapter.

In line with the idea of policy feedback discussed in chapter one, the following discussion suggests that programs such as the GHARH initiative can create positive feedback effects on the development of citizenship. This is exemplified through the achievements of the programme. And in this context, policy success is defined in terms of both processes and outcomes. The expansion of health services for young people, for instance, is central to the political agenda of nation-building. As Béland et al. (2018) suggest, such initiatives can become powerful symbols of national unity and social integration. This is particularly true when one considers the difficulties and negative feedback effects of the prior ADHD programme.
Similar to the ADHD programme, the GHARH intervention sought to promote and improve maternal health among the adolescent and youth population aged 10-24 years. But because it was conceived within the new development framework (i.e., the SDGs and related protocols), it addresses many issues that the ADHD did not. More specifically, the programme aimed at creating opportunities for improved
knowledge and behaviour surrounding reproductive health – a national maternal health goal that aligns with MDG #5 (i.e., reducing maternal mortality). Considering broad policy shifts in the global health arena, the programme was adapted to fit with SDG #3 (i.e., ensure healthy lives and promote well-being for all at all ages). Indeed, adapting the programme to the exigencies of the global environment not only reflects the national commitment of making adolescent health programmes more relevant to the contemporary needs of young people, but also captures the interplay of complex institutional forces that dictate the broader framework for health governance.

In line with reducing the overall rates of maternal mortality, Palladium sought to expand sexual and reproductive health services to young people in order to reduce the adolescent pregnancy burden, sexually transmitted infections, as well as school dropout rates. To achieve the aforementioned objectives, Palladium also directed effort towards strengthening government institutions and agencies in order to build the requisite capacity to effectively implement and manage efficient delivery of adolescent focused health initiatives. The idea of capacity building will be further elaborated in the chapter.

Given the renewed focus on multisectoral approach to policy implementation, Palladium engaged with 4 key national agencies: NPC, GHS, GES, and NYA. At the regional level, the organization worked with the Brong Ahafo Regional Coordinating Council (RCC), which houses the regional units of the

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11 The Sustainable Development Goals (SDGs) are broader and more ambitious in scope, and better address issues pertaining to poverty, gender equality and health relative to the Millennium Development Goals (MDGs). Unlike the MDGs, which gives prominence to child and maternal health, the SDGs seek to promote inclusive health and well-being for all age groups.
aforementioned agencies. Also, all 27 Ministries, Departments, and Agencies (MDAs) across the Brong Ahafo region were engaged. In line with Ghana’s decentralization efforts, Palladium also established a partnership relationship with five selected NGOs namely: Hope for Future Generations (HFFG), MAP International, Planned Parenthood Association of Ghana (PPAG), Women in Law for Development in Africa (WiLDAF), and Institute of Social Research and Development (ISRAD). In a broader sense, it is worth noting that the GHARH programme builds on, and is informed by the findings of the ADHD program evaluation report outlined earlier in this chapter.

6.3. Factors that Shape Adolescent and Youth Health Outcomes

The subsequent discussion is situated within the context of the ADHD and GHARH initiatives, and divided into sections that examine the key factors that broadly define the nature of interventions aimed at improving adolescent health and development. As argued from the outset, a better understanding of adolescent and youth health development cannot be fruitfully achieved without consideration of micro-level and, most importantly, macro-level factors. It can be recalled from chapter four that the literature locates adolescent sexual and reproductive health within the context of four thematic areas. By drawing on fieldwork interviews, in addition to document reviews, the following analysis builds on the existing literature and discusses why health programming should be considered a crucial element of the health discourse, as well as contextual factors that determine whether or not adolescent focused initiatives will yield positive or poor outcomes.
In this regard, the formulation and implementation of the GHARH programme is instructive.

6.3.1. Political Structure

As discussed in chapter three, a better appreciation of the role of actors and ideas is central to understanding policy outcomes. As such, the character of the political landscape matters. Certainly, the series of new global protocols (i.e., SDGs, Global Strategy, and AA-HA!) are far reaching and obviously do not only speak to the Ghanaian context, but the big question is – to what extent do these global policy frames affect citizenship and development outcomes for young people? As already noted in chapter five, scholarly work on policy research suggests that meta-cultural frames or meta-ideas can significantly affect problem definitions, policy choices, and political action, thus structuring the broader policy process or institutional framework, which, in turn, shapes policy outcomes (Schon & Rein, 1994; Mehta, 2011; Stone, 2012).

Broadly speaking, empirical evidence from the GHARH programme in Ghana illustrates that the intervention has, to a significant extent, produced tangible outcomes for the youth population across the various districts in the Brong Ahafo region. And despite implementation obstacles, which will be discussed later in the chapter, the relatively navigable character of Ghana’s political landscape is worth noting. The following discussion will shed light on the virtues of the GHARH intervention, while situating the analysis within the broader theoretical literature discussed in chapter five.
The interviews conducted with Palladium officials, as well as document analysis, revealed that the GHARH intervention draws significantly on the SDGs, the updated Global Strategy, and the AA-HA! as viable frameworks for improving health service delivery for young people, while operating through the Government of Ghana agencies and GHS facilities. The Team Leader of Palladium, in his observation, underscored the relevance of reframing or refocusing adolescent health.\(^{12}\) According to him, one of the major failings of the global body, and particularly in Africa, is identifying the strategic place of the youth in the development agenda. As he pointed out:

> The world has changed now; young people are seen as having great potential to impact their own life and the life of their community. I think we didn’t encourage young people to be empowered enough to know that these rights are theirs, and that they can champion it themselves.

In a similar vein, a senior technocrat with Palladium noted that adopting an overarching global frame allows for comparability of policy options and outcomes. In other words, a global frame positions the nation strategically to draw on “best practices” on adolescent health, and to work towards common expectations in the African and, more broadly, global community.\(^{13}\)

On the basis of this understanding, Palladium officials highlighted some positive elements about the GHARH intervention. It was brought to the fore that significant investment was directed towards education awareness, counseling,

\(^{12}\) Interview with Team Leader of Palladium, Mr. David Logan, Ghana, March 13, 2017

\(^{13}\) Interview with Mr. Jacob Larbi, Ghana, Feb. 08, 2017
antenatal and postnatal care, family planning, training of service providers and other institutional bodies such as the NPC, GHS, GES, and NYA. Based on comparative analysis of DHS data dating back to 2003, it was noted by Palladium that the GHARH intervention had impacted family planning uptake quite positively.\(^{14}\) Health services were provided for almost over 153,000 young people. As revealed in the interviews, about 25 per cent of young people use family planning in the Brong Ahafo region, suggesting some degree of improvement in maternal and antenatal care.

Another significant achievement of the GHARH intervention is the establishment of 54 adolescent health corners (including new and refurbished) across the 27 districts in the Brong Ahafo region. It should be pointed out that these health corners were not isolated units. The placement of the health corners was based on the location of existing health facilities within these districts. Given that Palladium did not have their own facilities, the organization worked through existing GHS delivery channels. As such, the health corners were mostly extensions of the main hospital facilities, but solely dedicated to young people. Each district was provided with two adolescent corners, and these corners are specialized health units that provide various health services to young people.

To be sure, the concept of ‘health corners’ is not new. The previous ADHD programme also championed the idea of providing “safe spaces” for young people to encourage a more adolescent friendly approach to dealing with adolescent

\(^{14}\) The Ghana Demographic and Health Survey (GDHS) provides the Government of Ghana and international partners with periodic statistics on the health and welfare of the Ghanaian population. It provides data on key indicators such as fertility, family planning, infant, child and maternal mortality, nutrition, reproductive health, and other essential health information.
health issues, and ultimately utilization of health services. However, as pointed out earlier, most of these existing health corners were compromised by staffing and financial problems, as well as other infrastructural constraints. Thus, prior to the GHARH intervention, the broader discourse surrounding adolescent health, as revealed in the interviews, was that “adolescent health corners don’t work.” The GHARH intervention, therefore, sought to change this narrative by refurbishing existing GHS health corners, as well as establishing new ones. Materials and equipment such as examination beds, gloves, refrigerators, among others, were provided to enhance the operation of these health facilities.

Scholars have written extensively about the need to provide safe spaces for engaging with adolescents in terms of their reproductive health. For instance, the WHO (2002) call for adolescent-friendly health services is based on the empirical evidence that the lack of trust in health systems tends to further alienate young people, and hence the need for a more robust, inclusive, and welcoming approach to engaging the youth. Recall that in the Ghanaian context, emerging scholarship captured similar findings: the lack of respect, confidentiality, privacy, and judgmental attitudes of service providers appeared to be the norm in most general hospitals, thus reinforcing the stigmatization and marginalization of the youth (Hampshire et al., 2011; Kumi-Kyereme et al., 2014). As such, the health corners were specifically established to remove prevailing barriers and improve young people’s access to health facilities.

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15 Interview with Mr. David Logan, March 13, 2017
In Ghana, adolescent pregnancy is generally stigmatized and met with great disapproval, and this obviously resonates with the culture of silence surrounding discussions that revolve around sexuality. In a broader sense, one could argue that the revitalization of the health corners is a symbolic attempt at shifting the historical discourse about adolescent pregnancy from the realm of intentional cause to that of institutional responsibility.\textsuperscript{16} As an NGO official indicated:

Culturally, as a young person, you’re not supposed to get pregnant. That’s the time you have to concentrate on your education. So, if you become pregnant at that time, then of course, society frowns on that because they don’t want to see young people going into that. But the incident has happened, so what do you do? The person you don’t want to see is pregnant; you still have to accept that person and provide the needed attention or care.\textsuperscript{17}

As indicated in chapter two, the districts selected for the study are predominantly urban in character and share similar social identities and institutions. Overall, the data collected, as well as field visits to some of the health corners suggests that these corners have been positively received by young people in the region. As noted by an NGO official, the first three months, for instance, recorded an estimate of about 590 young people visiting the corner. As part of measures to further enhance the operation of the adolescent corners, recreational games such as ludo, cards, checkers, scrabble etc. were also provided to attract and engage young people. My research findings revealed that some adolescents and youth visit the

\textsuperscript{16} In this context, adolescent pregnancy is not interpreted as an outcome of irresponsible individual behaviour, but rather underscores the state’s responsibility to young people. Stone (2012) outlines an insightful causal framework to show how the world works in terms of assigning responsibility for problems (intentional cause; mechanical cause; accidental cause; inadvertent cause).
\textsuperscript{17} Interview with Team Leader of Map International, Mr. Gilbert Asante, Ghana, May 09, 2017.
health corners mostly to play games or watch television. As noted by a health practitioner:

They [young people] come here a lot. And, we have other games. Apart from the counseling, they come here for recreational games. We have ludo, draft, cards, and scrabble. We also have television where they watch educative movies. Palladium has provided us with dvd sets, so we use it to educate them (Field Interview, 2017).

Of significant interest is the idea that these engaging activities offer a remarkable platform for health practitioners to build rapport with the adolescents, educate them on reproductive health issues, as well as respond to sensitive questions bothering them.

But some important gender and age differences were noted in terms of the frequency of visits to the adolescent corners. In one district, for instance, the resident health practitioner (youth facilitator) mentioned that the boys and young men often frequented the health facility mostly to play compared to their female counterparts, who had more interest in the family planning services offered at the health corner. Also, it was observed that young people who usually visited the facility were between 20-24 years. On the other hand, a different health corner reflected a more balanced outlook in terms of gender. However, it was also noted here that adolescents between 10-18 years paid more frequent visits to the facility compared to those between 20-24 years. The reason for these differences is not entirely clear. Perhaps these notable differences may speak to the geographic composition of the districts, or relate to how young people are generally targeted
with interventions. It might also be a function of the implementation-cultural nexus, a point that will be further examined in the chapter.

Another interesting strategy worthy of attention is the television-based drama series, ‘You only Live Once’ (YOLO), introduced by Palladium. Evidence suggests that this educative health programme not only sustains the interest of adolescents and youth at the health corners, but has also been widely embraced by young people across the Ghanaian landscape. Perhaps its widespread appeal lies in the fact that the movie characters are young people, or it could also be the case that a broader section of young people were reached by Palladium through social media platforms such as Facebook, YouTube, Twitter, and Instagram. Evidence suggests that the drama series has caught on very well and has a large following on social media. Indeed, YOLO was ranked in 2017 as the most influential radio and TV program on social media (Modern Ghana, 2018). As noted by the Team Leader:

We want to be able to get into the minds of young people. How do we best target them, and with what kind of messages? What things are we bringing to the table to give another perspective to the issue of young people’s health?  

To be sure, the YOLO programme is not the first of its kind. In the West African Youth Initiative Project (WAYI), for instance, peer educators were trained to develop and present their own dramas on broad topics such as reproductive health, drug use, and parent-child communication in their own communities (Brieger et al., 2001). Also, the Ghana Social Marketing Foundation (GSMF) has, in previous years, supported TV series that target young people’s reproductive health such as “Things

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18 Interview with Mr. David Logan, Ghana, March 13, 2017.
“We Do for Love” (Awusabo-Asare et al., 2004). However, a distinguishing feature of the YOLO programme speaks to the dynamic use of technology, as well as the idea that the TV series has been strategically packaged as part of a broader interventionist programme and weaved into the health corner initiative.

In fact, the influential nature of the YOLO program is a testament to its unique positioning within adolescent health programming. The TV programme encompassed a broad range of topics, including adolescent pregnancy, adolescent peer-pressure, abortion, STI’s/HIV, and adolescent-parent communication. It should also be mentioned that the programme was largely successful with support from NPC, GES, various media houses such as GTV, TV3, Radio BAR, Storm FM, Sky FM, and other stakeholders (including religious leaders). As pointed out by the Team Leader of Palladium, the policy and advocacy environment has improved significantly, thus allowing for the promotion and expansion of adolescent sexual and reproductive health. Drawing from the study by Awusabo-Asare et al. (2004), this development is in direct contrast to the socio-political environment that prevailed during the airing of programs such as “Things We Do for Love,” which some religious bodies and traditional rulers perceived as promoting promiscuity.

A major success story emanating from the YOLO programme relates to a young man residing in a rural area in the Brong Ahafo region, specifically the Sene East district.19 Apparently, this young man had dropped out of school under the influence of his peers, whose main preoccupation revolved around establishing

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19 The Sene-East district is one of the hard-to-reach areas in the Brong Ahafo region
sexual relations with the opposite sex. Upon watching the YOLO series, which somewhat reflected his present social predicament and the possible ramifications of his continued association with his peers, he withdrew from the group and enrolled back in school to continue his education, with the help of some NGO officials. As noted by a Palladium official:

The young man identified with popular actors in the YOLO series – one of them is called Drogba, the other is called Cecil. So, the Drogba guy was influenced by Cecil to have sex with one girl called Jane, and she became pregnant. So, one day, this guy [the young man] realized that those colleagues he was following were mounting pressure on him to engage in sex, just as Drogba [in the TV series]. So, he advised himself that his colleagues were behaving like Cecil, so there was the need to break away. But each time he attempted to break away, he had the deep fear of becoming an outcast. He was afraid of that isolation and consumed with fear that they [his peers] will gang up against him. But upon reflecting on the fate of Jane and Cecil, he said: come what may, I must break from this group. So, he broke from the group and informed the NGO supervisors that he wants to go back to school, and they put him in school. Now, he’s about to write his final exams.

Aside from the YOLO programme, Palladium also developed a mobile application for service providers to provide a technological channel for interaction with adolescent health resource persons. This helped to bridge the knowledge and experiential gap that had been identified in relation to adolescent health delivery over the past decade. Through the mobile application, service providers are able to access training and policy documents, information, education and communication materials, as well as updated health standards and protocols. As noted across the

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20 In Ghana, this risky sexual behaviour translates in local parlance as ‘hunting for girls’. The term is often used particularly among the male youth population.
21 Interview with Palladium’s overall Monitoring and Evaluation Coordinator, Mr. Bashiru Adams, Ghana, May 10, 2017.
interviews with Palladium officials, the mobile application has been a great attraction among service providers and health managers. Evidence suggests that the mobile application was adjudged the best innovative enterprise in 2015 by the GHS Special Award Committee (GHS, 2015).

Indeed, the findings of this study discussed so far reveal that (1) an enabling political environment is critical to the success of interventions; (2) global policy frames could potentially affect citizenship and development outcomes for young people; (3) when young people are effectively and meaningfully engaged, they respond positively to health interventions targeted at them; and (4) the future prospects of adolescent and youth health rest on innovative health programming. These points will be further reinforced as the chapter unfolds, but we will also gain deeper understanding of the ideational and institutional forces that facilitate or constrain policy direction in terms of adolescent and youth health development.

In many ways, the GHARH programme was made possible due to a number of factors, and among these variables, one needs to pay critical attention to the discursive processes surrounding the intervention. In other words, what was the nature of communicative exchange among state and non-state actors? As discussed in the literature review section in chapter four, the relationship between the state, government ministries and agencies, NGOs, and other political actors’ matter, and should be accounted for if adolescent health is to be understood in the proper context. Of significant importance is the discourse produced by these actors that helped shape the conversation around adolescent health and, ultimately, the implementation of the GHARH programme. Many theorists have underscored the
importance of agency and the need to show the mechanisms by which ideas impact
the policy process (Beland & Cox, 2011; Parsons, 2002; Schmidt, 2008). To see this
relationship in greater detail, it is worth keeping in mind the national and
international dimension of the GHARH programme.

As discussed in chapter five, the past few decades have witnessed a greater
emphasis on the need for concerted action in response to the complex challenges
associated with policy delivery, particularly across multi-level jurisdictions. In
relation to health, the concept of multisectoral action, otherwise known as
intersectoral action, has gained much prominence in the literature, and has been
widely used in the global, national, regional and local health discourse (Rantala,
Bortz, & Armada, 2014). For instance, the past few years have witnessed the WHO
championing multisectoral action as critical to addressing health inequities,
disadvantage, and social injustice (WHO, 2008a, 2008b).

In a similar vein, the SDGs, Global Strategy, and AA-HA! underscore the vital
importance of multisectoral action as a viable tool to addressing complex
challenges surrounding the global development agenda, which includes issues such
as poverty eradication, climate change, conflict prevention and resolution, systemic
inequalities, health and well-being, among others. Generally, the concept of
multisectoral action is rooted in the understanding that most social determinants
of health are located outside the exclusive jurisdiction of the health sector, hence
the need to engage with other sectors of government and society to effectively
navigate the challenges associated with health and general well-being (WHO,
2008b). In essence, the rhetoric of multisectoral action boils down to a simple, yet
complex mechanism - that is, partnership. Importantly, this philosophy was invoked by Palladium in the implementation of the GHARH programme.

As already noted, the GHARH intervention sought to expand sexual and reproductive health services to young people, support service delivery, create demand for the services established, and inform the intervention through operation research. Given the ambitious and complex nature of these tasks, the project was designed with a multisectoral lens as a pathway to attaining successful outcomes. In the words of a Palladium official, the idea behind a synergistic relationship was to “allow much-needed resources to be pooled from various sources to maximize the impact of the intervention.”\(^\text{22}\) In this regard, broad consultations were held with the Ghana government, DFID, MOH, GHS, GES, NYA, with the NPC acting as the coordinating unit. Through this “coordinative discourse,” other relevant actors and stakeholders at the regional and district levels, including the Brong Ahafo Regional Coordinating Council, District Assemblies, and NGOs were identified and engaged to enhance the efficiency and effectiveness of the intervention.

This strategy was based on the premise that each of these entities could bring unique perspectives and resources to the implementation table. Most importantly, it was noted that the boundaries of adolescent health extended beyond the health sector. For instance, the NYA was engaged due to its broad mandate of developing particularly out-of-school adolescents, the GHS was involved by virtue of its expertise in the area of adolescent health, the GES also had

\(^{22}\) Interview with Mr. Jacob Larbi, Ghana, February 8, 2017.
a long-standing commitment in reaching in-school adolescents, while NGOs were
noted as having particular strengths in community mobilization. In line with the
framing and implementation literature discussed in chapter five, it is obvious that
the process dimension of the GHARH programme was taken into serious
consideration, and as will be seen later, these dynamics largely challenge the
approach used in implementing the ADHD programme. According to the Team
Leader of Palladium:

The project’s [GHARH] life span was from 2014 – 2017. So, the
period was short, aiming for intensity not to spread out too thin.
We adopted a bottom-up approach to implementing the project,
and that’s one unique thing we did to support the government
decentralization policy. We’re a grant provider; the money DFID
gives to us, we disburse it as grants to our implementation
partners – The NPC, GHS, GES, and the NYA. At the regional level,
we give grants for coordination and monitoring to the Regional
Coordination Council, as well as the 27 Grantees in the Brong
Ahafo region.23

The comment above certainly captures the multifaceted nature of adolescent
health, and reinforces the theoretical argument that the “top-down” approach
yields better outcomes when complemented with the “bottom-up” approach. At the
same time, it also points toward the utility of adopting a partnership frame in
executing the programme. Indeed, there is good reason to suggest that the framing
of the issue dictated the circle of actors engaged, as well as the strategies employed
to navigate the complex challenges of adolescent health. As noted by the Team
Leader:

23 Interview with Mr. David Logan, Ghana, March 13, 2017
Adolescent pregnancy also has a lot of social dimension – that is, issues surrounding parenting, poverty, gatekeepers etc. So yeah, it was critical for all of our partners to understand those dynamics at the outset: this is not just a health intervention, there’s a social side, as well as community-driven side to it. We had to sell that point quite a bit. Again, we were ahead of the game regarding the decentralization effort. So, we started bottom-up, giving our grant money directly to the district assembly. The district organization principle is that we had a district focal person who worked together with the implementing partners at the district level to plan and jointly come up with activities for the project. So, we disbursed the money and signed the agreement with the district assembly. It sort of empowered them to identify the adolescent health issues while working through partnership. Our partners have accepted the partnership arrangement and principles that we deployed. So, to my mind, I think we’ve done a good thing.24

With the benefit of hindsight, a district health officer who was privy to the implementation of the ADHD programme reiterated a similar point to buttress the relevance of drawing on the global protocols. From his perspective:

The ADHD programme was flawed due to the absence of technical direction. If our authorities had sat down and understood, or had been advised deeply into this demographic dividend alone, it could have strengthened the economic argument and allowed for greater resources and mobilization.25 [It should be noted that the concept of demographic dividend is germane to discussions surrounding the Global Strategy and AA-HA!].

Following from the theoretical framework adopted for the present study, it is apparent that the above interorganizational arrangements were aimed at building trust and legitimacy for policy action. But as Schmidt (2008) explains, the

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24 Interview with Mr. David Logan, March 13, 2017
25 Interview with Mr. Owusu Asante, May 09, 2017
legitimation process applies not only to the “coordinative discourse” among policy actors, but also, the “communicative discourse” that plays out between political actors and the general public (p. 310). In this regard, the communicative discourse speaks to how ideas are conveyed to the citizenry or target population through political actors such as the media, experts, community leaders etc. (Schmidt, 2008). And as already indicated, a central concern among ideational scholars relates to the loose connection between ideas and policy action. Indeed, aside from the discursive exchanges in the coordinative stream, the GHARH intervention also illustrates that the vehicle of ideational legitimation translates as technical support.

Of course, to achieve success in the GHARH intervention, Palladium had to work with identified gaps in the ADHD programme, and this was brought to bear through its strategic and renewed emphasis on operational research and institutional capacity building. In fact, this approach was not only aimed at ‘softening the ground’ in terms of generating receptivity to ideas, but also ensuring that implementing partners had the requisite knowledge, skills, and attitudes to provide quality service, and to effectively advance adolescent health. In this regard, some training and capacity building initiatives were developed for a broad range of implementing partners including the NPC, GHS, GES, NYA, NGOs, peer educators, youth facilitators, and service providers.

There are various dimensions of capacity building worth paying attention to, and this includes the following: First, the establishment and refurbishment of existing adolescent health corners, as discussed earlier, is one area of capacity building that helped to expand and strengthen the delivery of adolescent health
services. Second, specific training in adolescent health was oriented towards discontinuing the use of general practitioners in responding to adolescent health needs (as had been the practice in previous years). As explained earlier in this chapter, the development of the mobile application by Palladium and other stakeholders was designed to further promote conversation between health service providers and experts within the field of adolescent health. Third, a database for recording the uptake of services, which was hitherto non-existent at the adolescent health corners, was created to provide relevant statistics on adolescent health. Fourth, specific training on coordination and monitoring of adolescent-oriented programmes was provided for the NPC and key implementing partners to address gaps that were previously identified in the ADHD programme.

Overall, it is estimated that Palladium trained not less than 7,000 individuals. For a senior technical consultant at Palladium, capacity building is crucial because it constitutes the ‘missing link’ that has long been neglected in the implementation architecture regarding most developmental initiatives across the country. As he noted:

Some of the positives have to do with the strength in capacities that have been built across these national agencies and institutions. In many areas in many institutions, it just becomes an afterthought . . . But now, what we’ve tried to do, and have succeeded in doing is that, we’re seeing capacity building in adolescent reproductive health being put upfront in these institutions. So, they’re able to put together the skills and the personnel that drive the intervention . . . we’re seeing a caliber of staff that are being trained specifically in providing adolescent-led, adolescent-focused, and adolescent-targeted services.26

26 Interview with Mr. Jacob Larbi, Ghana, Feb. 08, 2017
Indeed, the issue of training and capacity building is, in part, central to the challenges and subpar outcomes associated with the earlier ADHD programme. So, in order to ensure that the GHARH programme was well-received by young people and the broader community in the region, the communicative discourse had to be further strengthened. A senior policy official corroborated this point, which had been raised in the ADHD program evaluation report. According to her:

The ADHD program didn't receive much of the needed support, so in terms of training, there was a significant gap in relation to staffing, even at the national, regional, and district levels . . . and sometimes, they assign just a general practitioner to handle adolescent issues, which is not really acceptable. Because adolescent health is not like any general health practitionering; it’s a specific specialized area. You really need to understand; it’s a complex area, so if you don’t really understand the issues well, it’s difficult to handle. So, it takes someone who’s really interested and willing to push forward that agenda (Field Interview, 2017).

Another health official lamented the challenges he personally faced with the ADHD program at the district level. He indicated:

As it were, those of us who even got into it went there with the interest, but not with the kind of know-how that was expected. The knowledge I had acquired was obtained by learning on the job, undertaking my own sort of courses and schooling. So, I would have expected that we tackle that so that all the health workers produced over time would be individuals who know the business of adolescent health (Field Interview, 2017).

On a different but related spectrum, the same official pointed out the power dynamics associated with the ADHD programme. From his perspective, although
the ADHD programme had the semblance of a collaborative arrangement, the internal framework reflected a superior-subordinate apparatus. As he noted:

We had managers in that sector who had limited to no background knowledge in health, but because the activity had to be carried out by that department, that supremacy prevailed. They should have invited the technical input to ensure that at every stage, there was technical guidance all through, but in some respects, this was lacking. You know, I personally went to facilitate a workshop for out-of-school adolescents and we were expecting these young people to be specifically above the ages of 15 years. I went in and looked at their faces, and they happened to be younger than the expected age. Out-of-school adolescents were just about five, out of the 30 people [overall number] I was to teach. The whole arrangement got defeated because we had a separate arrangement for in-school adolescents. We needed out-of-school adolescents because the issues pertaining to the out-of-school population is different from that of the in-school cohort. The selection would have been guided by the concept of who we’re trying to reach, and with what information. But because they’re not technical people, they went and made their own selection; the selection was off target. So even though I did my best as a facilitator, I knew it was an exercise in futility (Field Interview, 2017).

Undoubtedly, the point raised above captures a key challenge in interorganizational arrangements – struggle over values and power. As noted by Kernaghan and Borins (2000), the ‘command-and-compliance’ approach to implementation often has the potential to result in failed outcomes. Within this dicey context, Palladium had to take cognizance of the power relations in the political and health environment, and work strategically within the complex hierarchical structure in order to bring about a shared understanding and commitment among all implementing partners and stakeholders.
To be sure, the concept of multisectoral action is not new in the Ghanaian health arena. As already pointed out, the ADHD programme also involved a multiplicity of actors, and sought to integrate adolescent health at various levels of health policy delivery. Nonetheless, the GHARH programme suggests that the structure, quality, and depth of partnership matters if further inroads are to be made in the area of adolescent health and development. In fact, partnership must be understood within the broader context of strategic engagement. On a more critical note, various scholars have noted that multisectoral action for health could prove elusive despite its far-reaching benefits (Ndumbe-Eyoh & Moffatt, 2013; Rantala et al., 2014; Rasanathan et al., 2017).

As discussed earlier in this chapter, Palladium provided extensive training to a wide range of actors, and it is worth expanding our understanding of the dynamics of social engagement in the ‘communicative sphere’. In the effort to build legitimacy and strengthen the resonance of ideas relating to sexual and reproductive health (SRH), Palladium championed advocacy programs that targeted a broad range of stakeholders including parents, youth groups and associations, community gatekeepers such as chiefs, religious leaders, the media, etc.

Recall the earlier discussion on the centrality of religion in the lives of individuals, community, and the state in Ghana. Taken at face value, it may appear that chiefs and religious leaders are targeted as stakeholders in health interventions mainly because of the respect and resources they command in their respective communities. But a more careful analysis suggests that these entities are
largely viewed as principal channels of influence, invested with social and cultural legitimacy. Such legitimacy, in turn, translates into broader social dividends in relation to youth outreach and behavioural transformation. In terms of sensitization and community mobilization, it is estimated that not less than 400,000 people were reached across the Brong Ahafo region. Advocacy materials such as booklets, banners, t-shirts, caps, fliers, and newsletters were used to create awareness about the GHARH programme in the various districts. The technical group involved in the review and development of the IEC materials include NPC, Marie Stopes International, PPAG, GHS Health Promotion Department, among others. With support from the various implementing partners and stakeholders such as NPC, GES, GHS, NYA, NGOs, as well as the media, Palladium was able to successfully follow through with its advocacy program in the region.

Central to the community mobilization effort was the establishment of about 600 school health clubs in the junior and senior high schools across the region. This initiative was spearheaded by Palladium, with support from the School Health Education Programme (SHEP) Unit of GES, PPAG, and other implementing partners. These clubs were created to complement the adolescent health corners by serving as educational platforms for the youth. While these clubs have patrons (i.e., peer educators) that facilitate discussions surrounding adolescent and reproductive health issues, the interviews also revealed that trained GHS staff, mostly from the health corners, also visited these health clubs on a monthly basis as a form of providing outreach services. Field visits to some of the adolescent health corners also revealed that a number of peer educators also organized students to the
corners on a voluntary basis to learn more about programmes at the facility, and to engage the staff with questions pertaining to their health and future well-being.

At the NGO level, peer educators were also trained by MAP International, for instance, to work hand-in-hand with trained youth facilitators at the health corners to deliver on the goals of the GHARH programme. It should be pointed out that the five NGOs engaged by Palladium worked within the same districts, as well as across other districts in the Brong Ahafo region. As noted by an NGO official, this sometimes led to duplication of activities. However, this challenge was later identified, which allowed for variation in the activities of the NGOs (although their organizational programs remained similar in scope). Aside from educating the youth about sexual related health issues, the youth facilitators were also trained to imbue young people with a sense of focus and planning, which is deemed critical to fulfilling their potential. As noted by an NGO official:

Some young people feel that once I get pregnant, that is the end. So, these people are brought back to the life planning sessions. That is not the end of your life. There’re other things that you can also do, so the youth facilitators walk them through these prospects. And those who perhaps don’t even know why they’re there, the facilitators try to teach them based on the youth manual: it talks about who I am, where I am, and where I’m going to, so that the young person is able to decide for him/herself – This is what I want to do in future, so if I do ABCD, I’ll be able to reach there. And so, if I become pregnant on the way and give birth, it will become challenging for me to reach the target; if I get pregnant and give birth, there’s an extra responsibility on me.27

Generally, the Ghanaian society tends to emphasize traditional family values and division of sex roles (i.e., men as breadwinners and women as caregivers). It is

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27 Interview with Team Leader of Map International, Gilbert Asante, May 09, 2017
worth noting that these cultural values are pronounced in the rural communities. So, once a young girl gets pregnant, their future aspirations go into free fall, with priority given to home-making. Incidentally, transforming the narrative surrounding adolescent sexual and reproductive health was not only limited to the school health clubs. A service delivery activity known as the mobile clinic outreach was instituted by MAP International as a means of reaching young people in the rural and hard-to-reach areas that had disproportionate access to services such as antenatal and post-natal care, counseling, family planning, HIV screening etc. The mobile clinic outreach team consisted of a nurse, midwife, doctor, a control officer, as well as personnel from GES to ensure that the issues were addressed in a comprehensive manner.

As part of measures to reach a broader section of young people, the NYA was also provided with grants to mobilize the out-of-school adolescents and youth, who have long been marginalized in the health discourse. In this regard, the NYA picked representatives from existing youth groups (popularly referred to as adventure clubs or welfare clubs) and built their capacities on many areas of reproductive health. Some of these young people are also unattached out-of-school youth (i.e., not involved in the adventure or welfare clubs), and are into apprenticeship such as tailoring, hairdressing, manicure and pedicure. And as noted in the interviews, these young trainees are part of community associations such as Tailors or Hairdressers Association. Thus, the rationale was that selecting youth leaders from these associations would be viewed as a more legitimate and effective channel of getting information to young people.
Overall, the interviews conducted suggest that the broad strategy deployed in reaching out to the youth had been remarkably successful, and a key indicator is the high patronage of the adolescent health corners established across the region. In terms of the out-of-school population, a senior official at NYA noted, “in fact, they [the youth] keep calling on us to come, but due to lack of other logistics, we’re unable to go.” 28 This point will be further discussed later in this chapter to provide insight on the economic forces that work against adolescent and youth health initiatives. Ultimately, the discussion above reinforces another simple reality – when young people are effectively and meaningfully engaged, they respond positively to health interventions targeted at them. Indeed, this evidence challenges the prevailing discourse that young people in the contemporary era are recalcitrant and uncooperative, hence the seeming ‘crisis’ of adolescent health. In the words of a senior official:

We shouldn’t blame the youth. Sometimes, it’s just that we’re not doing what we’re supposed to do. You know, we don’t even start the education early. At home, we don’t give them the necessary guidance they’re supposed to get; we don’t give them the right information. When they have the right information, they have the potential to take the right decisions. But we leave them to form their own characters, get the information from outside, from their peers and other sources. And if we target them for intervention and the intervention doesn’t tackle the problem very well, then you find the interventions not working. Because you need to even plan with them and really understand their needs, and they would help you propose things that would benefit them. But sometimes, we sit somewhere and then assume, oh! this is the problem, then we try to create a certain intervention for them. And we execute but it bounces back; it doesn’t work. So, it’s not that they’re

28 Interview with Brong Ahafo Regional Co-ordinator of the National Youth Authority, Mr. Pascal Edwards, Ghana, May 10, 2017.
stubborn, but rather it’s a complex stage that unfortunately, if they’re not given the necessary information to handle it right, then they find themselves in something they’re not supposed to, or regret later...Of course, there’re certain times that you give the person all that it takes and yet the effort yields no fruitful results. But generally, I think we’re all not doing too well (Field Interview, 2017).

In a similar vein, an educationist noted:

> It is wrong to make a blanket generalization that the youth are stubborn and refuse to take advice. Every cohort is different and has their peculiar needs. We should continuously appeal to the conscience of these youth, as well as their parents, and within a space of time, we’re likely to see positive changes (Field interview, 2017).

The point above certainly captures a central point that resonates with this thesis – adolescent and youth health development is a complex multifaceted issue. How do we account for the successes discussed above in the context of religious, cultural, and gender constraints? To be sure, this is a difficult question that may require further reflection and investigation. Nonetheless, some of the answers lie in the strategies employed by Palladium in implementing the GHARH intervention, available ‘opportunity structures’, and more provocatively, cultural norms that bind the state to society. As I later argue in this chapter, positive experiences can be built around ‘culture’ as a transformative paradigm in ways that contribute to social progress and human development.

While education is crucial to changing people's perspectives and altering behaviour, adolescent health development requires thinking beyond these boundaries. As will become clear, community sensitization and mobilization efforts are also hindered by a number of factors including governmental policies, financial
constraints, and cultural impediments. It goes without saying that although the GHARH intervention had a more consistent and coherent framework relative to the ADHD programme, it did not result in implementation utopia. On the contrary, the implementation process was characterized by some level of frustration due to undue delays arising out of conflicting ideas, faulty documentation on the part of some partners, delays relating to funds transfer from some MDAs to implementing partners, feet-dragging by some GoG partners, among others. As some Palladium officials recounted, some GoG partners expressed enthusiasm about the programme, yet preferred to work at their own conventional pace, which ultimately affected the implementation process.

In fact, while the GHARH programme was officially launched in 2014, it was not until 2015 that the project actually started. So, although the programme spanned three years (January 2014 – March 2017), it is worth noting that the actual project entailed just about two years of activities. Much has been said about policy implementation, and it is clear that the bureaucratic machinery must be whittled down if further gains are to be made in the area of adolescent and youth health development. Most importantly, the role of the state in adolescent health must be re-introduced into the national discourse. We will see later on in this, and subsequent chapters, that the language of inclusion makes no sense in the absence of committed support from the political leadership.

While Palladium managed to circumvent some of the aforementioned challenges, further analysis of the constraints posed by the political structure is in

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29 Interview with Brong Ahafo Regional Coordinator of the National Youth Authority, Mr. Pascal Edwards, Ghana, May 10, 2017.
order. As noted above, capacity building is critical to transforming the governance structures and processes surrounding adolescent health and development. But it is worth noting that the sustainability of such initiatives is also contingent on staffing in the respective agencies and institutions at the national, regional, and district levels. As revealed by the ADHD evaluation report, a key problem with advancing adolescent health relates to the training of staff involved with adolescent health issues. But what is the relevance of such training if these personnel are not retained to provide the necessary services for which they were trained? As lamented by a Palladium official:

We’ve had the issue of staffing. You train people, and you know how the government works; if they need you in another region, they transfer you. So, you train new people, you return only to be informed that they’ve been transferred. How do we keep training people? Meanwhile, we have x budget for training (Field Interview, 2017).

An official at the NYA echoed a similar sentiment as he lamented the precarious state of staffing at the agency. In the words of the official:

NYA in the region is seriously challenged as far as our human resource is concerned. I don’t know, but it appears to be a government policy, that the government tries to cut down on its expenditure, which it claims majority of it is also on personal emolument. As a result, when our officers get retired, we don’t get replacement. So, most of our offices in the district are vacant. Yet the towns and villages keep expanding (Field Interview, 2017).

Besides the political structure, it is clear that the above comments draw attention to financial consideration as a macro variable in the toolbox of adolescent and youth health development, a point that will be discussed in the next sub-section.
6.3.2. Economic Framework

Similar to other research findings, as discussed in chapter four, financial security emerged as a significant theme across the interviews conducted. More specifically, adolescent pregnancy and other related reproductive health issues were mostly described as a developmental problem rooted in poverty. The Team Leader of Palladium, when asked about the trend in adolescent and youth pregnancy rates, pointed to the issue of economic impoverishment. As he noted:

Research has shown that some of the young people engage in early sex due to want. They need something; little little things.\(^{30}\)

It is insightful to note another observation made by the regional coordinator of NYA. In his words:

Particularly, the issue at the moment in Ghana is youth unemployment. And most of these youth, particularly the girls have nothing to do. Their families are facing difficulties. So, any little amount of money that someone is able to give to the young girl, she succumbs to that sexual pressure. Particularly, these girls who are serving in restaurants, beer bars, and even the hotels – how much are they being paid? The amount is so scanty. Sometimes, the moment the parents even notice that the child is doing some sort of work, they think the child is okay and is left to take up issues on their own. So, the issue of poverty is paramount. Until we have been able to address it, I'm afraid our progress will continue to be in jeopardy.\(^{31}\)

In a similar vein, an NGO official also pointed to the economic underpinnings of adolescent pregnancy in the region. He noted:

\(^{30}\) Interview with Mr. David Logan, Ghana, March 13, 2017.

\(^{31}\) Interview with Mr. Pascal Edwards, May 10, Ghana, 2017.
I think mothers should be equipped with financial opportunities. One thing I realized when implementing our project was that some of the parents attributed the pregnancy of their adolescent children to their lack of capacity to take care of these children. You see, I told you earlier that we focused on out-of-school youth; some of them have dropped out of school and have no means of support. So, assuming I have a guy who will give me 5 cedis every day in exchange for just 5 minutes of sex with me, we both gain in the end. But if this young person had the money, the temptation to succumb to such influence would be reduced. Of course, it may not eliminate the problem completely (Field Interview, 2017).

Similar to the points raised above, another official pointed to the uniqueness of the region as a key consideration in examining the problem of adolescent pregnancy. Recall the earlier reference to Brong Ahafo as a “transit point.” For this official, poverty, migration, and adolescent pregnancy are inextricably intertwined, hence the need to pay attention to these dynamics. As she noted:

If you have a region that has a lot of migrants, you see the prevalence of teenage pregnancies. Take a place like Western or Central region, or where you have these trucks travelling across the towns. In communities where you don’t have a lot of migration happening, they tend to do better; that’s what I’ve noticed. But the bottom line is poverty. The poverty situation is so dire, so you find them doing all kinds of things they’re not supposed to. When you take Brong Ahafo, for instance, like Techiman. Techiman is one of the towns that record the highest adolescent pregnancy because of the business; it’s a commercial centre and a transit point, so all kinds of things take place. If people are comfortable, I don’t see why they’d be chasing after these material gains, except that young people have become more exposed these days. When you have the parental support, it minimizes some of these things. If the youth have to fend for themselves, they fall prey to some of these challenges (field Interview, 2017).
A final observation was made by one of the youth facilitators at the health corners, which reinforces the notion of poverty as a root cause of adolescent pregnancy. As she noted:

It seems most of these adolescents have problems with their needs, so they're going in for money from the young men. They have no intention of getting pregnant; they just want to satisfy their needs. So, the actual problem is coming from the home – the parental care (Field Interview, 2017).

Like much of the existing literature, it is clear from the above observations that financial consideration is a key component of adolescent and youth health development. But it is also important to consider the various levels of abstraction. On the one hand, adolescent pregnancy is viewed as a function of poverty at the individual level. On the other, reference is also made to the broader economic structures that impinge on the lives of young people, leading them to take subpar decisions that ultimately affect their health and well-being.

Of course, these two categories are dovetailed, but it is clear that macro-level elements lie at the heart of the puzzle. In the case of migration, for instance, why would young people migrate from the North to the South in droves, if not for better opportunities and life prospects? In Ghana, the Northern part of the country is largely poor and underdeveloped in comparison to the South (Ghana Statistical Service, 2015; UNICEF, 2016). As a result of the precarious life conditions, a significant number of young people believe the solution lies in migrating to ‘greener pastures’. Ironically, most of these young people migrate further south only to be faced with even greater challenges of integrating into the so-called ‘big cities’. Thus, majority of them end up on the streets disillusioned, helpless, and
vulnerable, and it goes without saying that the situation is particularly dire for young girls and women who often become sexual prey for the young men in the community.

In fact, the issue of poverty and unemployment is a widespread phenomenon that traverses jurisdictional boundaries, and this is particularly true of many developing countries – a relationship that obviously has significant implications for adolescent health and development. This, however, is not to say that economic growth and poverty alleviation should be viewed as a panacea to the problem of adolescent and youth pregnancy. Rather, the central point being advanced is that without a meaningful source of livelihood and financial security, the youth are more prone to devices inimical to their health and well-being, an issue that clearly speaks to fundamental questions of governance and the role of the state in meeting this challenge. In all of this, it is apparent that the focus on poverty is key to understanding the broader and complex issue of adolescent health, but equally important is identifying its structural linkages and ideational mechanics.

Arguably, the economic factor is not limited to the conventional approach to adolescent health, which places key emphasis on the existential security of adolescents. As argued from the outset, a vital component of adolescent and youth health speaks to the question of agency, which brings into perspective the institutional arrangements established to shape people's ideas, perception, and behavior. The research findings and document analysis suggest that the ADHD programme failed to yield the desired outcomes partly due to limited and
infrequent GoG financial support. The GHARH programme, however, received generous funding from DFID, which facilitated the implementation of the project, despite initial delays. Given the official closure of the GHARH project in line with its contractual stipulation, the findings of the research revealed that most implementing partners and stakeholders seemed very much concerned about the sustainability of the programme, especially considering that it was solely funded by DFID.

This development, of course, reinforces the argument that macro-level factors matter to a significant degree. Adolescent health programming in itself is a resource-intensive task that requires a significant level of financial input. As noted in the implementation literature, the availability of financial resources is a prerequisite for adopting certain government programs. But equally important is the obvious fact that the sustainability of such programs rest on continuous financial support. For example, evidence shows that the successful reduction in England’s adolescent pregnancy rate was due to long-term financial commitment from the political leadership (WHO, 2017). As the GHARH intervention demonstrates, adequate financial resources are required at various phases of the program cycle – pre-adoption, implementation, and post-adoption. As a district health officer noted:

When you talk of adolescent health and understand the whole concept well, you would want to have an arrangement where there is some kind of permanency, or a permanent structure that keeps adolescents well-oriented all the time.32

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32 Interview with Mr. Owusu Asante, Ghana, May 09, 2017.
In a similar vein, another elite respondent argued:

Reproductive health is an attitudinal issue ... Every day, someone enters into the adolescent stage. So, you may have addressed an issue with a cohort of adolescents, but in the next two or three years, you have a different set of cohorts also coming who may not have been reached. So, it needs to be a continuous project (Field Interview, 2017).

**Figure 2: Ghana’s Population Growth Trend, and Projected Growth**

Based on figure 2 above, it is evident that Ghana has witnessed a rapid population growth rate over the past decades, and the data suggests further sharp increases in the following year and beyond. Ghana’s population growth has been projected to be about 39.5 million by 2050 (GHS, 2007). Given the youthful character of Ghana’s population, the observations made by the respondents above in terms of sustainable arrangements for adolescent health are certainly in order.

As should be clear by now, adolescent health programming does not occur in a financial vacuum. Against this backdrop, it is worth noting that assembling the relevant players to the decision table in the first place requires the necessary
logistical support, a consideration that has been overlooked by the dominant perspectives in the literature. Indeed, the availability of resources may serve as an incentive to attract individuals, agencies, and organizations to actively engage in deliberations surrounding adolescent health. This, however, is not to say that implementing partners act primarily based on the rational choice model of reasoning, which is premised on the self-interest calculus. Of course, shared meanings drive collective action, but starting an adolescent focused programme with a weak financial base or lack of financial strategy conjures up images of potential failure, which could diminish interest or derail policy discussions. The GHARH programme began on a relatively sound financial premise, but it is useful to examine its implementation trajectory. The point is to stress economic factors as an essential ingredient for successful social interventions, and more broadly as a structural determinant of health.

While it is widely acknowledged that national level initiatives may fail due to lack of support at the local level, little attention has been paid to how or why this may happen. Empirical evidence from this research demonstrates that funding plays a key role in the success or otherwise of policy initiatives. Ironically, while the global frame of inclusion has been strategically weaved into Ghana’s national discourse, the substance of young people’s citizenship remains open to debate, particularly at the local and district level. Broadly speaking, the construction of young people’s identity at the global level risks legitimacy problems if the seeming discourse of exclusion at the domestic level diffuses on a broader scale. On a more cautious note, young people risk being left behind in the development discourse,
which is obviously anathema to the norms and values embedded in the new development agenda.

Given the new socio-political identity accorded to young people, it is not unusual or incongruous to expect that the national government, health practitioners, and other major stakeholders would respond more positively and urgently to adolescent health issues than before. But as the GHARH programme illustrates, this was not the case, particularly at the local and district level. According to an NGO official, a major challenge faced at the local level was the preeminence of women and child welfare over health-related issues of the youth. As he lamented:

Working with GHS is sometimes a challenge because they have their itinerary that they’re working with. When embarking on the mobile clinic outreach, you need these health workers to work with. Sometimes, it becomes quite challenging getting access to them; you have to pay their TNT [i.e., transportation fare], you have to give them food, so many things. And even aside that, they also have things that they are engaged with, which is of more relevance to them than what you are doing, unless of course, those that are in the health unit. And even sometimes, with those in the unit, you have to kind of plan your activity to meet theirs. So, our activity is fed into the child welfare clinic; both the child welfare clinic and youth clinic are held concurrently. So, you have to do it that way before you get them. This makes planning quite difficult sometimes because you want to achieve a specific goal within a specific time frame, but you’d have to wait till their activity is due before you’re able to go. It’s quite challenging.33

As already discussed, it has been brought to the fore that some GoG partners prefer to work at their own pace, and this institutional or attitudinal dimension, broadly

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33 Interview with, Mr. Gilbert Asante, Ghana, May 9, 2017.
defined, may perhaps help explain such developments at the local level. But another critical look at the situation also suggests that the GHS possibly might want to maximize their time and resources. Indeed, it is important not to lose sight of the financial dimension of the dilemma. Nonetheless, while this logic may seem efficient and likely result in financial savings in the short term, the long-term impact on adolescent health cannot be overemphasized. Therefore, it is imperative to rethink this cost-benefit discourse, especially for the reason that it could potentially compromise the health and well-being of young people. Ironically, as will be seen in chapter seven, the framing of adolescent health could also possibly explain why the GHS staff seem indifferent to the new citizenship status accorded to young people.

From a historical standpoint, the practice of subsuming adolescent health under maternal and child health has long been criticized, an advocacy that has partly resulted in a rethinking of the global development agenda and subsequent update to the previous Global Strategy. Despite the commonalities across maternal, child, and adolescent health, to overlook their conceptual distinctiveness is to erode the gains achieved in the area of young people’s citizenship. In terms of commonalities, maternal, child, and adolescent health obviously fall under the broad umbrella of inclusive health and well-being, as conceived in the SDGs. The relationship becomes clearer in light of the argument that earlier gains achieved in young child health could be lost in adolescence, thus affecting the future adult lives of young people (WHO, 2017). The issue here is that despite these apparent shared characteristics, each category of interest has distinct health needs, not to mention
the diversity within these sub-groups. Taking these complexities into consideration, it may perhaps be out of place to use maternal and child health as a proxy for attending to adolescent health needs. As exemplified by the case study above, such practices hold the potential to alienate young people from the health system altogether.

As a matter of fact, the achievements attained in the GHARH programme would not have been possible without adequate funding. For instance, establishing the adolescent health corners, outreach programmes, technical support and training, community engagement, among other things, required significant financial support. At the district level, the economic argument is reinforced particularly in relation to the remote or hard-to-reach areas. As an NGO official pointed out:

I remember in Sene East [remote district], we selected 12 communities, and about 7 of these selected communities were island communities. You need a boat to travel to these places, and it’s very challenging. Some of the nurses are even reluctant to go there. And this is the case where you as the project officer are required to be visiting the community every week. So, it’s quite challenging. The cash to do that every week is not available, and even the risk of being on the water is quite telling.34

As already mentioned, the GHARH programme engaged peer educators to assist with community mobilization and sensitization. Given the broad scope and demanding nature of their activities, one would be inclined to incentivize them, which perhaps may involve some remuneration. But as explained by a respondent, this may not always be the case. As he noted:

34 Interview with, Mr. Gilbert Asante, Ghana, May 9, 2017.
These peer educators may expect some form of remuneration, and sometimes these programmes or interventions don't take that into consideration (Field Interview, 2017).

It is worth pointing out that while this issue may not necessarily affect the successful execution of health initiatives, the potential to undermine the quality of the related programme cannot be overemphasized. To buttress the point discussed above, an example can be drawn from the experience of the Brong Ahafo NYA regional coordinator. Recall that emphasis was placed on the fact that when the youth are meaningfully engaged, they do exude enthusiasm and energy for health interventions targeted at them. As will be further explained in chapter eight, meaningful engagement goes beyond treating the youth as ‘objects’ to be studied, to a genuine commitment to engaging them as equal partners in shaping their own health trajectories, while encouraging and developing their sense of agency and individual potential. Generally, the research findings revealed that although the GHARH programme had been largely successful in terms of generating interest in adolescent health issues among the youth population in Brong Ahafo, the NYA office was severely handicapped in meeting the requests of the youth for further engagement. As the Regional Coordinator indicated:

The towns and villages keep expanding, and there’re communities beyond it where you need to reach. Unfortunately, mobility is an issue. If I mean to go to any place, I have to use transport, and that shouldn’t be a problem if at least some funds are made available for that purpose; but it is not available. And at times too, the organization needs to take proactive steps in reaching the youth, but due to the lack of resources, we’re unable to do so. So, what we’ve adopted as a means of not also relaxing on our mandate is that we try to use the youth associations. Once it’s a bigger
association and closer in proximity, they can just invite you to come talk to them. So, if they don’t also invite us, then it becomes a challenge. So, we allow it to be a demand-driven issue. But I think it should have been the other way around; we should rather be going to them with the information.\[35\]

In all of this, it is clear that a strong economic framework is critical to discussions surrounding adolescent health and development. The GHARH project has exhausted its funding period, and the uncertainty surrounding the sustainability of the programme raises two fundamental questions: 1) How should the issue of funding be approached? 2) How can future adolescent health interventions avoid the conundrum surrounding programme sustainability? Certainly, there are no easy answers to these questions, but again, the central role of the state is brought to the fore. A senior policy advisor argued:

We have the policies developed, and it needs to be implemented. But you need the resources to implement. The GHARH programme, for instance, is being funded by the UK government. But it should be us funding our own programs, not relying on another government. All things being equal, the development of the youth should be our responsibility. Adolescents are our future; they’re the future of the country. So, we shouldn’t sit for someone else to come and support us to put in the necessary interventions or implement the policies that we have. And even the policies are supported by these same donors; they provide us with the money to develop the policies. You know, so it’s all dependent on the resources, and that’s what is failing us (Field Interview, 2017).

The statement made by the official captures a significant relationship between financial resources, political will, and government policies. On the one hand, it appears that the advancement of adolescent health initiatives may not necessarily

\[35\] Interview with Mr. Pascal Edwards, May 10, 2017.
be due to the absence of political will to develop the requisite policies, but rather the lack of financial resources. On the other, it also seems the provision of financial resources is a function of both political will and policy. Nonetheless, the bottom line is that these three elements are key forces that drive health interventions. Both the ADHD and GHARH programmes rest on existing national legal and policy frameworks, which demonstrates the government’s commitment to, and promotion of the health sector goals for adolescent health. But a common challenge with both programmes speaks to the issue of resource constraint. A notable difference, however, relates to the overarching economic arrangement driving the programmes, which helps to explain why the ADHD initiative produced relatively poor outcomes.

At the time of the field research, the Adolescent Reproductive Health Policy, which was developed in 2000, was under revision and yet to be approved by Cabinet, in addition to the new Adolescent Health Service Policy and Strategy (2016 – 2020), which was developed by the GHS in partnership with Palladium, WHO, UNICEF, UKAID, UNFPA, and other partners. Put together, the central objectives of these documents reflect Ghana’s commitment to the new global development agenda and related protocols, as well as provide a robust framework for the coordination and efficiency of adolescent related health initiatives. Of course, these developments obviously bring into sharp focus the impact of global policy frames in shaping citizenship and development outcomes of young people.

However, it remains to be seen whether these policies will effectively attract the requisite financial resources towards adolescent and youth health, a discussion
that will be taken up in the final sub-section of this chapter. For now, the discussion below will focus on ‘culture’ as a defining component of adolescent and youth health outcomes.

6.3.3. Cultural Discourse

Culture has come to be regarded as a central element in understanding politics, and indeed, it is difficult to grasp the politics of adolescent health without considering how culture interacts with, facilitates or challenges existing institutions, policies and programmes. The concept of culture has no precise meaning (Eckstein, 1988), and there is general consensus among a growing number of scholars that it is neither fixed or uniform, and a function of context and structure (Ross, 2009; Schmidt, 2008; Wedeen, 2002). But culture in itself is considered an institution, which encompasses beliefs, values, norms, and practices that structure individual and group behaviour (Inglehart & Norris, 2003; March & Olsen, 1989). In the context of the GHARH intervention, findings from the study suggests that culture matters, which is consistent with other studies as discussed in chapters four and five.

It is undeniable that people’s social identity and behaviour shape, and in turn, is shaped by their immediate environment. As already indicated, the Brong Ahafo region is prone to a large inflow of migrants from the Northern part of the country. While these migrants primarily move down South in search of better social and economic opportunities, they also carry along their customary values, which include the practice of early marriage. The pattern of early marriage in the
developing world, particularly sub-Saharan Africa, is well documented in the literature, and most scholars recognize the phenomenon as a growing public health concern rooted in poverty (Jensen & Thornton, 2003; Walker, 2012). In the Ghanaian context, research shows that there has been a significant cultural transformation in the Northern region, with increased adolescent autonomy and falling fertility rates attributable to increased urbanization and education (Mensch, Bagah, Clark, & Binka, 1999).

Despite positive changes in the patriarchal structures governing early marriage, the practice still persists in some districts and communities, especially in the rural communities where poverty is most prevalent. Aside the fact that early marriage serves the purpose of economic security for the family of the young girl, it is also seen as a protective religious order, especially for young women (Alhassan, 2013). In his study on girl-child education in Northern Ghana, for instance, Alhassan (2010) argues that some families withdrew their daughters from school for marriage purposes because higher education was considered a barrier to getting a husband. And it goes without saying that the Ghanaian society generally places a high premium on childbearing. As Adomako Ampofo (2001) succinctly puts it, childbirth is not only associated with prestige, but is considered “an important aspect of marriage, providing “proof” of fertility and ensuring the continuity of the lineage” (p. 199).

In the context of the GHARH intervention, findings from the research revealed that the migrant communities contributed significantly to the high
adolescent pregnancy burden in the region. When asked about the trend in adolescent and youth pregnancy in the region, one health practitioner reported:

The type of area and the prevailing habits there contribute to the problem. Over here, we have this ‘tribal’ issue. The Northern immigrants are settled in a town not far from here. It seems they get married as early as 16 years. So, they contribute to that. Early marriage is normal to them, and most of our teenage pregnancy records are from there (Field Interview, 2017).

Ironically, the Ghanaian social fabric appears to be embedded with some degree of cultural tension, from an analytical standpoint. As already discussed, society generally frowns on adolescent pregnancy largely due to its broader socio-economic implications. But puzzlingly, adolescent pregnancy is also celebrated as a mark of womanhood and fertility in some communities. With the benefit of hindsight, a health officer recounted a significant flaw in past health interventions. As he argued:

We probably needed to have done some baseline studies. I know some of the projects undertook a number of researches but failed to take into account some significant social factors. Based on a symposium, it was brought to the fore that in some places, people get pregnant not because of lack of information or support, but because certain realities were overlooked. In some cases, people find it prestigious to even try their womanhood and manhood once they become adolescents. This is to have proof that when I finally mature and become responsible, I have a testimony to show that I can reproduce. And in some contexts, it is described as an advantage for such people to get married easily when they become older. These ideas will tell you that your intervention shouldn’t have been based on the provision of free condoms, but rather adjusting people’s ideas. If we have bought condoms, embarked on trainings and we’re still not achieving a change, then we probably are dealing with different factors. And that kind of information didn’t come out (Field Interview, 2017).
Another cultural dimension worth paying attention to is the resistance to sensitization programs in some communities, which occurs at both the individual and community level. As indicated in chapter four, existing studies shed some insight on this subject, but further detail will be useful in illuminating the broader institutional forces that explain this dynamic. On the one hand, this research revealed that the young men and boys in some communities resist SRH sensitization programs primarily because they perceive it as a challenge to their masculinity. When asked about some of the challenges faced in meeting the goals of the GHARH programme, the Team Leader of Map International expressed:

> Even among the youth themselves, the young boys and men alike think that by providing them with such training or orientation, you’re rather preventing them from having access to their girlfriends. And so, when you go there, it’s not easy at all. Because on countless occasions, most of the peer educators complain to us that when they embark on their daily education, the young people chase them out – why are you doing this? we don’t want you to talk to the young girls. Because if you do this, they put up certain attitudes when we approach them. And they often respond by saying, you know I’ll get pregnant, I don’t have time for you, I’m going to the youth corner, and that kind of stuff.\(^{36}\)

Clearly, while this is a cultural issue, it also borders on gender, particularly considering young boys or men’s opinion on gender empowerment in some communities. As Inglehart and Norris (2003) argue, culture and gender intersect with religion to produce institutional legacies of inequality, and given that Ghana is a deeply religious and gendered society, such disempowering discourse among segments of the youth population is not surprising. To be sure, Ghana has

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36 Interview with Mr. Gilbert Asante, Ghana, May 09, 2017.
mainstreamed gender in policies and programmes, and remains committed to promoting gender equality across the national landscape. The nation is signatory to several international and national conventions and declarations on gender, which include: the Universal Declaration of Human Rights, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), Domestic Violence Law, National Gender and Children’s Policy, National Health Policy, among others (MOH, 2009). But as pointed out in chapter three, unequal gender relations remain a growing concern, and culture (broadly defined), is undeniably an underpinning factor.

It is apparent that resistance to programs such as the GHARH initiative is reflective of masculinity ideations and structures of power that dominate daily discourse, and not merely due to the influence of modernized or Western values as largely portrayed in the literature. This, however, is not to discount the modernization argument as discussed in chapter four. Rather, the point is to emphasize that such resistance by the youth is also rooted in deeply internalized value systems, and the traditional inclination to establish male dominance in the communities that reflect these ideational tendencies.

In a nuanced and complex way, the pattern of resistance extends beyond the individual level. Similar to previous studies, this research also discovered resistance to sensitization programs at the community level. But it is important to understand this dynamic within the broader context of “cultural silence,” as discussed in earlier sections of this thesis. Given the restrictive character of the environment in terms of discussions surrounding sexuality, advancing adolescent
health interventions becomes particularly challenging, not to mention the age bracket of the peer educators. As discussed in the section on youth participation and citizenship in chapter three, age is significant in the Ghanaian society, and needs to be leveraged if adolescent focused health interventions are to yield positive outcomes. Within the context of implementing the GHARH initiative, one NGO respondent reported:

> You see, we’re living in an environment where sexual issues are frowned on, and nobody wants to talk about it. So, it becomes very difficult when you go into a community to talk about sex and sexuality to the young people. The parents are there and you’re talking about penis, vagina, sex, condom, and so on. It becomes very difficult because the parents think that by exposing the child to such topics, you’re rather corrupting the child instead of providing them with the necessary protective tools. Some of the communities, you may go with the intention of reaching out to the young people, and their parents are like, no! We’re not ready to release our young ones to you (Field Interview, 2017).

Before moving ahead, another important cultural element is worth discussing. Historically, women in Ghana (i.e., mothers), just like elsewhere, have carried the burden of blame for the pregnancy of their adolescent daughters, and relatively little has changed over the past few years. The onus is often on mothers to train their daughters appropriately, as the culture dictates that men (fathers) are the breadwinners, hence spend less time at home. Thus, in the event that a young girl gets pregnant in the adolescent stage, society ridicules the mother for failing in her responsibilities. Within this context of understanding, findings from the study revealed that most reproductive health documents, as well as adolescent focused health interventions appear to be skewed towards young girls and mothers.
Perhaps the idea is that empowering mothers, and particularly young girls, would provide them with greater autonomy and capacity to navigate the prevailing social order and, ultimately, dismantle the structural forces of male dominance and power.

Although the GHARH programme was largely gender-sensitive, the research findings suggest that more focus should be directed towards male behaviour and health concerns (boys and fathers). This conclusion is based on consistent reference to mothers across the interviews conducted. As an NGO respondent indicated:

So, we were kind of, what specific time can you pick up a conversation with the young person? Sometimes, even the young person may come to you with the issue. The parent-child communicators were supposed to go into the community and train the mothers. That is like a role-play session. You do it and other mothers look at it so that they can also replicate it when they go home (Field Interview, 2017).

In a similar vein, a health administrator argued:

The young girls are closer to their mothers, so we have to engage with them more often. As for the young boys, once they get a young girl pregnant, they can even vanish from the community, and it becomes the responsibility of the mother and the girl to take care of the child. In fact, some young men even care less about their irresponsible behaviour (Field Interview, 2017).

In a related vein, field visits to some of the health corners also revealed that the resident health personnel (youth facilitators) in charge of the facilities were all female. While this may not necessarily be a problem in terms of attending to the health needs of boys, it obviously raises a concern in terms of how young people
are targeted for interventions. Of course, these may just be isolated incidents, and may not necessarily reflect the broader pattern of staff recruitment across the region. But it is worth noting that empirical evidence suggests that the lack of male health care staff restricts open communication. In their study on the utilization of reproductive health services in the Eastern region of Ghana, for instance, Koster, Kemp, and Offei (2001) observed that boys felt apprehensive or afraid to share their reproductive health problems with female staff, mostly due to concerns about privacy and gender consciousness.

All in all, it is clear that the GHARH programme somewhat reflects and reinforces the historical discourse that women and young girls should assume center stage in interventionist programmes. While the present intervention appears to weave young boys and men into the broader conversation on adolescent health, the discursive orientation and health practices need to shift toward greater appreciation of boys and men as critical agents of social change. Importantly, it is useful to recognize that the one-size-fits-all approach often used to engage the youth has serious limitations, and may perhaps help explain the gender puzzle in terms of youth empowerment.

If the evidence suggests that boys and girls are socialized differently, thus affecting their future health behaviour, then, it makes sense to argue that the use of a value-based approach to tackle the “problem” is in order. In this context, efforts should be directed towards a better understanding of strategies that resonate with young boys or men in particular, rather than universal interventions that overlook these distinct masculinity values and dynamics. This, however, is not to promote or
endorse a traditional stereotypic culture that problematizes masculinity as a panacea to the challenges of gender inequality and adolescent pregnancy. Rather, the argument being advanced here is that, young men should be equally engaged as partners in transforming the gendered discourse and practices that place women at a disproportionate socio-economic and political disadvantage relative to their male counterparts.

6.3.4. Policy Framework

To effectively assess whether or not an intervention will produce the desired outcomes, it is important to consider the broader policy context in which those interventions operate. As most scholars have noted, policies shape politics by structuring the attitudes and behaviours of individuals and political elites, which ultimately impacts the political landscape in profound ways (Hacker & Pierson, 2010; Mettler & Sorelle, 2014; Schneider et al., 2014). Notably, the policy structure creates opportunities for intervention, thus allowing change to occur. But policies, just like cultural discourses, could also produce and reinforce existing social constructions, resulting in negative feedback (i.e., maintaining stability in daily discourse). Drawing from the previous section, it will be seen that culture and policy go hand in hand, particularly in the context of advancing sexual and reproductive health in Ghana. Indeed, culture and policy are creatures of ideational power that shape health interventionist discourses for young people.

The Government of Ghana is committed to promoting sexual and reproductive health, and this is seen in the policies and programs that have been
developed over the years, including the National Population Policy (revised in 2015), National Adolescent Sexual and Reproductive Health Policy (revised in 2015), School Health Education Programme (revised in 2014), among others. These policies were primarily revised due to identified gaps, and the need to follow through with the country's international commitments. In order to effectively prosecute the GHARH agenda, Palladium had to work with key institutional bodies such as the GES and GHS. However, through the interviews, it emerged that the content of sexual and reproductive health education had been a highly contested subject not only among these institutions, but across other government agencies as well. As bemoaned by a senior policy official:

Even at the primary and high school level, we're still fighting with GHS and GES on what kind of information we should provide for young people in school (Field interview, 2017).

An educationist with the GES collaborated this point:

There has been intense disagreement on the content of the sex-ed curriculum over time. However, I will say that even though Ghana’s sex-ed curriculum was initially scattered, we’ve managed to re-package it (Field Interview, 2017).

Fundamentally, the key source of conflict is rooted in the imperative of providing sex education for young people, while ensuring that it is done through a culturally appropriate lens. The content of policies certainly rests on the perspectives held by key government ministries and agencies, and navigating the terrain of adolescent health requires paying attention to the ideas and discursive exchanges among policy actors. Culture obviously informs policy, but policy also serves as a conduit
through which traditional discursive norms surrounding gender inequalities and inequities are perpetrated and ossified.

In their comprehensive review of sexuality education policies in Ghana, for instance, Awusabo-Asare et al. (2017) observed that while government officials and policy makers were generally supportive of the provision of SRH information in schools, there was significant division in terms of the scope of such education. On the one hand, it was argued that certain SRH topics such as usage and accessibility of contraceptives were inappropriate for some age groups. On the other end of the spectrum, some also maintained that such education must be culturally sensitive to ensure that the traditional values and norms of society are preserved.

In line with this understanding, their study revealed that primary, junior high and senior high school curricula placed heavy emphasis on abstinence, while promoting a fear-based or negative approach to SRH education. For example, premarital sex was dominantly conveyed as an irresponsible, dangerous, and immoral behavior, with negative repercussions for the individual and society. Not surprisingly, their study also reported that some teachers felt embarrassed teaching such topics in class, while a significant percentage of students also cited embarrassment regarding discussions surrounding sexual and reproductive health. Indeed, negative feedback maintains and reinforces the status quo, and this, in many ways, is reflective of the stigmatized nature of adolescent pregnancy across the socio-political landscape.

In Ghana, the past few years, for instance, have witnessed skirmishes regarding the right of pregnant adolescents to stay in school and complete their
respective programs of study. In some instances, pregnant adolescents have been directed to withdraw from school, stay home during pregnancy, or barred from writing their final exams to ensure discipline and serve as a deterrent to other students. Ironically, while GES and other civil society groups have dismissed such practices as discriminatory and unconstitutional, the besieged principals of such institutions have also defended their actions as grounded in broader GES policies, rules, and regulations – “a female student who becomes pregnant will be made to withdraw for a minimum period of one year, to apply for readmission.” (Ghana-News-Agency, 2013).

While GES now appears to be supportive of female pregnant students in school following media pressure and civil society activism, the controversy seems to linger on. A case in point is a more recent incident where a pregnant nursing student was removed from an examination hall, resulting in contradicting viewpoints, accusations and counter accusations among senior officials of the Nursing and Midwifery Council (Joyonline, 2017b). Central to the disagreement was the policy governing the institution regarding pregnant students, which some officials believed had been properly applied, whereas others maintained the practice was inconceivable. Although this issue has prompted widespread criticism from a broad array of political actors and stakeholders over time leading to related policy changes, the examples provided throw light on interesting policy dynamics that hold implications for adolescent and youth health outcomes.

Indeed, it would be a travesty of analytical justice to discuss the political nuances and complexities of adolescent and youth health without analyzing the
policy framework. In the next chapter of this thesis, the discussion will be expanded to shed further insight on the broader impact of policy design on youth health and citizenship, as well as the opportunities and hurdles it presents.

As should be clear by now, policies also dictate how resources are distributed, especially in a growing era of increasing socio-economic demands and competing resources. As already discussed, adolescent sexual and reproductive health is a resource-intensive sector, but the key question is whether the government is up to the task of delivering on its commitments to advancing young people’s health and well-being. As implementation and innovation theorists have argued, the availability of financial resources informs a government’s willingness to adopt a new policy, proposal, or extend the frontiers of existing programs (Berry & Berry, 2014; Brinkerhoff, 1996; Thomas & Grindle, 1990; Zahariadis, 2014). But between a policy and its manifestation lies a deep chasm – that is, policy action.

In earlier sections of this thesis, it was made clear that Ghana has several policy documents that showcase the government’s commitment to young people’s health and well-being. But the key question is, are these policies and subsequent revisions mere political rhetoric, or sufficient to push the necessary resources towards the transformation of the adolescent health landscape? Good policies are not enough. They need to be translated into substantive outcomes that have a meaningful and sustainable impact on the lived experiences of the youth. In the words of Palladium’s monitoring and evaluation coordinator:

If all the policies that they have developed are implemented to the letter, that’s one thing that can help solve these adolescent health and development issues. If there’s a sustainability plan such that
When GHARH or Palladium folds up from this region and Ashanti, the investments that have been made will not just be left to be a white elephant and continues to be operational, then that can be helpful. Like I mentioned, we have 54 adolescent corners, and we have invested huge sums of money putting up the structures and equipping them. So, when we leave, and they [the government] happen to leave them to their fate – nobody goes there, nurses are not posted there, or they are posted but not motivated to work, then all this funding would have gone down the drain . . . You know, funding is always the major problem.37

When asked about the policy dimension regarding resource allocation, a senior policy advisor also responded:

It depends on the government; it also depends on those at the top of the bureaucratic hierarchy. Unfortunately, with the health budget, they just put everything in one basket. When it gets to the Ministry, the Ministry decides how to allocate it. So, if they don’t see the seriousness in really allocating enough resources to that side of programming, then it becomes a problem. So, it’s like you have few eggs and you’re sharing for a number of things – Malaria, HIV, STI’s, and Nutrition etc. So, in their own perspective, they’re looking at things that need the resources. So, it’s either you get someone who really has insight into adolescents and their problems, or we make so much noise about it in order to attract the needed support (Field Interview, 2017).

Given the reflective tone of the above comment, one is compelled to push the boundaries of the conversation about adolescent health a bit further – young people’s health development is a domain that could be politicized or sabotaged for political ends. Recall the NYA official who bemoaned the state of NYA facilities in the region by pointing to government policy. In his study on voting patterns in Ghana, for instance, Nugent (2001) provides some insight into why the National

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37 Interview with Mr. Bashiru Adams (Overall Monitoring and Evaluation Coordinator on the GHARH project), Ghana, May 10, 2017.
Democratic Congress (NDC) lost the 2000 election to the New Patriotic Party (NPP). According to him, “the NPP made a calculated pitch for the youth vote,” which was deemed a decisive element in the outcome of the election (pg. 419). Given the youths’ large demographic profile, Nugent (2001) suggests that the NPP projected a strategic image to convince young voters of the party’s commitment to addressing their needs.

Of course, these issues raise troubling concerns, but in all of this, the goal is not to cast a pessimistic outlook on the prospects of adolescent and youth health development in Ghana. At the very least, the objective is to stimulate an intellectual and practical dialogue on the need to take into account the policy framework when thinking about strategies and innovations that border on adolescent and youth health development.

6.4. Chapter Summary

Implementing health programs is a complex and challenging exercise. This chapter has analyzed two key adolescent-oriented health programs in Ghana, and the central objective was to understand why the GHARH programme constitutes a significant improvement over its predecessor, the ADHD programme. In other words, why did the ADHD programme fail to yield the expected health outcomes for young people? A critical assessment of the GHARH intervention demonstrates

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38 Although Ghana is a multiparty democracy, political power has remained, and continues to rotate between the two dominant political parties – National Democratic Congress (NDC), and the New Patriotic Party (NPP).
why health programming should be prioritized as part of the ongoing discourse on adolescent and youth health development.

While the findings of this research resonate with conventional theories on adolescent reproductive health, it also shows that adolescent health development is a function of the complex and dynamic interaction of the micro and broader macro political environment. Through a critical analysis of the global and Ghanaian political landscape, four key variables were identified as crucial contextual factors that shape citizenship and health outcomes for young people, as reflected by both the ADHD and GHARH interventions – political structure, economic framework, cultural discourse, and policy framework.

Unlike the ADHD programme, the advantage of three mutually reinforcing global protocols (i.e., SDGs, Global Strategy, and the AA-HA!) leveraged Palladium’s implementation of the GHARH programme. As the study shows, available ‘opportunity structures’, coupled with innovative strategies employed by Palladium, positioned the GHARH programme in ways that enhanced its overall effectiveness and relevance to adolescent health. However, the analysis also suggests that careful account must be taken of the aforementioned broader contextual factors, which simultaneously served as enabling and constraining mechanisms in relation to the implementation of the GHARH programme. This paradox sheds insight into the dynamic nature of the political environment and complex institutional processes that inform adolescent health and development.
Chapter Seven

Framing and Policy Outcomes: Adolescent and Youth Health in Perspective

As this dissertation has made clear from the outset, adolescent health has long been a contentious issue that has garnered more attention in recent years. While some actors strongly argued for the isolation of adolescents as an independent group, others in the global community held to the belief that adolescent health needs could equally be addressed under the broad umbrella of maternal and child health. While this tension has abated (with the development of new global protocols), the current framing of adolescent health profoundly renews this interesting debate in subtle ways.

This chapter builds on the previous discussion on the factors that shape the dynamics and outcomes of adolescent health. Specifically, it provides theoretical insight into the strategic framing of the policy problem, deconstructs the policy frames that structure the meaning of adolescent health, as well as demonstrates the utility of an integrated ideational policy discourse. As discussed in chapter five, there are various categories of frames – rhetorical, action, and metacultural – that provide insight into the social construction of policy problems. This chapter expands the discussion to show how policy makers engage in strategic portrayal of issues as a pathway to managing policy conflicts. The task, therefore, is to advance understanding on the complex ways in which discourse shapes reality, taking into account the character of policymaking in what scholars refer to as the ‘network society’ (Hajer & Wagenaar, 2003).
7.1. Frame Analysis: Framing for Adolescent Health

The Sustainable Development Goals (SDGs) are a broad set of universally shared aspirations that seek to push humanity onto a sustainable path of freedom, equality, and prosperity, with the ultimate goal of transformational development across the globe. The new Agenda rests on the Universal Declaration of Human Rights, international human rights treaties, and other global instruments such as the Declaration on the Right to Development (The 2030 Agenda for Sustainable Development).

Building on the foundations of the Millennium Development Goals (MDGs), it is notable that the new Agenda espouses a moralist ideology that speaks to the notion that no one should be left behind in the global vision of a better future. In other words, every individual and country matters (both developed and developing countries). While the goal to eradicate poverty remains a key development priority, the SDGs also recognize that development in itself cannot be measured on a single indicator, but rather encompasses multiple areas of human development. As such, efforts to achieve the broad vision imagined by the global community must be cognizant of, or take into account the three interdependent dimensions of sustainable development – that is, the economic, social and environmental.

Importantly, SDG #3 addresses adolescent health, “Ensure healthy lives and promote well-being for all at all ages.” This goal certainly captures the element of inclusive citizenship, which was overlooked by the MDGs. In line with this goal, the SDGs aim at reducing maternal and child mortality, ensuring access to family planning and reproductive health-care services, as well as mainstreaming
reproductive health into national strategies and programmes. A related goal is SDG #5, “Achieve gender equality and empower all women and girls.” As part of measures to promote gender equality and empowerment of all women and girls at all levels of political, social and economic life, the SDGs propose the need for sound policies and enforceable legislation, universal access to sexual and reproductive health and reproductive rights, and abstention from discriminatory and harmful practices that debase the dignity of women and girls.

Lastly, SDG #4 also captures the adolescent population, “Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.” Through equal access to education for all girls and boys, the SDGs seek to promote a platform that provides the youth with the requisite skills that would enhance their employability outcomes. Incidentally, this goal also ties with SDG #8, “Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.” Specifically, it highlights the need to reduce youth unemployment, as well as remove young people from precarious employment while providing them with productive and decent work to enhance their livelihoods. The relationship between youth health, poverty and citizenship has been discussed at length in the previous chapter, and this provides an analytical foundation for the discussion in this chapter.

Given the ambitious character of the SDGs, emphasis is placed on the need to strengthen global partnership as a means to maximizing the available opportunities, while confronting the challenges to the new Agenda. As noted in The 2030 Agenda for Sustainable Development, this involves partnerships with
Governments, civil society, the private sector, the United Nations system, and other relevant actors. Essentially, the SDGs provide the overarching framework for the Global Strategy and the AA-HA! document, thus an analysis of the embedded frames in these three protocols will shed insight on the dynamics of issue framing and its implications for policy outcomes. For analytical purposes, the following discussion consolidates this broad framework into three core frames (i.e., human right frame, development frame, and adolescent health frame).

7.1.1. The Human Right Frame

Human rights commitments and human rights norms constitute a dominant discourse that finds expression across the three global protocols – SDGs, Global Strategy, and the AA-HA! Perhaps its prominence and appeal lie in the fact that it holds unique ideational properties that hold promise for the realization of peace, gender equality, dignity, and social justice within the broader context of human development and prosperity. It is, therefore, not surprising that the human rights frame is embedded in most international conventions and declarations as the centerpiece for political mobilization and action (e.g. Convention on the Rights of the Child, Convention on the Elimination of all Forms of Discrimination Against Women, Universal Declaration of Human Rights etc.). As Austin (2001) rightly observes, the human rights ideology constitutes one of the most “globalized political value[s]” in contemporary politics (p. 183).

Turning to the updated Global Strategy, young people are recognized as central to the achievement and overall success of the new Agenda and, therefore,
“by helping adolescents to realize their rights to health, well-being, education and full and equal participation in society, we are equipping them to attain their full potential as adults” (Global Strategy, p. 5). The introductory statement also notes, “no woman, child or adolescent should face a greater risk of preventable death because of where they live or who they are” (Global Strategy, p. 5). This language not only strategically casts health as a social good, but also as an inherent entitlement that cannot be compromised. Towards this end, the right to health includes physical, mental health, and general well-being. This resonates with the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2011).

In line with advancing women’s, children’s and adolescents’ health, the Global Strategy adopts three overarching objectives – Survive, Thrive and Transform. While the first component, “Survive” tackles maternal, newborn and child mortality, the remaining two – Thrive and Transform – speak directly to adolescent health and well-being. Focusing on the subject of human rights, the Global Strategy highlights systemic barriers that restrict women, children and adolescents from realizing their full human rights. As a result of these barriers, the MDG era recorded 289,000 maternal deaths, 2.6 million stillbirths, 5.9 million deaths in children under the age of five – including 2.7 million newborn deaths – and 1.3 million adolescent deaths (Global Strategy, p. 10). In a similar vein, the AA-HA! Guidance to support Country Implementation (hereinafter “the AA-HA! guidance) also notes that “more than 3000 adolescents die every day from largely preventable causes (p. iv). Overall, it is argued that the annual death toll
constitutes an enormous loss and costs for countries worldwide, a catastrophe that could have been prevented.

It is clear that while these numbers are empirical facts, they have also been invoked for symbolic purposes to capture the gravity of the problem and its related impact on the attainment of human rights goals. In this instance, the reported number of deaths is viewed as a gross violation of individual and collective human rights, a more compelling reason for political action to address such social injustice. Both the Global Strategy and AA-HA! guidance contain a significant range of statistical data that strategically focus attention on the need to take maternal, child and adolescent health issues more seriously. As noted by Stone (2012), policy makers strategically emphasize the measurable for policy purposes. As such, ‘numbers’ are a means to an end – a story of decline backed by numbers – illustrates how bad the situation is at the moment. Importantly, such stories push issues or problems into the realm of human agency.

The human rights frame embedded in the Global Strategy is further strengthened by its far-reaching appeal to the marginalized and hard-to-reach population. “It focuses on safeguarding women, children and adolescents in humanitarian and fragile settings and upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances” (Global Strategy, p. 11). In consonance with the SDGs, the Global Strategy projects education, gender equality, and child marriage as human rights issues. First, it is argued that access to education could result in delayed pregnancies and reduced fertility rates, as well as improved health for mothers and their infants. Second,
safeguarding women’s equal rights to decent, productive work and just remuneration could help bridge the gender disparities in workforce participation.

Third, child marriage violates a child’s right to sound reproductive health, educational and economic attainment. As stated explicitly in the document, “every woman, child and adolescent have the right to make informed choices about their health, and seek and receive services they want and need” (Global Strategy, p. 38). In light of these issues, the document recognizes the need to ensure that women and adolescent girls are not only aware of their rights, but also able to demand gender sensitive services devoid of stigma and discrimination. In fact, the Global Strategy portrays the underlying structural causes of preventable death and ill-health (e.g., poverty, gender inequality, discriminatory policies and practices, marginalization etc.) as human rights violations that affect individuals and groups throughout the life course, with a spill-over effect into the next generation (Global Strategy, p. 24 & 25).

The AA-HA! Framework, like the SDGs and the Global Strategy, reinforce the need to uphold young people’s rights as a prerequisite for achieving the goals outlined in the development agenda. In the brochure regarding the call for the design of the AA-HA! Framework, for instance, the WHO notes: “We are failing adolescents”; “Adolescents are UNIQUE in the neglect they face”; “Adolescents are largely invisible in national health statistics”; “[they] have capacity for decision making yet often face policies that unnecessarily restrict the exercise of their rights” (p. 2 & 3). In the AA-HA! guidance, it is argued that adolescents have the fundamental right to “the highest achievable standards of health and access to
health services,” and, therefore, focusing on diverse sectors, including education and awareness about legal entitlements, social protection, urban planning and the criminal justice system is crucial to protecting and fulfilling adolescents’ rights to health (AA-HA! Guidance, p. 4 & 14). An argument captured in the AA-HA! guidance is noteworthy – “Adolescents are not simply old children or young adults. This deceptively simple observation lies at the heart of Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation, which reflects the coming of age of adolescent health within global public health” (Foreward, iii).

Put together, the strategic representation of women’s, children’s and adolescents’ health via the human rights frame is evident across the three global protocols, and captures the dynamics and importance of issue framing. In particular, it reinforces the ideological relevance of human rights norms and lays out an important theoretical tool for understanding the contextual realities of adolescent health, as well as discourses that shape the character of change in the international system. Indeed, human rights norms hold up well in the international community as substantive tools for state development. Despite its virtues, however, it is not without criticism, a discussion that will be taken up in the final section of this chapter.

7.1.2. The Development Frame

The second frame worthy of attention is the development frame. In relation to the SDGs, it has been argued that the vision of a shared prosperity can only be realized
by making significant investments in young people, and this requires focusing on key important areas, particularly youth unemployment. This idea is reinforced by the Global Strategy, which outlines the social, demographic and economic benefits that could be derived by creating an enabling environment for health. It is argued that implementing the Global Strategy would yield “high return on investments.” First, it would significantly reduce maternal, newborn, child and adolescent deaths and stillbirths. Second, it would yield at least a 10-fold return on investments in terms of better educational attainments, workforce participation and social contributions. Third, the investments would also produce at least US$ 100 billion in demographic dividends. Fourth, the investments would result in a global convergence, where all women, children and adolescents have an equal chance to survive and thrive (Global Strategy, p. 7).

In essence, such investments are central to poverty alleviation, job creation, economic productivity and growth. A theme that cuts across the SDGs, Global Strategy and the AA-HA! guidance is the idea that investments in adolescent health hold the potential to yield a “triple dividend” of health benefits (AA-HA! Guidance). This ties with the concept of “demographic dividend,” which speaks to the economic growth that may occur in response to changes to a country’s mortality and age structure. The argument here is that as a country transitions from high to low fertility, the birth rate also declines, which, in turn, results in the reduction in the ratio of youthful dependents vis-à-vis the working age population. In effect, a “demographic window of opportunity” is created for wealth creation and further investments in areas such as education, health, and economic development (NPC,
2014). In the context of Ghana, for instance, it is argued that the gradual demographic transition places the country in a strategic position to harness the potential of the demographic dividend over the next 20 years (NPC, 2014).

The triple dividend argument, therefore, implies that the health benefits derived from investments in adolescent health would not only positively impact the present lives of adolescents, but also their future adult lives and the next generation of adolescents (including their children) – that is, an intergenerational transmission of health resources. As noted in the Global Strategy, for instance, the combined demographic dividends for young people in sub-Saharan Africa “would be at least US$ 500 billion a year, equal to about one third of the region’s current GDP, for as many as 30 years” (Global Strategy, p. 20). In addition, the justification for investment in adolescent health is grounded in the argument that benefits derived from investments in child health are often lost in the adolescent stage. This relationship, without question, brings into perspective the link between maternal, child and adolescent health, which, of course, is admirable but problematic at the same time. This confusion will be discussed in the next section.

Finally, the AA-HA! guidance suggests that consistent investments in adolescent health could potentially reduce present and future health costs, while enhancing social capital. Situating this within the context of the “demographic dividend” and “triple dividend” arguments, insight can be drawn from Putnam (1993), who argues that the norms of general reciprocity and networks of civic engagement (i.e., social capital) drives economic growth.
In the previous section, it is clear how the story of decline (i.e., outrageous maternal, child, and adolescent deaths) is strategically used to galvanize attention to adolescent health issues. The ‘development frame’, as seen in this section, is judiciously couched in a language of ‘gains’ that could be harvested from investments made in adolescent health. Consistent with the argument advanced by Stone (2012), a story of progress is equally as effective as a story of decline. While the arguments for investment in adolescent health is laudable, the Global Strategy and the AA-HA! guidance predominantly conveys adolescent health in economic terms. To be sure, the documents do not overlook the social dimension of adolescent health. However, it appears that the reasons for investing in adolescent health are almost always tied to the economic argument, which obviously raises concerns about the neo-liberal character of the “investment” project.

Indeed, all the potential benefits associated with commitments to adolescent health are translated, understood, and codified in a business language as a “high return on investments.” Undoubtedly, reducing the ‘development frame’ (with its comprehensive and ambitious dimensions) to a simple ‘economic frame’, as Prentice (2009) would argue, could potentially sidestep the more important and complex issues of social inequality and gender injustice.

7.1.3. The Adolescent Health Frame
The third frame – adolescent health – brings into sharp focus the new set of commitments and advocacy for young people’s health, a significant departure from maternal and child health as the center of global attention. The revised language, as
seen in the GHARH programme in Ghana, holds the potential to attract external resources to a policy area that has largely been neglected. The shift in language is noteworthy, as it depicts adolescents as a unique population with distinct health challenges. As the Global Strategy expresses, “for the first time, adolescents join women and children at the heart of the Global Strategy. This acknowledges not only the unique health challenges facing young people, but also their pivotal role alongside women and children as key drivers of change in the post-2015 era” (p. 11).

The brochure on the AA-HA! Framework also notes: "Adolescents are unique in their return on investment, yet [they] are unique in the neglect they face" (p. 2). Adolescents are also considered unique not only because they are positioned in a rapidly changing phase of development, but also due to the fact that “the range of determinants that influence human health take particular forms and have unique impacts in adolescence” (AA-HA! Guidance - Summary, p. 5). As reflected in the AA-HA! guidance, the frame of adolescent health is also important for two reasons. First, it expands the “entry points” for access to funding to addressing adolescent health issues beyond HIV/AIDS or sexual and reproductive health. Second, it allows for a broader conceptualization of the health problems faced by adolescents to include issues such as depression, injuries, etc. Against this backdrop, the evidence suggests that adolescents are particularly vulnerable and experience a disproportionate percentage of the global population’s disease and injury burden (AA-HA! Guidance).
Although the SDGs, Global Strategy, and the AA-HA! guidance have parallel goals in terms of attention to maternal, child and adolescent health, the AA-HA! guidance is exclusively dedicated to addressing adolescent health issues. Perhaps the reasoning behind this arrangement is to reinforce the newly recognized identity of adolescents as an independent symbolic frame in global public health. Ironically, it is also clear that the three protocols treat maternal, child and adolescent health as inextricably intertwined to the extent that it remains unclear whether the branding of adolescent health is just a policy fad, or holds the potential for sustainable change in health outcomes. As illustrated in the GHARH programme, NGOs were faced with the unique challenge of having to constantly align their schedule of activities to fit with maternal and child health priorities of the Ghana Health Service, a situation that can perhaps be linked to the strategic, yet complex framing of adolescent health. In fact, the fusion of child and maternal health also raises concerns about the capacity of women and children to make claims as independently vulnerable populations.

To be clear, the focus of this dissertation is on adolescent and youth health development, but briefly expanding the scope to include maternal and child health helps to advance understanding on the complex and perplexing character of issue framing. From a discursive standpoint, all the documents stress the need to take into account different national contexts and cultural realities in the quest to achieve the goals outlined in the development agenda. On the surface, this suggestion seems practical, but a closer look raises key questions about the applicability of the various frames which, of course, have been isolated for
analytical purposes. The final section of this chapter will shed further insight on the conundrum of issue framing, as well as appreciating the complexities of adolescent health within the broader context of a discursive architecture.

7.2. ‘Leaping’ into an Integrated Ideational Policy Discourse

As discussed, human rights norms form the fundamental basis of almost all international conventions and declarations, including the SDGs, Global Strategy, and the AA-HA! Adolescent health in itself is an embodiment of several related rights. But the rights discourse is a contentious issue embroiled in long historical debates that continues to generate attention in policy and social circles even today. Towards this end, it would be useful to first situate the present discussion within these broader debates in order to properly appreciate the basis for an integrated ideational policy discourse.

The penetrating influence of the rights paradigm across the globe is beyond question. As scholars have noted, the conceptualization of human rights as an inherent and indivisible entitlement explains the far-reaching appeal and impact of the ideology. According to Austin (2001), the currency of the rights approach is rooted in the idea that every person can, and should be able to make certain claims by virtue of their humanness. Elliott (2007) also points to a global moral space “where the individual is increasingly regarded as sacred and inviolable” (p. 343). Perhaps the power of the rights ideology is also grounded in its intrinsic force as a legitimizing catalyst for policy action and international recognition, thus serving as a fertile instrument for framing national and international issues. It is, therefore,
not surprising that the language of human rights is often employed in collective action that revolve around issues of social justice, equity, and human dignity (Bawa, 2012; Johnson, 2011). The potency of the global rights regime, as described by Elliott (2007), also lies in the fact that it can be used as a weapon to shame states into compliance, thus altering their behaviour in significant ways.

But the universal applicability of human rights is not without question. Despite its normative appeal, there is apparent tension in terms of how human rights norms are interpreted in varying contexts. In her argument for the “relative universality” of human rights, Donnelly (2007) maintains that cultures differ across time and space, thus human rights are subject to the conventional demands and respect for cultural differences. To her, this explains why some states refuse to implement or violate internationally recognized rights with impunity. As Donnelly (2007) argues, “universal human rights, properly understood, leave considerable space for national, regional, cultural particularity and other forms of diversity and relativity” (p. 281).

While this argument appears compelling, it has been challenged on the grounds that a universal human rights discourse refracted through a cultural lens often opens up avenues for legitimised forms of exploitation and violation of women’s rights (Andreopoulos et al., 2014; Bawa, 2012; Fox, 1998). Given that the SDGs, Global Strategy, and the AA-HA! emphasize the need to appreciate different national contexts and priorities, one cannot overlook the complex potential challenges that would be encountered as states embark on the ambitious quest to
achieve the goals of the development agenda, especially considering the broader debates between the universalist and relativist traditions.

Adolescent health, as earlier discussed, is a human rights issue, and as noted by Austin (2001), “a link between health and human rights may allow us to meet global health challenges in a better way” (p. 186). While this argument holds true, this dissertation maintains that Ghana’s prior ADHD programme failed to yield the expected policy outcomes partly due to (1) the lack of a unifying global frame; and (2) consistent appeal to the human rights paradigm. To better understand how global ideational frames can facilitate or constrain policy direction and delivery, the following discussion will draw some insights from the framing literature.

While the literature shows that global discourses are instrumental in bringing about social change (Austin, 2001; Johnson, 2010), scholarly work in this area also demonstrates that global frames could equally function as rhetorical devices without necessarily producing any substantive change in policy outcomes (Johnson, 2010; Labonté, 2008; Stone, 2012). Other scholars have also underscored the importance of context, institutional barriers, competition between different frames, power resources of actors etc. as important considerations that shape the impact of policy frames (Fischer, 2003; Labonté, 2008; Shiffman & Smith, 2007; Yanow, 2003). The key issue here, then, is that even though there may be opportunities for political action, change may not necessarily happen due to constraining factors, and this idea speaks particularly to countries that are currently struggling to initiate arrangements for comprehensive adolescent health programming.
Of particular concern here is the human rights paradigm, which is often portrayed as a tide that lifts all boats. As some scholars have noted, the human rights frame, which is generally considered a master frame, has proved ineffective in dealing with issues surrounding reproductive injustice, gender inequality, and poor maternal health outcomes over time (Cornwall & Molyneux, 2006; Johnson & Das, 2014). Indeed, a key constraining factor that is often missed in policy analysis is the ideational barrier, which may or may not necessarily be a function of cultural predicates. In the context of Ghana, it is evident in preceding chapters that the policy arena abounds with several adolescent-oriented policies rooted in the human rights paradigm.

Building on the four contextual factors discussed in chapter six, one of the observations we can make is that the leverage of the GHARH programme rests on the bedrock of an integrated ideational policy discourse. The following excerpts from interviews already discussed in earlier sections of this dissertation illustrate this position:

The world has changed now; young people are seen as having great potential to impact their own life and the life of their community. I think we didn’t encourage young people to be empowered enough to know that these rights are theirs, and that they can champion it themselves.\(^{39}\)

The ADHD programme was flawed due to the absence of technical direction. If our authorities had sat down and understood, or had been advised deeply into this demographic dividend alone, it could have strengthened the economic argument and allowed for greater resources and mobilization.\(^{40}\)

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\(^{39}\) Interview with Mr. David Logan, Ghana, March 13, 2017
\(^{40}\) Interview with Mr. Owusu Asante, May 09, 2017
Adolescent pregnancy also has a lot of social dimension – that is, issues surrounding parenting, poverty, gatekeepers etc. So yeah, it was critical for all of our partners to understand those dynamics at the outset: this is not just a health intervention, there’s a social side, as well as community-driven side to it. We had to sell that point quite a bit.41

The core argument here is that adolescent health initiatives benefit from a strategic approach that draws on multidimensional frames. Arguably, the successful implementation of the GHARH programme lies in part on Palladium’s ability to integrate the human rights frame with other substantive action frames, while paying attention to the broader institutional settings for effective intervention. In other words, the dimensional properties of a policy frame determine its usefulness in terms of enabling or constraining policy direction. For the purpose of this dissertation, an integrated ideational policy discourse is defined as a discursive policy strategy that constructively draws on multiple integrative frames.

Of course, this strategy raises concerns about the issue of competing frames, but the fundamental argument of this chapter is that frames should not compete with each other. To be sure, frame competition is a fact, and the purpose here is not to downplay its theoretical or practical relevance. But a point worth noting is that the substance of a competing frame is defined by the contextual realities of the political and policy environment. Thus, a supposedly competing frame may surprisingly produce innovative policy alternatives in one context, yet create further complications in another – a feature that makes policy frames deceptively admirable and paradoxically frustrating at the same time.

41 Ibid., 1.
In making the case for an integrated ideational policy discourse, it is useful to situate the discussion within the contextual framework of the Global Strategy, which maintains that “only a comprehensive human-rights based approach will overcome the varied and complex challenges facing women’s, children’s, and adolescents’ health. To succeed, countries and their partners will have to take simultaneous action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multisector action; humanitarian and fragile settings; research and innovation; and accountability” (p. 48). By narrowing down this comprehensive and complex approach to three frames – human rights, development, and adolescent health – we are better able to connect the substantive ideational elements embedded in the global protocols.

However, deconstructing the frames does not fully address the issue of how this complex ideational framework can be fruitfully applied to adolescent and youth health development. As Shiffman and Smith (2007) argue, “some frames resonate more than others, and different frames appeal to different audiences” (p. 1371). If this argument is correct, then it also holds that a sustained effort at framing and reframing policy issues could produce meaningful outcomes. In other words, an integrated ideational policy discourse creates a window of opportunity for the framing and reframing of policy issues that may otherwise be non-existent in a fragmented and unidimensional discourse. Indeed, such an approach not only offers a seat at the decision-making table, but also provides leverage in terms of achieving policy goals.
The concept of ‘design rationality’, as discussed in chapter five, lends analytical currency to the idea of an integrated ideational policy discourse. Based on this frame of reference, it can be seen that the various action frames, as discussed in the previous sections, become reconcilable. Although the framing of policy issues may not always be successful, the push for an integrated ideational policy discourse (although shrouded with complexities), is not a hopeless endeavor. Indeed, in the context of adolescent health and well-being, the idea of an integrated ideational policy discourse holds important insights that are worth highlighting: (1) it helps to capture the full complexity and multidimensionality of the health problem; (2) provides a multidimensional language that opens up a variegated set of policy tools, policy options, and resources to state and non-state actors; (3) allows for a better appreciation of contextual environmental realities and constraints; and (4) provides new perspectives on the sustainability of policy initiatives. For the avoidance of doubt, respect for environmental and cultural realities, as used in this context, rests on a moral rights framework that upholds individual and collective identity, agency, equality, and dignity.

Suffice it to say that adolescent health initiatives that fail to consider the utility of an integrated policy discourse inevitably constrain broader substantive frames around which policy action can be crystallized. Towards this end, the “designer” should “leap” optimistically into a policy window characterized by integrated discursive iterations, but also exercise caution by taking into account the intrinsic properties of individual frames. In other words, policy makers and health programmers should not attempt sweeping reforms based on universalist policy
ideas. Context matters. As this chapter demonstrates, integrated frames might be useful in terms of facilitating institutional change, but it is also crucial to consider their potential limitations. By operating within this framework of understanding, policy makers would be better equipped to leverage state resources, while simultaneously adapting to changes in the domestic and global health system.

7.3. Chapter Summary

Various institutional and environmental forces shape adolescent health initiatives. Global leaders have ratified several protocols that give prominence to adolescent health within the global public health landscape. This chapter has analyzed these protocols – SDGs, Global Strategy, and AA-HA! – in the effort to advance further understanding on issue framing. Building on the factors that shape citizenship and adolescent health outcomes, as put forward in chapter six, the discussion in this chapter centers on policy framing as a strategic tool for political action. Drawing analytical insights from the framing literature, the discussion focuses on three core frames extracted from the global protocols – human rights, development, and adolescent health – to illustrate the dynamics and power of policy framing.

Given the ambitious scope of the new development agenda, one may ask how the embedded action frames in the global protocols can be fruitfully applied in different environmental contexts, especially considering varying contextual and cultural realities. While this is a challenging endeavor, the discussion makes clear that states virtually have no better option but to adopt an integrated ideational policy discourse. This argument is grounded in the empirical reality that the human
rights paradigm, although powerful, is insufficient to address the contemporary realities of adolescent health. Indeed, a critical appreciation of Ghana's ADHD and GHARH programmes clearly demonstrates why states can no longer rely solely on the human rights ideology as a strategic device.

But the concept of an integrated ideational policy discourse is not without problems; it raises concerns about the possible danger of competing frames. Drawing on the concept of “frame reflection,” the discussion re-echoes the idea that political actors possess the qualities for constructive reflective discourse. Without these qualities, humanity becomes a pale reflection of itself. Of course, framing and reframing of policy issues does not always result in policy success. But an integrated ideational policy discourse that takes into account the sum of its parts holds much promise in the new era of identity rights and complex health politics.
Chapter Eight

Youth Citizenship and Development

This chapter examines the citizenship discourse, with particular attention to the dynamics of youth engagement in health programming. More specifically, the discussion examines the engagement of young people in the context of the GHARH intervention, and also draws on focus group discussions that I conducted with young people as part of the present study. Considering the notion that youth engagement in the policy process engenders better policy outcomes, the following discussion is aimed at bringing youths’ voices to the fore, while at the same time advancing understanding on the systemic challenges to self-expression within the broader context of inclusive citizenship. By drawing on the constructivist framework and power typology advanced by Schneider et al. (2014), the discussion seeks to encourage new ways of thinking about how young people are located within the citizenship narrative.

It is trite to say that the NPG philosophy has redefined the contours of citizenship, but it is useful to qualify this assertion. As discussed in chapter three, the new language of governance has been embraced enthusiastically by the Government of Ghana, but at the same time, there has been a tenacious effort, or better put, aggressive drive at keeping power at the centre of government. Thus, the extent to which the NPG movement has fostered deeper citizenry engagement in Ghana remains open to debate. To be sure, the increased use of consultation over the years is certainly a significant landmark in the Ghanaian policy environment.
However, despite these value shifts, it can be argued that Ghana still has a weak consultative culture, and this is clearly evident in the preceding discussion of the ADHD programme.

Nonetheless, it seems an old, yet new consultative regime has been engendered by changes in the global environment, especially in relation to youth engagement in the policymaking process. This dynamic, for instance, is exemplified by the input garnered from young people in the formulation of the AA-HA! The practice of engaging young people in health care initiatives is somewhat novel in Ghana and, therefore, warrants further exploration. As the analysis suggests, the strategic positioning of young people in the policy arena not only contributes to inclusive citizenship, but also legitimates policy decisions and implementation processes that hold significant implications for nation-building.

8.1. Youth Participation: Insights from the GHARH Initiative

The literature on youth citizenship places significant emphasis on encouraging youth voice and active participation in the design of health interventions (Arnot & Swartz, 2012; DiCenso et al., 2002; Ginwright & Taj, 2002; Levac, 2013b; MacDonald et al., 2011a, 2011b). This understanding is based on the premise that youth engagement fosters ownership of policy outcomes, promotes accountability, empowers young people and facilitates better connection with their communities. Importantly, initiatives or interventions that fail to accommodate youth voices risk possible challenges, including ultimate failure (MacDonald et al., 2011b).
The following discussion examines how Palladium engaged with young people to inform the GHARH intervention. The discussion also draws on excerpts from the focus group discussions conducted for the present study to illustrate young people’s perspectives, experiences, and expectations regarding citizenship and health interventions.

The idea of ‘citizenship as participation’, as discussed in chapter three, is somewhat reflected by the GHARH programme, which situates the intervention within a framework of youth engagement. As part of measures to inform, improve and strengthen the design of the GHARH intervention, the Reality Check Approach (RCA) was used by Palladium as a strategy to engage with young people aged 10-24 years, as well as youth in their late twenties (July – September, 2015). The primary aim of the study was to gather insights pertaining to adolescents’ perceptions, attitudes and behaviours surrounding sexual and reproductive health (Palladium, 2015a).

Also, the study sought to engage with several gatekeepers such as community leaders, parents, teachers, and the media to better understand their role and influence in young people’s decision-making process vis-à-vis their reproductive health. Overall, a total of 1,257 participants were engaged. It is important to note, at this point, that there are various types and means of participation, and this includes the popular use of consultative mechanisms. Consultation in itself is a dynamic process that manifests in various forms, ranging from informal to formal techniques (this includes surveys, interviews, public hearings, workshops, seminars etc.).
But there appears to be some degree of tension regarding the use of informal and formal consultative techniques that warrants further interrogation, particularly in the context of the GHARH intervention. The RCA can best be described as an informal method of consultation that involved the use of trained researchers to gather in-depth qualitative data through open conversation and participant observation. The rationale was that an “insider” approach would allow the researchers to effectively build rapport with the youth, while participating in their normal day-to-day activities and interactions. In other words, the study was experiential and contextualized to the lived experiences of the youth. The RCA is a longitudinal study that seeks to track changes in people’s behaviour and experiences over time. As noted in the RCA report, the study team involved twelve researchers (i.e., 2 international researchers and 10 Ghanaian researchers). In terms of study area, their research spanned diverse contexts in Ghana’s Brong Ahafo region – three rural villages, two university hostels, two secondary student hostels, one urban slum area, and three middle-class complexes (Palladium, 2015, p. 13).

Essentially, the informal nature of the RCA approach, as pointed out in chapter three, resonates with the argument on the need to shift attention away from institutionalized public decision-making processes towards the engagement of young people in everyday life contexts. Of course, the merits associated with this approach cannot be discounted, but the limitations are also worth exploring, a discussion that would be taken up in the latter part of this chapter. A number of insightful findings are brought to the fore in the RCA report, and it would be useful
to elaborate on these findings, which somewhat aligns with some of the views garnered from my focus groups.

According to the RCA report, majority of the young people consulted aspired to complete their education in order to secure good jobs. To them, the cost of marriage and raising children proved an incentive to postpone marriage until they attained financial security. However, most of them had financial challenges, which compelled them to work in the informal sector. In some cases, gambling seemed like a lucrative business for young people, especially among young boys. In other cases, the youth also engaged in transactional sex specifically for material benefits, school needs, as well as pleasure. However, it was noted that young people from middle class families mostly preferred sexual relationships within the context of marriage compared to those in the rural villages. For others, religion was a key determinant shaping their sexual behaviour. In some senior high school (SHS) hostels, it was observed that having a sexual partner was a norm that accorded some form of social status to students.

In terms of sexual and reproductive knowledge, the report suggests that older youth were generally familiar with various forms of contraceptives, particularly condoms. However, knowledge about the proper use of these contraceptives seemed to be lacking. Abortion also appeared to be prevalent, but the youth had little knowledge about its legality or appropriate facilities to have the issue addressed, hence resort to crude methods that endanger their lives. As revealed in the report, most of the young people considered abortion to be illegal, a crime that could result in arrest and conviction. Recall that the issue of abortion, as
discussed in chapter three, is highly controversial not only in Ghana, but across various polities.

Returning to the discussion on the RCA strategy, it was noted that while the youth were open to talks about sexuality, and sometimes discussed such issues with their parents and other authority figures, they generally preferred engaging with peers. Surprisingly, the report also noted that the youth in the villages failed to avail themselves of the opportunity to tap information from a former peer educator, and rather enjoyed the company of their peers as sources of information about their reproductive health. Overall, as can be seen from the RCA initiative, youth engagement is conceptualized as an important component of adolescent health programming. In other words, interacting with youth and encouraging participation can be useful in terms of engineering more effective policies and interventions.

In their recommendation, the study team suggests: (1) the need to shift messaging about sex from advice or moral instruction to safer sex. It is argued that such advisory or moralist information, which often places emphasis on abstinence, with fear-based undertones on the negative implications of premarital sex, tends to further alienate the youth. Therefore, safer sex platforms should be embraced – that is, approaches that focus on safe and healthy sexual behaviours such as accessibility and use of contraceptive methods, knowledge about sexually transmitted infections (STIs), safe abortion, as well as negotiation skills; (2) minimize the financial motive for transactional sex; (3) harness the power of the internet and social media as key modes of information dissemination; (4) adopt
informal peer-to-peer support and education processes; and (5) engage youth in private environments rather than through fixed formal structures for services (Palladium, 2015a).

8.2. Youth Engagement: Insights from Focus Group Discussions

In relation to the idea that youth participation promotes better policy outcomes, the discussion below draws on interviews that I conducted in Brong Ahafo with the youth (ages 10-24) in May 2017 for the purpose of exploring young people’s perspectives, experiences, and expectations regarding citizenship and health interventions. As already indicated, this consisted of four sets of focus groups (N = 40) conducted in a private space in Sunyani. In keeping with the ethical requirements for this research, the study locations are confidential. Also, for the purpose of confidentiality, pseudonyms have been assigned to research participants.

When asked about the extent to which they viewed adolescent pregnancy as a problem, most of the participants, particularly the older youth expressed concern that it had tarnished the image of the region. For those who followed the news on a regular basis, they felt the image of the region had to be salvaged from the negative press attention. For others, the state had consistently failed the youth by turning a blind eye to the problem. Generally, majority of the youth acknowledged the consequences of risky sexual behaviour on their health and future prospects. One SHS girl expressed:
Two of my friends died last year from abortion, so I have become more careful with my dealings with the opposite sex. Sometimes, the guys approach you to tell you how beautiful you are, but you know exactly where the conversation is leading. I am the only daughter of my parents so they cannot afford to lose me. I want to make them proud by studying hard. (Naomi, 2017)

A young girl also noted:

My mother is a nurse, so she talks to me about AIDS and pregnancy most of the time. My dad also wants me to grow up and become someone important in future. He always refers me to the Chief Justice to let me know that a woman can also make it to the top. I think they have played a good role in my life, and I am careful with how I relate to the opposite sex. As for the feelings, they are there, but if you don’t control it, you can mess up your life. And when it happens that way, your parents cannot help you. That is why you see some pregnant young girls on the streets doing kayayo [head porters]. Not all of them have been abandoned by their parents, but they have to survive because there is no money in the house. (Isabel, 2017)

The excerpts above not only demonstrate youth consciousness about their sexual and reproductive health, but also draws attention to young people’s agency in an increasingly globalized environment. But we also see the important role of parents in shaping the future direction of the youth. As indicated earlier in chapter four, adolescence is a vulnerable period, and receiving the necessary attention and care is critical to successfully navigating the challenges associated with this development stage. Arguably, receiving the proper support can further enhance young people’s agency in the choices they make regarding their reproductive health. Also, we see threads of the economic argument, as discussed in chapter four, across the interviews. Young people might engage in risky sexual behaviors
not because of the lack of knowledge about the potential consequences nor absence of parental guidance, but rather due to poverty at the family level.

A young boy in his late teens, however, did not share the idea that you need to engage in a sexual relationship to make ends meet. He noted:

Me and my sister come from a poor family, and sometimes we feel that life has failed us. But we try to manage with what our parents give to us. We also help our parents to sell their wares on the market to make some extra income. Personally, I have tried several times to search for a well-paying job but it hasn't been easy. The jobs are just not available, and sometimes I blame the government. All they care about is getting into office to stuff their pockets, and we need to talk about it. (Michael, 2017)

From the perspective of another young girl:

If you ask me, I’ll say that the leaders are supposed to help the youth so that they don’t get pregnant. There is a saying that the devil finds work for those who don’t have anything to do. If the government provides the youth with jobs, they’ll find something to do and not pay attention to young girls, and young girls will also not be looking for sugar daddies. If you go to town, you’ll see plenty young men pushing wheel barrows, and some girls also carrying people’s things for them for money. But the money is very small, and they sometimes get cheated too. I am not a politics person, but I think our leaders can be asked to do the right thing for the youth of today. Other than that, we’re all going to suffer one day. (Betty, 2017)

Another young boy in SHS also expressed:

For me, when I think about adolescent pregnancy, I feel that Brong Ahafo has a bad name, and it’s not our fault. Every day, you hear about it on the radio, and the government is just there and watching if things will change... It won’t change if you don’t do anything about it. (Kelvin, 2017)
As the above quotes suggest, young people expect government to assume a leading role in relation to the issue of adolescent pregnancy in the region. For some young people, the provision of jobs and other livelihood opportunities could help address the problem. Certainly, these perspectives reinforce the idea that young people are not ignorant about policy issues, and possess the capacity to make sense of the social realities that confront them in their daily lives. Importantly, young people can be effectively engaged on issues that directly affect them, as their ideas could provide alternative pathways to better policy outcomes. While some of the suggestions from the youth seem not specific enough to formulate policy solutions, the ideas garnered from the focus groups point to an important fact – that is, if they are empowered and given the opportunity, they could provide strategic insights that might prove useful for policy direction.

While some of the youth considered adolescent pregnancy to be a challenge, others also suggested that it has become a norm. As a result, they did not perceive it as much of a problem. In the words of a young girl:

Some of my friends have had abortions before, and some decided to keep their baby. So adolescent pregnancy is a common thing, and it happens if you make a mistake and don't protect yourself well. If the mistake happens, you can keep the baby or abort it. So, it's not a problem at all; you have to make that choice. If you think you're not ready to have a baby, then you know what you have to do so it doesn't become a problem. (Abigail, 2017)

A young boy also shared a similar sentiment, but challenged the idea of abortion. He argued:

Adolescent pregnancy is not much of a problem because you see young pregnant girls on the streets and in the markets every day.
So, it’s quite common. I don’t support abortion because you’re killing a baby. But if you want to do abortion, I think you should let a real doctor do it for you because it is risky; you can die if something goes wrong. (Daniel, 2017)

Another young girl also noted:

Generally, I think adolescent pregnancy is getting plenty attention now because young people are having babies early. But I think it’s not really a problem if the youth don’t have to abort it. God created us to multiply and fill the earth, so I don’t think He’s happy with abortion. For me, as long as you are ready and feel you want to give birth, no one should prevent you. Why should your parent beat you when you become pregnant? It’s not that you’re the first person in the whole region to get pregnant. If you look around, you see young pregnant girls, and some have given birth to nice babies. I have not given birth yet because I’m not ready, but if I am ready and have money, I can take good care of the baby. But you, you come from Canada. Don’t the youth there get pregnant too? Do their parent’s beat them? But here, you get pregnant, and everyone is shouting like you’re going to hell. (Nana Serwaa, 2017)

The comments above clearly resonate with the issue of culture, as discussed in chapter six. While the trend in adolescent pregnancy can be attributed to various factors, it seems the cultural environment somewhat encourages risky sexual behavior among the youth. But at the same time, we also notice young people’s consciousness about their reproductive rights. While there seems to be some tension between individual freedom and social constructions surrounding adolescent pregnancy, it is clear that these complexities boil down to issues of structure and agency. Given that the language of rights feed into the broader citizenship discourse, the strategic adaptation of policy makers to perspectives from the youth generate insights into what might be useful and effective strategies
in terms of addressing young people’s reproductive health and well-being. As already pointed out in the literature, a fear-based approach to adolescent health is counterproductive to the broad vision of development and social integration.

As a follow-up question, the youth were asked about family planning to gauge their knowledge on the issue, as well as sources of information. Similar to other studies, the youth appeared to have some knowledge on family planning. However, those between the ages of 10-12 years were mostly familiar with condoms. Most of the participants were also conscious of the fact that unprotected sex could lead to pregnancy, and were also abreast with the various pharmacies where contraceptives could be purchased.

As one boy noted:

I know about family planning, and I know they don’t want people to have plenty babies. On the TV, they show condom that if it’s not on, it’s not in [referring to a TV advertisement]. (Kwadwo, 2017)

Another young girl also noted:

There are different places that I learn about family planning. Our teachers teach us in the classroom. I also hear about it on radio and TV. Sometimes too, they have been doing campaigns about it, and you see someone in a car with a speaker talking about it. I remember they did some programme last year about adolescent pregnancy, and family planning was part of it. If you go to the small clinic at the main hospital [referring to the youth corner], they’ll show you how to wear condom, and the other types of family planning. I have been there with a friend before, and the nurse there is a nice person. (Ruth, 2017)

Another young girl also noted:

Family planning is not something that I really spend time to learn about. I hear about it every day on TV and radio, so I know a lot.
When you go to the pharmacy, you can ask them questions too, and they can help you. It’s just that some of the pharmacies, when you start asking about condoms and family planning, they think you’re going to have sex because you are young. For those of us who do not feel comfortable going to the pharmacy, we ask our friends, or ask our friends to ask our questions for us. (Sandra, 2017)

Another young girl also noted:

For me, family planning is not a new thing. As a young girl, I think you have to know about some of these things. I have heard about some of the youth programs on radio, but I can’t remember their names. I know there is male condom and female condom, but I don’t know if they have to use them together. Maybe, if you want double protection, then you and the guy have to wear it. (Aggie, 2017)

Another young girl noted:

I heard about the GHARH programme in school, but I haven’t been to the corner myself. I don’t think I’ll get pregnant before I finish school, and I read about sex on my own so I know a lot. Some of my friends, however, go there for information and pregnancy tests. (Nancy, 2017)

Some of the young boys also noted that they learnt about sex and family planning from adult newspapers, which are mostly displayed openly at the newsstands, whereas some of the young girls also obtained information from romantic novels. Hence, they did not see the need to go to special programmes or centres to be taught about family planning. However, in their responses, many of the youth underscored the relevance of the adolescent health corners after a few probing questions. Even though they paid no serious attention to them, it was evident that they welcomed such initiatives. As one young adolescent single mother noted:
If I had known about the existence of these resources a bit earlier, I
would not be in my current situation. I allowed my peers to mislead
me thinking that I was living the life. But things actually turned out
badly for me in the end, and here we are. I have learnt my lesson,
and I know God will see me through. (Betty, 2017)

Another boy also clarified his earlier position:

It is not that I’m saying the hospital is not a good place for going for
information about family planning. What I am saying is that if you
can get all this information around, then why go to the hospital?
The nurses are professional people, so maybe they are better than
the people at the market. (Nana Kwasi, 2017)

Given the extent of information dissemination and capacity building as part of the
GHARH intervention, the evidence from the focus groups reinforce the relationship
between youth participation and policy outcome. Some of the youth had heard
about programs executed by PPAG, and also had some experiences with the GHARH
intervention, but were not entirely sure about what these programs had to offer.
Others had no knowledge at all about these interventions. Incidentally, during my
field visits to one of the adolescent health corners, the youth facilitator
acknowledged that some of the youth had no knowledge about the existence of the
health corners, and mostly received direction from the general hospital. As she
pointed out:

Sometimes, some adolescents come here, and they’ve never heard
about this place. They came to the hospital, and someone
introduced them to the corner . . . But we’ll urge you to help us
spread the news to the adolescents that we have the health corner
here, and they should take advantage of these opportunities.
Because we have other schools who have not heard of these
corners. And because the staff here are limited, we cannot go out
for outreach frequently, and the funds too is a bit challenging. So, it
would be good to help broadcast the corner, so they can come and enjoy the services we offer here (Field Interview, 2017).

Generally, hospital facilities and the health corners were among the least mentioned sources of family planning for the youth. While this finding cannot be generalized to the entire region, it points to important sources of health information for the present cohort of young people. More effort needs to be directed at promoting health facilities, and particularly the adolescent health corners as rich avenues for health resources for young people. Certainly, the media can be engaged as key partners in this area. Also, it appears pharmacists need to be targeted as critical stakeholders in relation to young people’s reproductive health.

While most pharmacists were deemed to be receptive, some of the boys complained about discrimination in certain pharmacies. In the words of one young boy:

Some of the pharmacies are bias. When I go there to buy condom, they ask too many questions, so I don't go there anymore. One day, I went to buy condom, and one of the pharmacists said, "I thought you just came in here to buy two packs yesterday." Maybe, she was just joking, but I didn't know what to say because I didn't expect she will ask that. And there were other people there too. But I know lots of girls come here for the same thing every day, and they don't ask them questions. I have seen it because some of the girls come here and they don't even open their mouth to say anything, but the pharmacists know what they want and give it to them. (Gilbert, 2017)

Another boy also shared a similar experience. He noted that some of the pharmacists appeared to be friendlier with girls than boys:

There is a pharmacy close to my place, and I feel that it is more easy for the girls to buy condoms than boys. When the girls come to buy it, you see them smiling with them, but when we the boys come, they look at us with some eyes as if we’ve committed a crime. They
won’t say anything to you, but in your mind, you know what they’re thinking. So, for me, I tell my friends to buy it for me when they go to town. (Philip, 2017)

For the girls, some also raised concerns about gender differences regarding their access to contraceptives. In the words of one girl:

Most of the pharmacists here are very friendly, and will give you what you want. Some even take their time to show you the different types of contraceptives they have. But in some of the pharmacies operated mainly by men, they see you as a cheap girl when you come to buy contraceptive. One pharmacist once asked me in a joking manner when he would also “have his turn.” I don’t think he’ll ask a boy that dumb question. (Maame, 2017)

Another girl also raised the issue of finances as a barrier to purchasing contraceptives. She said:

My boyfriend does not like to use condom because he says he does not enjoy it, and I also don’t want to get pregnant. But I don’t have much money to be buying contraceptives every day. One day, I asked the pharmacist if I could pay for the contraceptive the following day, and he said that’s fine. The following day, I told him I didn’t have the money on me, and he said if I keep asking for such favours, I’d have to start paying in kind. At first, I thought he was just being funny, but he really meant bedroom business. And that if I wasn’t ready, I shouldn’t come borrowing on credit. (Linda, 2017)

In similar fashion, it emerged from the discussion that some of the girls shared the contraceptives bought by their friends. As one girl revealed:

Some of my friends come from rich homes, so buying contraceptives is not really a big deal to them. They understand that we cannot get pregnant while we’re still in school, so when you speak to them, they’re willing to share. Sometimes, I don’t feel comfortable asking them, but they’re good friends, and they don’t gossip that much. (Nana Yaa, 2017)

By now, it is clear that adolescent health is informed by socio-economic status, geographic location, and gender dynamics. Given that the research participants live
in predominantly urban areas, the differences in responses are particularly striking. Based on the mixed responses from the respondents, reasons for the underlying gendered differences regarding access to contraceptives among young people remain unclear. However, the element of gender (as a power construct) and its impact on adolescent health and reproductive rights needs to be taken into more serious consideration by policy makers and health programmers. In line with the dictates of sound reproductive health and well-being, every person should have equal and unhindered access to health services based on their specific health needs and choice (WHO, 2011). But it appears this is not the case. While it is difficult to generalize from this study, the findings from the focus groups might perhaps point to broader subtle gender barriers regarding accessibility of contraceptives in Ghana.

The issue of poverty and its impact on adolescent health has been thoroughly discussed in various sections of this dissertation. In the context of the focus group discussions, it seems that while young girls seem somewhat empowered to take the necessary precautions to avoid getting pregnant, their financial situation undermines this effort. Of course, the distribution of condoms and other forms of contraceptives might not be a panacea to addressing the myriad health issues facing young people. However, bridging the economic gap across the broader spectrum of society, coupled with enhanced accessibility to family planning kits significantly contributes to young people’s health and citizenship.

As noted earlier, the concept of citizenship revolves around issues of distribution, provision, and access. From this perspective, it is clear that the
adolescent and youth condition as presented above challenge the very meaning of citizenship. Young people have reproductive rights, and these include unhindered access to reproductive health services, and to make decisions concerning reproduction free of prejudice. Yet we see a picture of young people trapped in a vicious circle of poverty, sexism, inequality, as well as norms and practices that detract from adolescent pregnancy as an issue of health concern. In the face of these provoking issues, it is necessary to examine the citizenship discourse in the context of adolescent and youth health programming and intervention. In other words, how do health interventions embody citizenship in relation to distribution, provision, inclusion, and access?

Arguably, young people’s expectations about citizenship has evolved dramatically; they expect to be engaged as stakeholders in the health industry, particularly in relation to programs that directly affect them. The conversation got interesting as the youth started assigning blame for their lack of knowledge about the health interventions. This, however, is not to discount the general empirical evidence about the information and mobilization efforts by Palladium, or the fact that the youth corners were highly patronized by the youth. To be clear, the youth participants interviewed for this study were selected based on a randomized arrangement, and not specifically targeted at young people who had patronized the corners or recruited for the RCA initiative. Certainly, the blame discourse centers on the substance of citizenship. Indeed, the interviews highlight how historical marginalization of youth from citizenship affects how they react to health initiatives and give us some insight into what needs to be done. While the concept
of citizenship appeared foreign to them, they expressed their lack of voice in health interventions. As one young boy noted:

They [the government] expect us to know about these programmes but they don't talk to us first. Then all of a sudden, you hear that there's a new programme in town. Maybe, they feel that we're small children, so they know what is good for us . . . In my area, even eight-year old children are having sex, so if you say they're small children, they'll just laugh at you. (Nii, 2017)

Another young boy also suggested:

Even the way we're having this discussion right now can be used to learn about these programmes and ask questions. So maybe, they can organize something like this first and see the kind of questions people will ask. So, when they bring the programme, people will not be surprised and will have plenty of information about it. Some of us will even want to help them with the programme so that it will benefit everyone. I do a lot of volunteer work in my church, and I know some of my friends will also be willing to participate in such programmes. (Samuel, 2017)

In agreement with the above sentiment, another young woman expressed:

What you just said is true. I think we should know about these programs before they bring them to us. But there's no opportunity for us to discuss what the programme is all about. Sometimes, you see a car going around the community making announcement that a particular programme has come and that it will benefit us. But some people don't really care because it has become a normal thing. It's like elections; if they want our votes, they come to us, so you're more likely to get involved to see what will happen. But with these programmes, it's not like that. (Joyce, 2017)

The observation above is particularly striking in the sense that, even though some of the youth may have heard about these adolescent-targeted health initiatives on
radio and in their communities, they not only confuse them with other general health programs, but also show little interest due to the sense of disengagement.

Considering the debates on sex education as a positive social force in relation to adolescent reproductive health, the interviews highlight important contextual elements that give some clues as to how to improve the process. When asked about the extent to which they think more information on sexual and reproductive health would help address the problem of adolescent pregnancy, there were mixed views among the youth. Below are some insightful perspectives from the youth:

I think more information on sexual and reproductive health is good but most of the youth are poor. So even if they have the information, there is the temptation to put that aside and go in for the money through sex, which is an easy source of money. And there’re rich guys around too. (Paulina, 2017)

The youth of today are not moved by textbook stories, so if you want to bring them more information on reproductive health, then you have to bring along young people to share their real stories and mistakes. Personally, I learn more effectively through people’s experiences, and I’m happy our young mother here shared her experience with us. I’m sure I’m not the only one who was touched by her experience. (Mary, 2017)

There is too much information these days, so adding more information only pushes the youth away. If we’re taught more about how people made it big in life, bought their cars and houses, everyone will also want to get there someday. Me, for instance, I want to become a DCE [District Chief Executive] in my community, so more information in this area will take away the attention from sex, and my education will come first. (Kojo, 2017)
As revealed in the interviews, a section of the youth maintained that even though strengthening sexual and reproductive health education could be useful, it might not necessarily curb the problem of adolescent pregnancy due to poverty and bad peer influence. Also, the suggestion that the dissemination of information should be coupled with practical experiences from the youth themselves seems very insightful. In that way, the information would not be viewed as conspiracy theories designed to curtail young people's freedom and happiness.

Other participants also pointed to the nature of the present information era, characterized by fast-paced inflow of information about sexual and reproductive health. For some, this makes the information difficult to digest. In other words, targeting the youth with more information about sexual and reproductive health could be counterproductive, leading to information overload. The challenge, then, is how to engage the youth with comprehensive information about sexual and reproductive health, while at the same time ensuring that it is presented in a digestible form.

Rather than provide excessive information on reproductive health, the interviews suggest that young people’s attention could also be shifted towards positive role models in the society. In other words, the youth might be ‘hooked’ by messages that emphasize the values of hard work, achievement, and community building. Such approaches, would, in turn, foster the drive for leadership, as well as competition among young people to achieve success in their various fields of endeavour. Essentially, effective health interventions would require not just getting into the minds of young people with sex education, but also affecting their belief
and value system about politics and institutions central to nation-building (including addressing the issue of poverty). This finding resonates with other studies that suggest that knowledge about sexual and reproductive health might not necessarily inhibit young people from engaging in risky sexual behavior.

In one of the focus groups, my question on whether or not more information on sexual and reproductive health was useful for the youth reinforced the idea of participatory governance. As one young boy argued:

For me, if you talk about more information on sexual and reproductive health, then I think you're going in the wrong way. If we are allowed to take part in discussing these programmes before they bring them to us, there would be no need for more information because the information would already have been discussed. It's almost like eating the same food for breakfast, lunch and supper. (Nii, 2017)

In agreement with the above sentiment, another boy noted:

I like what you have said. Plenty information is not good. It’s like when you go to church and the pastor is saying the same thing and saying the same thing again. It is boring, and some people even go home early. If the church wants to build something or buy something, they tell the church people first, and then they ask them to bring their suggestions. It is the church people who will give you the money to buy what you want to buy, so if you don’t mind them and just bring offertory bowl, you’ll see their faces. You will only get one Ghana cedis and coins. I am talking too much, but if they say they’re bringing youth programme to the youth, then the youth can bring in the information, and the information can be divided into different areas. If it is in different areas, you will see that some of the information is the same, so you can delete some, and you won’t have plenty information. (Daniel, 2017)
Another girl also added her voice to the conversation:

We are all talking like football experts, but it is true. If Asamoah Gyan [captain of the Ghana national football team] is not scoring a goal, then we’re blaming him. But maybe, he too he’s not getting the passes from the other players, so we have to blame them too. And if the team loses the match, then people too will say it is the coach, so we have to sack him. The thing, it is team spirit. If the youth have team spirit, then they can come together and share information, then everybody will benefit. If your friend is in a bad relationship, you can find a good way to tell them, so that they don’t continue and later become pregnant. The team spirit, it is everybody – the leaders, the youth, and even the drivers who have been impregnating the girls and giving them money. Me, I think it is the leaders who are not passing the ball well to the youth, and they too, they're letting the drivers and the young boys take advantage of them. (Mary, 2017)

As the interviews above suggest, the outcome of health interventions is strongly tied to the design stage. The formulation of adolescent-oriented health programmes must be understood within the broader framework of participatory governance. Involving young people in such programmes would allow policy makers to target them with more specific information, which might not only be cost-effective, but also time-saving in terms of implementing health initiatives.

Given that school health clubs were established as part of the GHARH intervention, the conversation was re-directed towards gaining insights about the youths’ experiences. In their responses, it was observed that some youth were familiar with the health clubs in their schools, and did participate in their activities. Those who were not aware or had not participated in these clubs also provided several reasons. Below are some excerpts from the discussions:
For me, I think the health club is good. You meet with your friends and other people who are your age mates, and you discuss a lot of things that is worrying you. Sometimes, they bring the nurses to talk to us, and you can ask them any question. (Alima, 2017)

It is my friend who said we should go. So, we go together, and we like to be part of the club. One day, one of the boys was like, the feelings are getting high so what should he do? Then one of his friends said he should go and play football, and everybody was laughing. We have fun listening to other people, but we also learn new things and how to handle ourselves well, especially as young girls (Ruth, 2017).

I have heard about the health clubs and it’s not that I don’t have the interest. It’s just that I find it difficult to attend and involve myself. Maybe, it’s just because I’m not managing my time well, but maybe one day, I will go there and see what they’re doing. (Mustapha, 2017)

As for the health club thing, I don’t really know if this new one is better. I was in a similar one sometime ago but I stopped going because when you ask your question, it’s as if the response is indirectly telling you that you’re a bad girl. Sometimes, you go and the leader doesn’t even come, so I lost interest. (Abigail, 2017)

I think some of the clubs don’t have focus. They start very well, but as time goes on, you’ll see that people are not going anymore because they’re not getting any benefit from attending. They keep hearing the same message every day, and sometimes the information being given to them is not relevant to them, so why should they come? (Rosemary, 2017)

The clubs can be a good thing for the youth because adolescent pregnancy is going high. But I think the girls should be the ones going for more education from these clubs because they’re causing the guys to fall. You see them wearing short skirts and shaking their buttocks when they see the guys coming. They need more advice so that they don’t come and tempt us. (Asante, 2017)

There are plenty girls in the clubs than boys, so you can’t even express yourself well. You’ll get more support from the guys when you make your point, but when you have just two guys and twenty girls, they’ll just laugh at you. I think the club thing is a girl’s thing, and that’s why the guys are not going. (Philip, 2017)
As can be seen from the interviews, the health clubs embody citizenship in the sense that it provides avenues for young people to access information services about their reproductive health in ways that would otherwise not be convenient or available to them. The youth who had participated in these health clubs shared some positive insights about their experiences. To them, the health clubs were helpful in the sense that it not only provided useful information about sexual and reproductive health, but also provided a sense of community where they could share their concerns and receive useful feedback from various resourceful people. Some of the youth also had difficulty providing tangible reasons why they were not members of the health clubs.

Others also indicated that they had been members of similar clubs in the past but revoked their membership due to poor organization, judgmental attitudes from peers and patrons, as well as general lack of interest. As a result, they were reluctant to join new clubs that had a sexual health orientation due to fear of experiencing similar patterns. Some of the young boys also felt that such clubs were primarily for girls, an understanding which, of course, is clearly gendered. This worrying situation certainly recaptures our attention to the gendered character of the Ghanaian society as discussed in chapter three, and also reinforces the argument that young boys should be more effectively targeted in health interventions to better enhance policy outcomes.

In sum, it is clear that youth engagement and participation in health initiatives are critical to better and effective health outcomes. Not only does it enhance young people’s citizenship, but also bolsters policy responses aimed at
social transformation. Insights from the focus groups certainly provide rich perspectives from the youth, their experiences and expectations about citizenship, which highlight important clues about how to further strengthen interventionist programs and initiatives. While the youth are often considered as naïve, the evidence points to young people’s agency and expectations about the state's central role in reconfiguring and protecting their citizenship entitlements. Importantly, the youth expect to be engaged as stakeholders in the reform process.

The issue of gender and its impact on adolescent health, as well as current information sources for young people, point to the complexities embedded in the social and health arena. Nonetheless, building on this insight suggests the need for careful reflection on strategies directed at improving the health system and promoting young people’s health and well-being. In short, the challenges associated with implementing health initiatives for young people could be minimized if the youth are better engaged in the process. That said, it is also clear that the perspectives shared by the youth in the focus groups somewhat resonate with the views from the RCA initiative discussed earlier in this chapter. However, the big question is: to what extent is the RCA reflective of inclusive citizenship? This important question will be addressed in the next section.

8.3. Rethinking Youth Participation as Citizenship

The culture of participatory governance has obviously encouraged the increasing use of consultative mechanisms across various government institutions, departments and policy sectors. In the context of youth participation, inclusive
citizenship is, however, often narrowly equated with the art of consultation. As discussed in chapter three, this growing phenomenon perhaps raises the more important question of the extent to which young people are regarded in the broader decision-making process.

To answer the question on whether the RCA is reflective of inclusive citizenship, it is important to state that it marks a significant threshold on Ghana’s national agenda in terms of youth engagement, which obviously should be celebrated. However, by deconstructing the RCA, some issues regarding inclusive participation are brought to the fore. As already discussed in this chapter, the RCA reflects an informal participatory arrangement used to collect data on young people’s views regarding sexual and reproductive health in Ghana’s Brong Ahafo region. However, it is not clear the extent to which the views garnered influenced policy and practice, especially considering the longitudinal nature of the RCA method.

Indeed, based on the report by the RCA study team, it can be argued that the RCA sells the concept of inclusive citizenship short. While the RCA encouraged youth input by allowing young people to determine the agenda and direction of the conversation, the extent of youth empowerment and inclusivity, broadly speaking, is called into question. It is important to reiterate that the present study did not specifically target individuals who were engaged as part of the RCA initiative. To be sure, there was some form of personal empowerment at the individual level, as the RCA report indicates that some of the youth expressed satisfaction for participation in the research. As the report suggests, the youth considered the informal approach
as an easy and more open channel for expressing themselves in their own space. This point, of course, reinforces the argument regarding the youths’ interest in being engaged as relevant stakeholders in policy decisions.

Participatory governance, from a citizenship standpoint, helps to define the broader society. Thus, the idea of citizenship and empowerment misses the point if the youth are able to express themselves in their personal space, but unable to relate to this experience at the broader political level. It is one thing expressing yourself, and another knowing whether your opinion counts. As the RCA shows, the element of feedback, and the degree of youth power and influence in shaping the substantive content and delivery of health initiatives, is open to debate as far as the consultative process is concerned. Data was collected over a period of four days, after which the RCA study team members discussed the study findings and implications for reproductive health programming. Here, it can be seen that information flow was primarily one way – that is, from youth to policy makers. The longitudinal nature of the RCA approach gives cause for hope. However, considering the uncertain nature of the funding environment, the promise of follow-up and strong empowering culture remains to be seen. Indeed, inclusive citizenship as young people’s testimonies in this study demonstrates, goes beyond consultation on how interventions or services should be executed.

Perhaps more problematic is the RCA’s emphasis on the need to engage young people through informal structures or support arrangements. To be sure, engaging the youth in their organic everyday environments is useful, as it challenges formal participatory spaces characterized by power differentials
between the youth and power holders. As argued by Percy-Smith (2010), “opportunity spaces” abstracted from the state promotes autonomous action and self-determination, which, in turn, engenders creativity and learning for social change (p. 117). Despite the virtues of this informal approach, it could be argued that such discourse and practices exacerbate the problem of inclusive citizenship by pushing the youth further into marginalized spaces. Recall the earlier comments by some of the youth participants in the focus groups:

Even the way we’re having this discussion right now can be used to learn about these programmes and ask questions. So maybe, they can organize something like this first and see the kind of questions people will ask. So, when they bring the programme, people will not be surprised and will have plenty of information about it. Some of us will even want to help them with the programme so that it will benefit everyone. I do a lot of volunteer work in my church, and I know some of my friends will also be willing to participate in such programmes. (Samuel, 2017)

What you just said is true. I think we should know about these programs before they bring them to us. But there’s no opportunity for us to discuss what the programme is all about. Sometimes, you see a car going around the community making announcement that a particular programme has come and that it will benefit us. But some people don’t really care because it has become a normal thing. It’s like elections; if they want our votes, they come to us, so you’re more likely to get involved to see what will happen. But with these programmes, it’s not like that. (Joyce, 2017)

As the interviews suggest, the youth expect to be thoroughly engaged prior to the implementation of health initiatives targeted at them. Importantly, they consider formal structural spaces as good avenues for youth engagement (the focus groups were held in the form of a roundtable discussion). Indeed, young people may not
necessarily be empowered through informal structures for participation, but rather, risk being further alienated from social life and the broader decision-making arena. In the context of Ghana, one could argue that such discourses provide legitimacy to the culture of silence surrounding youth voices in the policy landscape.

Citizenship in itself is a dynamic construct that revolves around contestation. As argued by some scholars, it is a struggle over inclusion and space (Johnston, 2012; Oduro, 2009). In other words, it is a quest for meaningful participation. In light of this understanding, rather than accepting the power imbalance in the policy system as a given, attention should be shifted towards how the youth can effectively challenge the participatory ceiling that undermines their citizenship. The barriers to youth citizenship are widely acknowledged, and it would be useful to expand the conversation beyond the emphasis on informal youth engagement.

As discussed in chapter five, the fourfold typology of social constructions advanced by Schneider et al. (2014) provides a useful framework for analyzing young people’s locus in the political system. In their analysis, the youth, although positively constructed, fall under the “dependent” stream. Their access to benefits is limited due to the lack of political power. But their lack of political power is intrinsically tied to their status as ‘dependents’, coupled with weak power resources and negligible contribution to national wealth. So far, the data from the present study clearly demonstrates the virtual lack of youth voice in policymaking,
as well as endemic poverty and dependency, which tends to structure young people’s citizenship and access to health services.

As pointed out in chapter three, the youth in Ghana face significantly higher levels of unemployment relative to the rest of the population. The aim here, of course, is not to construct a linear and mechanistic conceptualization of citizenship – that is, the idea that economic empowerment would automatically result in a reconfiguration of young people’s positionality within the citizenship narrative. Rather, the point is to underscore the fact that the social construction of young people within the broader citizenship discourse, and practices surrounding youth engagement suggest the need for critical rethinking of the participatory landscape.

8.4. Chapter Summary

The analysis of this chapter lends support to the idea that positive dividends emanate from youth engagement in the policy process. Specifically, that genuine involvement of young people in health initiatives engenders better policy outcomes. By exploring young people’s perspectives, experiences and expectations, one is drawn to young people’s agency and sophistication regarding their ideas about citizenship development. Young people do not conceptualize the state as an abstract entity, but an institutional force for social change, of which they constitute legitimate actors. In other words, the youth are fed up with conventional policy approaches that seek to marginalize them in the policy arena, particularly in relation to programs that directly affect them.
While the concept of participatory governance has been enthusiastically embraced as a key component of adolescent-oriented health initiatives, the analysis suggests that gaps remain particularly regarding the extent of young people’s involvement in the broader decision-making process. Insights from the focus groups raise important questions about inclusive citizenship, which is often masqueraded as consultation. Against this backdrop, the analysis points to the need to reconcile both informal and formal participatory approaches as meaningful pathways to citizenship development, as this holds significant implications for policy processes and outcomes. In short, adolescent health initiatives face a number of potential challenges that undermine their overall effectiveness, and thus could benefit from insights surrounding young people’s perspectives, experiences and expectations about program interventions.
Chapter Nine

Contested Citizenship: An Agenda for Policy Change

“Some parents think government should provide everything. But government cannot cater for it all. It is not the government that gave birth to the child” (Field Interview, 2017).

This chapter delves further into the structural dimensions of citizenship, and point towards mechanisms central to institutional and social change. The above quote by an educationist reflects a fundamental truth – that is, parents have a responsibility towards nurturing adolescents into productive adults, including the provision of their health needs. But at the same time, the quote is indicative of a deep-seated frame that challenges the social rights of citizenship. Such discourse, as a matter of fact, tends to shift the moral locus of adolescent health largely away from institutional to individual responsibility. Indeed, evidence suggests that such neoliberal language (dominant discourse) explains why the United States has consistently failed to establish a universal health care system (Hacker, 2004).

As noted in chapter three, the youth have been negatively impacted by social constructions that inadvertently punish them as “underserving,” hence the need to explore avenues by which they can effectively challenge the power imbalance that structures their citizenship entitlements. As Schneider et al. (2014) argue, the political power of target groups is defined by the extent of their political power resources. And as they note, the youth fall within the socio-economic bracket of ‘dependents’ and, therefore, “lack the political power to effectively demand more” (Schneider et al., 2014, p. 112). As I have explained in the previous chapter, young
people’s citizenship rights and access to health services are relatively limited partly due to their socially constructed identities within the citizenship discourse. These constructions perpetuate the cycle of inequality, disadvantage, and vulnerability. Perhaps the solution to the citizenship puzzle lies in the balance between contestation and state-activated access.

Recall the earlier point made in chapter six by a senior policy official regarding adolescent health:

It depends on the government; it also depends on those at the top of the bureaucratic hierarchy. Unfortunately, with the health budget, they just put everything in one basket. When it gets to the Ministry, the Ministry decides how to allocate it. So, if they don’t see the seriousness in really allocating enough resources to that side of programming, then it becomes a problem. So, it’s like you have few eggs and you’re sharing for a number of things – Malaria, HIV, STI’s, and Nutrition etc. So, in their own perspective, they’re looking at things that need the resources. So, it’s either you get someone who really has insight into adolescents and their problems, or we make so much noise about it in order to attract the needed support (Field Interview, 2017).

The above comment certainly raises troubling concerns about the future of young people’s health and well-being. As social movement theorists suggest, actors who lack resources on their own could expand them by forming alliances with more powerful groups or influential citizens (Keck & Sikkink, 1998; Tarrow, 2011). From a contentious politics perspective, collective actors, through connective support structures, can have a dramatic impact on the state. This is possible insofar as social actors are conscious of their shared identity and recognition of common
interests. Indeed, through collective challenges, actors are able to broaden and solidify their claim-making efforts.

In her study on reproductive rights and maternal health in Cuba, for instance, Johnson (2011) argues that the Federation of Cuban Women (FMC) mobilized around human rights issues pertaining to health care and gender equity. Through this strategy, coupled with the inflow of resources from international feminist networks, women secured a space in political decision-making. What is particularly striking in this case is that the government was initially unresponsive to the demands for women’s inclusion in certain policy areas. Also, through the FMC, networks of activists were able to advocate for progressive government openness to issues including family planning and sex education for young people, among others.

As social movement scholars argue, political opportunity structures determine how, and the extent to which people can act collectively. In other words, changes in state structures or the political system defines the nature of interaction between collective actors and the state. But as Tarrow (2011) suggests, “political structure on its own does not determine outcomes” (p. 250). Rather, outcomes are determined, to a large degree, by the strategies adopted by activists in response to the available opportunities.

By now, it should be clear that the global framing of adolescent health and well-being, coupled with Ghana’s transition to democratic rule, has opened up unprecedented opportunities that could give young people leverage against social
and institutional forces that challenge their citizenship. Recall the earlier point made in chapter six by the Team Leader of Palladium:

The world has changed now; young people are seen as having great potential to impact their own life and the life of their community. I think we didn’t encourage young people to be empowered enough to know that these rights are theirs, and that they can champion it themselves.

Different repertoires of contention have been used by collective actors in the Ghanaian context over time, including meetings (dialogue and consultation), lobbying, media campaigns, petitions, strike, and protest marches (Oppong et al., 2013). Given the weak capacity of youth groups in Ghana, the need for strategic and sustained engagement with broader powerful CSOs cannot be overemphasized. If the youth are to be effective in making claims on the state, innovation and ‘venue shopping’ cannot be stressed enough.

As discussed in chapter six, the allocation of financial resources for adolescent health development is based on the discretionary power of the Ministry of Health. Thus, the health budget and allocation of resources is an important area in which collective action could be directed. This would mean a strategic combination of the repertoires of contention. The discussion in chapter three has already provided some insight into the nature of Ghana’s CSO landscape, as well as the factors that undermine some CSOs in political decision-making. In light of this understanding, it is, therefore, instructive for youth groups or associations to navigate the political system carefully, particularly in terms of the CSOs they choose to associate with.
Most scholars tend to place heavy emphasis on the need for peaceful political exchanges between CSOs and the government (Debrah & Graham, 2015; Gyampo, 2013). This argument is premised on the idea that both entities complement each other in strengthening democracy and advancing development. Of course, it would be unwise to ignore such nuggets of wisdom. However, it is also imperative to ensure that CSOs do not become subservient to governments. Rather than waiting on the government to engage them in the policy process (which has proven to be tokenistic over time), CSOs can set the policy agenda. As noted by Carothers and Barndt (1999), a strong civil society can “discipline the state” to ensure that citizens’ interests are not taken for granted (p. 21). In fact, this thesis endorses the view shared by Carothers and Barndt (1999) that, “civil society can and should challenge, irritate, and even, at times antagonize the state” (p. 27).

But of course, this view needs to be qualified. Challenging the state over citizenship claims must be tempered with reason; there is no need risking repression through violent contention. Through meaningful, innovative, and sustained contentious strategies, young people could elicit active engagement with the issues through the political leadership. This goal can be fruitfully accomplished without subverting the authority of the state. To be sure, there is no guarantee that such alliances will yield the desired outcomes. But by adapting their strategies to the exigencies of the political environment, such collective action could potentially lubricate the machinery of institutional change. Undoubtedly, the global proliferation of women’s groups and sustained collective strategies help explain why women and children’s issues have garnered more attention and resources in
public policy relative to young people. This is particularly striking, especially considering that women, children, and young people constitute target groups under the same constructivist umbrella of “dependents.”

Put together, it is also worth noting that the state needs to play its role by being receptive to criticism, and fostering an enabling environment that encourages competition of ideas. In fact, Ghana’s political history teaches that when the state refuses to listen, there is a high tendency for groups to gravitate towards confrontation. There is no doubt that CSOs will continue to be part of the policymaking landscape, and it is imperative for governments to engage them in meaningful ways that strengthen their complementary properties.

**Chapter Summary**

There is power in contention that might help to define young people’s citizenship in relation to the state. The conventional understanding has been that the social rights of citizenship must be activated by the state in order for such benefits to be enjoyed by citizens. But as the analysis in this chapter suggests, these rights can be demanded. While Ghana has developed several initiatives in the area of adolescent reproductive health, the sustainability of such commitments remains open to debate. To be provocative, the attention given to adolescent health appears to rest on the benevolence of government and state officials, which suggests that young people’s health and well-being could potentially become an object of partisan politics well-suited to manipulation to serve the interests of the ruling elite.
As such, the prioritization of young people’s health, which is a significant component of citizenship, cannot be left in the hands of the state alone. From this standpoint, the youth could challenge the state over their citizenship claims, and considering their relatively limited power resources, forming strategic and sustained alliances with more powerful and influential groups may be helpful in setting the policy agenda. The progress made in the area of women and child health by women’s health advocates is instructive. With the emergence of new global protocols and shifts in the policy discourse on adolescent health, the substance of citizenship might well be a balance between contestation and state-activated access.
Chapter Ten

Implications and Conclusion

The central aim of this research has been to advance our understanding on the politics of health care, citizenship and policy intervention in the context of broader changes in the global policy environment. Specifically, the study explored factors that shape adolescent and youth health outcomes, examined the impact of global policy frames on citizenship development, and also enquired into young people’s experiences with adolescent health initiatives in Ghana. This chapter weaves together the findings of the study in a discussion that summarizes its implications and lessons for policy and health governance, with attention to the dynamics and complexities of the global and domestic political environment.

In keeping with the key objectives of this research, this dissertation contributes to the broader literature on health, youth studies, globalization, citizenship, and development studies. Importantly, the study offers critical insights that help to strengthen the relatively limited empirical knowledge on adolescent health interventions, particularly in the context of developing countries. So far, attempts in the literature to advance understanding on youth health have largely focused on micro-level factors to explain young people’s reproductive behavior and health outcomes. As such, the existing literature is limited in scope and provides a narrow understanding of the health ‘problem’. This, however, is not to say that micro-level factors are irrelevant to the conversation. By analyzing the ADHD and GHARH programmes in Ghana, this dissertation draws our attention to the need to
appreciate the complex intersection between micro-level elements and macro-level institutional forces and power dynamics that shape the global and domestic health landscape.

Against this backdrop, the analysis of this dissertation captures five key contextual factors that should concern policymakers and stakeholders in their quest to shape behaviour, protect, and advance adolescent health and well-being: (1) political structure; (2) economic framework; (3) cultural discourse; (4) policy framework; and (5) policy frames. In discussing these contextual factors, we see significant overlap across the aforementioned variables, which is particularly important because the dynamic reveals something about the complex interplay of ideas, institutions, actors, political and socio-cultural forces that dictate the broader framework for citizenship and policy intervention.

In line with the observations garnered from the analysis of this study, the following recommendations are worth considering as viable options by policymakers: (1) embrace a stronger accountability culture; (2) establish sustainable and concrete budgetary allocation for adolescent health; (3) encourage public-private partnerships, with attention to corruption and rent-seeking (4) adopt proper standards of human resource management; (5) pursue stronger community advocacy and broader gender transformation; and (6) encourage youth participation to enhance policy outcomes. The aforementioned strategies will be discussed in turn.

As the analysis of this study suggests, health care, citizenship and policy intervention are essentially tied to the framing and implementation literatures. The
discussion is, therefore, set in the theoretical context of an integrated analytical framework that appreciates the need to combine insights from the framing literature and implementation studies. Rather than focusing on the theoretical frameworks in isolation from each other, the study demonstrates that it is more fruitful to appreciate their combined analytical strengths. This not only allows for a better grasp of how ideas shape policy outcomes, but also their unique contributions to advancing understanding on the technical and discursive processes regarding adolescent health interventions and citizenship development.

One of the major finding from this study is that policy frames might or might not hold any implications for inclusive citizenship and adolescent health outcomes. As the study shows, the SDGs and other related global protocols have transformed the policy landscape in profound ways, such that young people are now recognized as key actors in the development agenda. In the context of Ghana, this thesis establishes that an open or enabling political structure is critical to institutional change and policy success. More specifically, it demonstrates that the Global Strategy and the AA-HA! framework, which are both ideational creatures of the SDGs, facilitated the implementation of the GHARH programme. The analysis suggests that the ADHD programme, which preceded the GHARH initiative, faced a myriad of difficulties largely due to domestic factors, as well as the lack of a coherent global discourse and consistent appeal to the human rights ideology.

Indeed, this research shows that the strategic framing of adolescent health and positioning within the broader development discourse helps to explain why the GHARH initiative produced relatively positive outcomes vis-à-vis the ADHD
programme. Through the GHARH initiative, significant effort was made to promote equity, availability and accessibility of health services for young people. These goals were addressed through investments in adolescent health corners, capacity building, and education awareness campaigns, among several other initiatives. Following from the successes attained in the GHARH intervention, key questions, however, remain in relation to how the programme can be sustained over time.

Drawing insights from both the ADHD and GHARH initiatives, it can be argued that there is an urgent need for a stronger accountability culture in Ghana. As illustrated in the ADHD initiative, poor accountability structures partly accounted for the subpar outcomes recorded throughout the programme’s trajectory. Overall, there was general lack of support for the programme, which manifested in various ways. Accountability was severely undermined due to poor supervision, coordination, monitoring and evaluation mechanisms. Given the difficulties of the ADHD programme from the outset, one might ask why it took several years for the challenges to be formally recognized and addressed at the policy level.

Perhaps the lack of appropriate evaluation tools and resources might help explain the problem. Or could the problem be symptomatic of a much broader cultural phenomenon that aligns with the linear rationalist idea that once programmes are initiated, implementation is bound to follow automatically? Might it also be the apparent disconnect between the state and other relevant stakeholders in the health industry? Or could the issue be related to general lack of interest in adolescent health? A better understanding of the underlying factors is
imperative in the context of arguments pertaining to the sustainability of the GHARH programme.

Ultimately, the responsibility of the state to safeguard the health and well-being of young people cannot be overemphasized. While the concept of decentralization should be celebrated, it should not be used as a veneer by the state to download its key responsibilities to other actors and agencies operating at the supranational or subnational level. Developing a strong accountability culture would require a state that is sensitive and responsive to the needs of young people, while recognizing the important oversight role of other actors such as development partners, NGOs, media, civil society, and other relevant stakeholders.

Although the GHARH programme is not reflective of an ideal accountability circle, it demonstrates that strong coordination and monitoring mechanisms matter. Palladium obviously had a greater stake in the programme’s management and ensuring value for the investments made in the adolescent health sector. As already mentioned, Palladium emerged as a preferred organization to implement the GHARH programme through a competitive bid. Arguably, then, the organization’s credibility was on the line, and had to be strengthened and sustained. Palladium was directly answerable to DFID and provided periodic reports on their activities and progress in delivering on their mandate. Indeed, the current global environment, characterized by shifts in funding away from the state towards NGOs, draws our attention to the nature of the political landscape that structured Palladium’s activities. Of course, as several scholars have suggested, some NGOs have managed to circumvent established accountability structures in
ways that make it difficult to reconcile their institutional mandate with local realities. Against this backdrop, the achievements of Palladium in relation to the GHARH intervention is instructive.

In a broader sense, the GHARH programme somewhat operated based on the principle of shared ownership and accountability for adolescent health outcomes, which is an essential feature of partnership. Key strategies, decisions, and timelines were discussed with the government and other stakeholders prior to implementation. But given that the programme has officially ended, the gains attained must be strengthened and sustained. This means that the established accountability framework must have a futuristic outlook that places emphasis on maintaining existing networks and accountability mechanisms, while searching for continuous improvement.

It stands to reason, then, that DFID and Palladium cannot completely absolve responsibility for the GHARH programme, as is often the case with most partnership arrangements. Of course, the national Government must actively drive the accountability process and demonstrate leadership that is reflective of the state’s commitments to improving adolescent health and development. It goes without saying that the current technological era offers exciting opportunities for network governance in the context of accountability strategies that must not be wasted.

Another important conclusion from this study is that adequate funding is critical for promoting, and particularly sustaining adolescent-oriented health initiatives. As this dissertation makes clear from the outset, the ADHD programme
failed to yield the desired outcomes due to inconsistent and inadequate funding. The GHARH initiative, on the other hand, received generous funding from DFID, which leveraged Palladium’s ability to embark on an ambitious health intervention across the Brong Ahafo region. But as revealed in the GHARH project, adolescent and youth health development is a resource-intensive sector that requires significant and sustainable funding. Financial support is required in several areas of programming, including but not limited to staffing, planning, capacity building, implementation, management, monitoring, among others.

Given that the GHARH project has exhausted its funding period, most stakeholders are concerned about the programme’s sustainability. To be sure, insufficient financing for adolescent health is not unique to the Ghanaian context, but a recurring global challenge that continues to receive attention across various polities. Donor-driven projects are mostly short-term, which suggests that effective and clear ‘exit’ financial strategies must be embraced at the outset of such interventions. In the case of the GHARH project, the research revealed that such discussions were ongoing at the time of implementation. This effort is laudable, but it appears the financial dilemma had not been resolved at the time of the field research (i.e., 3 years since the establishment of the programme).

Perhaps the ‘leap of faith’ strategy often adopted by governments needs further rethinking. To be sure, this is not to suggest that fleeting opportunities should not be maximized. The central concern here is that far too often, Ghanaian governments tend to implement programmes before thinking through sustainability measures, and empirical evidence suggests that most of such
programmes have become a burden unto themselves due to a plethora of difficulties. Notable among these programmes include the National Health Insurance Scheme (NHIS), Ghana School Feeding Programme (GSFP), and currently, the Free Senior High School Policy (which has increasingly become a politicized subject). While these programmes demonstrate governments’ commitment to advancing development and the well-being of citizens, it is imperative that such ambitious programmes are coupled with transparent and informed sustainability measures. A clearly mapped out sustainability strategy encourages government ownership of programmes, innovation and effective partnership.

Some scholars, practitioners and stakeholders have argued for the need to shift attention away from donor funding as it creates a cycle of dependency, uncertainty, and promotion of donor interests. Most importantly, such dependency shifts the locus of state responsibility for citizens towards non-state actors, thus encouraging laissez-faire political leadership. In the face of these debates, and considering increased competition for meager financial resources across various policy sectors, how should the financial challenge be addressed? There are no easy answers to this question, but the right policies, initiatives and strategies could be positive steps in the right direction.

First, it is imperative that the government backs its commitments with corresponding financial support. If the youth are considered assets in the broader national development agenda, then it stands to reason that their health and development needs should take center stage in the distribution of resources. In
other words, if the health and development needs of the youth are to be adequately met, they must be first prioritized as worthy of attention and development. This suggests the need for a critical restructuring of national spending on health in ways that go beyond mere political rhetoric to meaningfully affecting the discourse on adolescent health. The current national consciousness on adolescent health is a good first step, but concrete budgetary allocation, specifically for the adolescent health sector, is crucial.

As this study reveals, the health budget for adolescent development suffers from the lack of substantive allocation at the national level. As a result, the Ministry of Health has the discretionary power to allocate the resources as deemed fit. Thus, if the Ministry does not see the relevance of allocating resources to adolescent health programming, the development agenda is defeated, broadly speaking. Indeed, the political salience of adolescent health might be lost through competition with other programs, a situation that can best be described as a race to the bottom.

The lack of budgetary allocation at the top policy level raises even further provocative questions surrounding the politicization of adolescent and youth health. Given Ghana’s youthful population and the current wave of active youth politics, the issue of politicized health is a consideration that cannot be overlooked. Politicians could exploit adolescent and youth health development to maximize their electoral calculus. Therefore, an institutionalized budgetary allocation system would ensure continuity regardless of shifts in the political and administrative environment. To be sure, this is not to challenge decentralization as a system for
health administration. The emphasis here is that adolescent health development is a national agenda backed by policy, and thus, financial commitment must flow directly from the national budget to inform and streamline decisions taken at the ministerial and subnational level.

The past few years have witnessed a significant decrease in donor funding to developing countries, a development most scholars and development partners attribute to donor fatigue (MOH, 2015). In light of these developments, the current government’s political slogan, “Ghana beyond Aid,” is laudable. To be sure, this is not to dismiss the relevance of donor funding in meeting the country’s development needs. After all, even advanced industrialized countries have development partners. The key point here is that in order to make a better case for external funding, the political leadership must first demonstrate significant financial effort towards national initiatives. This would mean expanding the social safety net system beyond its current state.

As discussed in chapter three, partnership with the private sector might be useful in the government’s effort to respond to the demands of adolescent health, particularly in relation to financial constraint. However, it should be stressed that effective partnership cannot be established in the face of unnecessary difficulties that undermine investors’ confidence in the economy, and more specifically, the health industry. A number of institutional and structural constraints have already been discussed, and it is incumbent on the political leadership to take urgent action on addressing these concerns to foster an enabling, protective and productive PPP environment.
Of course, private investors are motivated by profit, and the tendency to treat young people as “clients” must be matched by due diligence and concern about accountability rooted in principles of trust, respect, transparency, integrity, and moral consciousness. Various scholars have pointed out a variety of ethical issues that could arise from the use of partnerships in both developing and advanced industrialized countries (Aryeetey & Owuo, 2015; Kernaghan et al., 2000; Whiteside, 2009), and it is instructive to take such insights into deep consideration. In short, responsible partnerships should be embraced as an integral part of the discourse on adolescent health, especially considering that PPPs could also undermine citizenship.

In order to further strengthen domestic financing for adolescent health, it is imperative to stimulate economic growth. Undoubtedly, the slow pace of economic development helps to explain the high levels of youth unemployment. Aggressive pursuit of job creation ventures inexorably attracts investment opportunities, which could be beneficial for advancing adolescent health in both the short and long term. The current government’s agenda on job creation is a step in the right direction, but it is imperative to integrate adolescent health into this broader thinking on national development. This is important, as the focus on young people’s health could be lost in the rhetoric of competing priorities. As noted in the National Health Policy (MOH, 2007), health is a precondition for wealth. Thus, the need for the prioritization of young people’s health and well-being cannot be stressed enough.
While the effort at job creation is laudable, it is equally important to address financial leakages in the political system, which largely occur through corruption. Clearly, this social problem has negatively impacted economic growth over the years. A recent high-profile scandal that has attracted significant political attention relates to the Ghana Youth Employment and Entrepreneurial Development Agency (GYEEDA). GYEEDA is an offshoot of the National Youth Employment Programme (NYEP), which was established in 2006 to mitigate high youth unemployment and underemployment. However, based on a ministerial impact assessment and review, it was discovered that the programme had resulted in significant loss of taxpayers money occasioned by corruption and fraudulent business dealings (Joyonline, 2013). According to the assessment report, the programme suffered from a number of institutional and system failures including: lack of an appropriate governance framework; poor financial oversight; poor human resource management practices arising from cronyism and political patronage; and sub-standard contracts, among others.

Like other countries in sub-Saharan Africa, scholars have noted that corruption in Ghana is an endemic and multifaceted problem that spans the judiciary, bureaucracy, private sector, and various institutional bodies (Amankwah, Bonsu, & White, 2017; Asiedu & Deffor, 2017; Nsia-Peprah, 2017). Important to the discussion is the fact that corruption undermines economic progress and development, erodes citizen trust in state institutions, creates distortions in government programmes, encourages political instability, and fosters a cycle of poverty, inequality, and exploitation (Asiedu & Deffor, 2017; Nsia-Peprah, 2017;
Pring, 2015). Certainly, a key strategy to mobilizing sufficient resources for the advancement of adolescent health is through economic investments. However, the purpose of such investments is woefully defeated if the returns are lost through ineptitude and blatant corrupt practices. Against this backdrop, strong political leadership and political will is obviously an asset.

Related to the issue of poverty and youth unemployment, this study also revealed that migration accounts for the high adolescent pregnancy burden in the Brong Ahafo region. Due to disproportionate levels of poverty in the Northern part of Ghana (i.e., Northern, Upper East, and Upper West Regions), most of the youth tend to believe that emancipation from their socio-economic predicament lies in migrating to the South. However, majority of these young people become disillusioned, homeless and vulnerable upon migrating due to the apparent lack of jobs and envisioned opportunities in the so-called big cities. In addition to the issue of vulnerability, these young migrants also carry along their cultural beliefs and practices, including early marriage. Regrettably, the high rates of adolescent pregnancy in the migrant communities not only challenges the health and well-being of the youth, but also reproduce intergenerational streetism and poverty – a vicious cycle that does not bode well for community and national development.

Given these considerations, the Ghanaian government, as a matter of urgency, needs to focus attention on bridging the historical North-South divide. While several initiatives have been undertaken over the past few years to address the issue, poverty still remains endemic to the Northern region. According to the WorldBank (2011), for instance, measures such as geographical targeting and
addressing holes in safety nets could be helpful in tackling the issue. However, it is worth mentioning that over the past decade, the development of the Northern region has particularly been a subject of ‘political game’, used to advance the electoral interests of politicians.

A related factor that further compounds the issue is the historical problem of corruption. In 2010, for instance, the Savannah Accelerated Development Agency (SADA) was established to transform the Northern part of Ghana by bridging the age-long poverty and development gap. However, over time, it was discovered that rather than accelerating development, the program had been used as a vehicle for “monstrous” economic crimes against the state by serving as a surreptitious channel for corruption and mismanagement (Joyonline, 2017a). While SADA has been restructured by the current political administration, its impact on addressing systemic poverty and vulnerability in Northern Ghana remains to be seen.

A detailed strategy for reducing youth migration to the South is beyond the scope of this study. Nonetheless, one could argue that the reformed SADA programme (presently known as the Northern Development Authority) is a step in the right direction, as it aims to provide livelihood opportunities to the youth within the framework of responsive and accountable institutions. The key objectives of the Northern Development Authority (NDA) are to:

- Accelerate economic and social development in the Northern Development Zone through strategic direction in the planning and prioritization of development projects;
• Mobilize public resources including financial resources and private and public investments for the accelerated economic and social development of the Northern Development Zone;

• Co-ordinate development activities in the Northern Development Zone with the aim of ensuring that:
  
  a. Public resources are effectively utilized; and
  
  b. Private sector investments achieve maximum development impacts to reduce poverty and deprivation in every part of the zone; and

• Formulate and implement initiatives towards achieving gender equality and empowerment of vulnerable groups in the Northern Development Zone *(Northern Development Authority Act, 2017)*.

It is clear that the new policy for the development of the Northern sector is quite comprehensive in scope, and holds the potential to transform the North-South development deficit. Nonetheless, as with other parallel ambitious and promising developmental initiatives undertaken in the past (which have often gone awry), it is important to stress that the state needs to consciously live up to its responsibility and commitment to good governance.

The fourth important conclusion of this study is that adopting proper human resource management policies and practices is critical to strengthening health programs for young people. As this study suggests, the establishment and refurbishment of adolescent health corners is a laudable initiative. However, the GHARH programme was limited to the Brong Ahafo region, and later extended to
some parts of the Ashanti region. Given the increasingly youthful character of Ghana’s population and broad implications of adolescent health development, it is clear that adolescent health programming should be expanded beyond these two regions to facilitate young people’s accessibility to sexual and reproductive health services. But as discussed, the expansion of these programmes must be matched with corresponding health personnel. The current distribution of health personnel and arbitrary culture surrounding staff transfers raises serious concerns.

The issue of staff transfers becomes clearer when we undertake a cost-benefit analysis. It is not only more expensive to train new health personnel when existing staff are transferred at whim, but also constitutes an unnecessary waste of scarce resources. In fact, such practices also reduce staff morale, and could possibly lead to loss of institutional memory over time. The issue of institutional memory is quite problematic, especially when situated in the context of my own fieldwork experience. Upon visiting a key partner involved with the implementation of the GHARH programme, I was informed that the focal person to speak to had just been transferred. As such, very little information could be obtained from the available staff as they had very limited knowledge about the programme.

Similar problems could beset the efficient and effective running of institutions and facilities established purposely for advancing young people’s health and well-being. As such, strong human resource management policies and a healthy culture of staff recruitment is recommended. Also, this study highlights the challenge of adolescent health intervention, particularly within the hard-to-reach communities at the local and district level. As a result of these challenges (e.g.,
distance, transportation, infrastructure etc.), some of the health personnel are reluctant to undertake interventions in these communities. Thus, it would be useful to establish a concrete, consistent, and graduated incentive package system designed to attract, motivate, and retain health personnel and peer educators working at the national, regional, and district levels. Furthermore, the staffing of the health facilities, particularly adolescent corners should be gender sensitive. As this study shows, the health corners visited as part of the field research were all female dominated in terms of staffing. While this recruitment issue may not necessarily reflect a broader pattern across other regions in Brong Ahafo, it raises potential accessibility and privacy concerns among male adolescents.

The fifth conclusion of this study, and related to the point above, is the need to pursue stronger community advocacy and broader gender transformation. As this thesis suggests, culture (as an institution) interacts with, facilitates or challenges policies and programmes aimed at improving adolescent health and well-being. In the case of the GHARH intervention, this study shows that although the influence of modernized or Western values is worth paying attention to, such explanations are inadequate in explaining young people’s sexual and reproductive behaviour. More specifically, youth resistance to interventions is also underpinned by masculinity ideations and power dynamics that structure daily discourse. Due to this complex interplay, one could interpret youth resistance to women’s empowerment as an ideational response to perceived challenges regarding their traditional authority and dominance in society. As the study reveals, some young boys and men believe that empowering women produces unnecessary barriers in
their quest to develop sexual relations with the young girls in their communities and, therefore, deliberately create hostile and unsafe environments for interventions.

Based on this ideational premise, it is imperative to engage young boys and men (including fathers) as development partners in shaping the institutional discourse that creates and reproduces gender inequality and vulnerability. As I have argued in this dissertation, the general idea that empowering young women will equip them with greater autonomy and capacity to successfully navigate the prevailing gendered order is flawed, hence the need to redirect attention to their male counterparts. As pointed out, a value-based approach that takes account of the differences regarding the traditional socialization of boys and girls in the Ghanaian society could be used to make a difference. In other words, if culture (as an institution) is considered a positive social transformative force, then affecting the belief and value system of young people holds significant implications for adolescent health, as well as broader social change and development. To be sure, problematizing masculinity is not a panacea to the historical problem of gender inequality, but shifting the conversation to a more nuanced venue offers rich perspectives on tackling the challenge.

The study also reveals resistance to health interventions at the community level. While some communities view adolescent health interventions in a more positive light, others also believe it encourages promiscuity and risky sexual behaviour among young people. Against this backdrop, stronger advocacy, coupled with sustained local community engagement by government and major
stakeholders such as the media, civil society, community and religious leaders etc. remains central to behavioural change and broader social transformation. As the research shows, this strategy offers a fruitful pathway to advancing national and global development.

This study also makes clear that culture intersects with policy to shape adolescent health interventions. Indeed, culture and policy are a function of ideational mechanisms that give force to the production and reproduction of gender inequalities and inequities. While this research reveals that efforts have been made to address the stigmatization of adolescent pregnancy over the past few years, it seems certain policies and practices continue to undermine such efforts. Historically, pregnant adolescents in school have been subject to various punitive actions as a form of discipline and deterrent to their peers. This phenomenon, although publicly denounced, is still practiced and also extends to some churches, where the supposed culprits (i.e., the pregnant adolescent and their partner) are reprimanded for their behavior.

Of particular concern is that these practices are embedded and legitimized by policy. A typical example is reflected in incidents where pregnant adolescents, as a matter of educational policy, have been barred from writing their exams or asked to withdraw from the educational institution by school authorities. As it stands, policy makers and other stakeholders are divided on the content and extent to which sexual and reproductive health education should be provided in schools. Although the educational curriculum has recently been revised, the debate on
comprehensive education about sexuality and reproductive health has yet to be fully resolved.

The main takeaway from these developments is that the culture of silence surrounding the issue of sexuality has been central to, and continues to structure ideas and conversations about adolescent and youth health development. Cultural norms will continue to be a part of the national landscape, and it is important to work within this cultural framework in ways that do not compromise adolescents’ health and well-being. As argued in chapter seven, an integrated ideational policy discourse requires careful attention to contextual factors that impede young people’s health development. In line with this understanding, it is equally important not to lose sight of the substantive frames that provide currency to young people’s identity rights, entitlement, and well-being within the broader health and development discourse.

Finally, this study draws our attention to the importance of youth participation in the policy process and, more specifically, in relation to adolescent-oriented health initiatives and interventions. The discussion addresses the issue of inclusive citizenship and youth development. Fundamentally, the objective was to understand young people’s perspectives, experiences, and expectations regarding citizenship development, as well as explore how young people are incorporated into decision-making structures. As the study shows, the youth were somewhat engaged in the GHARH intervention, a significant development that underscores the relevance of youth participation in the policy process. By drawing insights from the RCA approach used by Palladium in engaging the youth, the study
demonstrates the merits associated with encouraging youth voice and participation in health interventions. Indeed, through this research, it has become increasingly clear that when young people are meaningfully engaged, they respond positively to interventions aimed at improving their health and well-being. This finding resonates with other studies on health, youth studies, citizenship, and development studies that emphasize participatory governance as central to the democratic discourse.

However, this thesis also highlights the need not to confuse consultation with inclusive citizenship. This is particularly true in the case of the RCA initiative, where young people were consulted without clear indicators or knowledge about the extent to which their opinions were incorporated into the GHARH intervention. This is central to the citizenship discourse, and challenges the RCA’s emphasis on informal participatory structures. The focus group discussions that I conducted with young people in Brong Ahafo suggests that contemporary youth demonstrate agency in their day-to-day interactions, and have a predisposition towards active engagement as relevant stakeholders in the decision-making process. Against this backdrop, I argue that privileging informal participatory arrangements sells the concept of inclusive citizenship short. An approach that appreciates the virtues and limitations of both informal and formal participatory mechanisms rather makes sense insofar as a contextualized approach is adopted.

As the study also makes clear, the economic premise upon which youth citizenship is defined is hollow, and demonstrates a poor understanding of the broader issues. A conceptualization of citizenship that rests on the protection of
young people’s social rights accords prominence to their citizenship claims on leadership, agency, and better integration into the community, regional, and national governance framework. Given the passive character of state-activated citizenship, this thesis maintains that the youth could also contest their citizenship claims through legitimate institutional channels, a political strategy that aligns with the broader understanding of democratic citizenship.

Participatory engagement platforms such as Community-based Health Planning and Services (CHPS), and Participatory Action Research are estimated to be popular mechanisms for broad community engagement (Flicker, 2008; MOH, 2015). In the context of inclusive citizenship, various strategies, including the aforementioned mechanisms, can be modified and strengthened to engage youth in health programming and interventions. In the present digital age where the youth are considered to be technologically savvy, maximizing the use of technology in reaching out to young people cannot be overemphasized. As the GHARH intervention demonstrates, technology is a particularly useful asset in the adolescent health intervention toolbox, and could be harnessed for meaningful youth engagement.

Some scholars have argued that the lack of education and technical expertise, as well as language barriers, pose significant challenges to participatory processes (Kpessa, 2011). In line with this understanding, it is essential to note that varied approaches to youth engagement are required in different contexts, and most importantly, appropriate and timely training should be provided prior to intervention to ensure that the youth are well oriented to engage the issues in a
meaningful way. In fact, the lack of knowledge and expertise cannot be used as an excuse to legitimize the culture of exclusion. As already discussed, school health clubs were established as part of the GHARH intervention, and these avenues could serve as opportunities for training and building youth confidence and capacities for the larger purpose of citizenry participation. Also, such participatory mechanisms can be used to transform the gendered discourse on health clubs as a more suited forum for girls.

As discussed in chapter three, progress has been made in terms of addressing gender-based inequalities that dominate the socio-political landscape in Ghana. Yet women remain disproportionately disadvantaged in social policy and politics relative to their male counterparts. Understanding these realities within the broader context of participatory governance, it is important to recognize the impact of gender on participation, and make gender visible in the attempt to engage young people in the policy making process. In other words, the youth should not be conceived as a homogenous group, but as an entity with complex identities. In line with this understanding, young girls must be engaged with a proper understanding of the power dynamics and privileged spaces that reinforce the institutional culture of social exclusion. This is particularly important not only to the participatory discourse, but also to the persistent issue of social justice and citizenship development.

Undoubtedly, the development and sustainability of adolescent focused health initiatives is open to question in the face of subterfuge frames that reinforce the historical practices that have long provided legitimacy to the dominant
discourse on maternal and child health. Tellingly, the nation’s National Health Policy (which is the overarching policy framework for health development) explicitly projects women and children’s health as critical for national wealth (see figure 3 below). But if the youth have long been considered the ‘engine of growth’ in the development discourse, then, failure to recognize their identity in the national health discourse is arguably a puzzle that necessitates attention to national and global politics.

The picture becomes clearer when examined within the contextual reality that young people are still subsumed under maternal and child health. Ironically, the deceptively complex framing of adolescent health in global discourse suggests that despite the revolution in identity rights, young people might still be at risk of being left behind in the development agenda. Figure 3 below obviously raises important questions about citizenship, and the political efficacy of policy commitments to adolescent and youth health. Perhaps this projection might be an inadvertent omission. Nonetheless, the study suggests that it is imperative to update this policy document to reflect current discursive shifts in the global and national health discourse.
Figure 3: Institutional Framework for Health Development

The analysis of this study also suggests that at the heart of the citizenship discourse is the normative balance between contestation and state-activated citizenship. Much has been said about the latter, and in relation to the former, I have argued for the need to shift attention towards strategies by which the youth can effectively challenge the power imbalance that undermine their citizenship entitlements. Given the limited power resources of the youth, constructive and sustained engagement with powerful civil society groups with similar or shared interests could be helpful in advancing and protecting their social rights of citizenship. Of
course, there are no guarantees that such collective efforts will yield the desired outcomes, but sustained advocacy and commitment provides encouragement in terms of future policy direction.

All in all, this dissertation advances further understanding on the complex dimensions of citizenship and health care politics within the broader context of adolescent and youth health development. It teases out the broader political, social, and policy issues, and addresses salient theoretical and empirical gaps in the literature, thus contributing to the growing body of knowledge. While the study speaks specifically to the Ghanaian context, the findings are relevant to polities across the globe, particularly developing countries. There are no easy answers to the complex issues and questions surrounding young people’s health and citizenship development. But the Ghanaian experience suggests that with the necessary political will, coupled with the right policies, health initiatives and innovative strategies can have explosive and sustainable impact on young people’s overall well-being and development. Put together, an integrated ideational policy discourse, as discussed in this dissertation, offers a constructive discursive mirror moving forward.
References


