Building Partnership with Faith-Based Organizations: Integrating Youth-Friendly Services into the Health Delivery System of the Christian Health Association of Ghana

African Youth Alliance (AYA)
AYA
The African Youth Alliance (AYA) was launched by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Fund for Population Activities (UNFPA) in the fall of 2000. AYA was funded with a grant from the Bill and Melinda Gates Foundation and administered through the U.S. Committee for the UNFPA. AYA sought to improve overall adolescent sexual and reproductive health and reduce the spread of HIV/AIDS and other sexually transmitted infections in four African countries – Botswana, Ghana, Tanzania, and Uganda.

The main beneficiaries for the project were young people between the ages of 10 and 24, with an emphasis on 10-19 year olds. The secondary targets included teachers, health workers, social workers, and parents. In addition, the tertiary target group included religious leaders, the media, politicians, and policy makers. The latter group was crucial for creating a supportive environment for the project. The project was developed with a focus on six broad areas, including:

1) Advocacy and policy – The creation of supportive community and political environments through advocacy and policy efforts at both the national and community levels, and efforts to improve communication between young people and the adults in their lives.
2) Behavior change communication – The development and expansion of behavior change communication through interpersonal communication; folk and mass media, including drama; life planning skills programs for youth; peer education and counseling; and social marketing campaigns.
3) Youth-friendly services – The improvement of young people’s access to – and the quality of – reproductive health services by developing, expanding and institutionalizing youth-friendly services in a variety of settings.
4) Institutional capacity building – Strengthening the institutional capacity of the country-level partners so they can better plan, implement, manage, and sustain programs and services.
5) Life and livelihood skills development – The integration of sexual and reproductive health into existing livelihood skills development and training programs for youth.
6) Coordination and dissemination – Coordination and information sharing of program activities, lessons learned, and best practices.

Pathfinder International was responsible for the youth-friendly services and institutional capacity building components implemented in each country.
Pathfinder International
Pathfinder is a comprehensive reproductive health care organization whose programs address reproductive health in all its dimensions. Pathfinder works to improve individuals’ access to quality family planning and reproductive health information and services, provide young people with sexual and reproductive health services tailored to their needs, offers care for women suffering complications of unsafe abortion, prevent the spread of HIV/AIDS while providing care and treatment to those living with HIV/AIDS, and advocate in the U.S. and abroad for sound reproductive health programs and policies. In all of its programs, Pathfinder works with communities, partner organizations, and governments to strengthen local skills and create lasting change.

In Ghana, Pathfinder was first registered and incorporated as an international nongovernmental organization in January 2002. Until the initiation of the AYA project, Pathfinder had not been present in the country, though it had funded limited family planning activities through the Planned Parenthood Association of Ghana.

The Christian Health Association of Ghana (CHAG)
The Christian Health Association of Ghana (CHAG) is an umbrella association of Christian Health Institutions in Ghana. The association, first known as the Christian Hospital Association of Ghana, was founded in 1967 with the assistance of the World Council of Churches, the Catholic Bishops Conference, and the Christian Council of Ghana. It was registered as a nonprofit, nongovernmental organization (NGO) in 1968. The aim of CHAG is to foster closer partnership between church-related health services and the Ministry of Health in order to promote competent total health care for the people. Its mission is “to provide holistic spiritual and physical health services in fulfillment of Christ’s ministry to people of all races, colors, and religions and social/economic status.”

CHAG grew from 25 health institutions in 1967 to 152 institutions in 2005. These institutions are made up of hospitals, primary health care facilities, and health-related personnel training centers in the country. Together, the CHAG members provide health care for an estimated 35-40% of the population, mainly in the rural underserved areas, making CHAG the second largest provider of health care in Ghana, following the Ministry of Health.

The highest decision-making body of CHAG is the council, which meets once every year. CHAG also has a 16-member executive board drawn from the health directorates of member health institutions. There are five specialized subcommittees of the executive board, which provide effective direction to CHAG and support the management to effectively and efficiently manage the affairs of the association. The office of the executive secretary is subordinate to the CHAG board and is responsible for the day-to-day administration of the secretariat.
Executive Summary

The Window of Hope Project was a three-year collaborative project between the African Youth Alliance (AYA)/Pathfinder and the Christian Health Association of Ghana (CHAG). The goal of the project was to integrate Youth-Friendly Services (YFS) into the mainstream health service delivery of 10 CHAG facilities. The facilities are located in urban, peri-urban and rural communities in three regions and seven districts of Ghana. Six health directorates of CHAG participated in the program, including: Presbyterian, Methodist, Church of Christ, Seventh Day Adventist, Salvation Army, and Pentecost.

Integration of YFS into the health service delivery systems of Faith-Based Organizations (FBOs) is an appropriate and critical step toward increasing access of SRH services to young people. However, particular sensitivity around adolescent sexual and reproductive health issues makes it difficult for FBOs to integrate YFS into their health service delivery system. In the past three years, AYA/Pathfinder has worked with CHAG to integrate YFS within 10 of its facilities. This case study describes that partnership, including both the dialogue and integration processes. It also presents the concept of YFS, the case of integration, the facilitating factors, achievements, challenges, and lessons learned.

The case study is based on a review of documents concerning the implementation of the project including: proposals; quarterly, annual, and field reports; and minutes of meetings. The review of the documents provided background information and context for further understanding of the integration process. The review was supplemented with interviews and focus group discussions with the project’s key players such as the board and management of CHAG, five of the health coordinators and administrators, members of facility management committees, AYA facility project managers and supervisors, service providers, peer providers, and community leaders.

Key achievements of the AYA/Pathfinder and CHAG partnership include:
- YFS has been fully integrated into 10 health facilities and has become part of their health delivery system. Outreach to young people has also been integrated into the facilities’ health delivery systems.
- More youth have been reached with Adolescent Sexual and Reproductive Health (ASRH) information and services. The static and outreach strategies resulted in 449,723 youth visits and contacts and the distribution of 117,699 male condoms.
- The environment for providing YFS has improved and access to YFS has increased.
- CHAG has demonstrated commitment to and the sustainability of YFS through financial contributions and other forms of support.
- Youth representatives serve on the facility management committees and there is increased youth involvement in the design, implementation, and monitoring of the YFS facilities.
- Communities are more aware and accepting of CHAG facilities providing ASRH information and services to young people.
The monitoring and evaluation capacity of CHAG service providers and managers has increased and includes the ability to use the facility assessment tool, collect and analyze service statistics, and design and implement mystery client studies.

Lessons learned from the program include:

- Adequate knowledge and understanding of faith-based organizations is critical in soliciting the support of FBOs on sensitive issues such as ASRH;
- Commitment and a flexible approach are needed to work with faith-based organizations;
- Knowledge of government policies on ASRH, the Bible, and the mission and by-laws of faith-based organizations serve as facilitating factors in the negotiation process;
- Extensive dialogue and compromise is often required to gain support for sustainability of activities and to reach consensus on programmatic issues, such as the provision of contraception; and
- Young people should play a meaningful role at every stage of the design, implementation and evaluation of the project and should be used as project advocates.

**Purpose and Methodology**

The objective of this case study is to document the process of integration of Youth-Friendly Services (YFS) into the health delivery system of the Christian Health Association of Ghana (CHAG) under the African Youth Alliance (AYA) program. The documentation of this project experience will provide guidance in designing and managing similar programs. It will also contribute to the global effort to improve the health and wellbeing of young people.

This case study is based on both primary and secondary sources of data. During project implementation, much of the project was documented through quarterly reports, minutes of meetings, and field monitoring reports. Therefore, these documents were reviewed to provide background information and context. In addition, thirty key stakeholders were interviewed, including the YFS program technical officer of AYA/Pathfinder, the executive secretary of CHAG, CHAG board members, health coordinators and administrators of the affiliated religious organizations, facility management committee members, AYA/Pathfinder-supported facility project managers and supervisors, health care service providers, peer providers, and community leaders. Each stakeholder was asked eight questions about their experiences of integrating YFS into their health delivery system, including why they were motivated to integrate YFS, challenges encountered, and how they intended to sustain activities after the exit of AYA.
The Problem

Adolescent Reproductive Health Status in Ghana

Young people account for about one-third of the sub-Saharan African population. Their Sexual and Reproductive Health (SRH) needs cannot be ignored. Young people in sub-Saharan Africa are at acute risk for Sexually Transmitted Infections (STI), HIV infections, unintended pregnancies, and unsafe abortions.\(^1\) Approximately 42% of Ghana’s 20 million people are below the age of 15. A third (31.9%) of the population is between 10-24 years. By age 24, 78% of males and 85% of females have engaged in sexual activity.

HIV/AIDS is Africa’s biggest challenge and has devastated the economies, communities, and development of some sub-Saharan African countries, as nearly 1,000 adults and children die from AIDS each day in the region. The continent is losing a significant portion of its most productive workforce. The executive director of UNAIDS has said that social and economic development will not be able to flourish until HIV/AIDS is rapidly brought under control.\(^2\) Approximately one-half of all people currently infected with HIV are females in developing countries, 25 years old, or less. The National AIDS/STI Control Programme report has revealed that young people between 10-24 years account for 13% of the cumulative AIDS cases reported in Ghana.\(^3\) The report further confirmed that women are infected at an earlier age than men. Though the estimated HIV/AIDS prevalence rate among 15 to 24 year olds in Ghana dropped from 3.4% in 2001 to 2.5% in 2005, some of the age groups recorded rates between 4.5% (20-29) and 3.5% (15-49).\(^4\)

Teenage pregnancy and unsafe abortion are common and of major concern in Ghana. Of all pregnancies reported to public health facilities in 2001, about 15% were to mothers between the ages of 15-24.\(^5\) Although the true number of abortions occurring in Ghana is not known, unsafe abortion is believed to be one of the major contributors to the high maternal mortality rate in the country. A recent maternal mortality survey estimated the rate of abortion at 17 induced abortions per 1,000 women of childbearing age. The study found that the majority of women who have had an abortion were younger than 30 years, more than a third had never given birth, and a quarter had two children.\(^6\) According to the Ghana Demographic and Health Survey, among young pregnant women between 15-19 years, about 39% terminated their pregnancies.\(^7\)

Various studies in the country have established that knowledge of family planning is very high, while its usage is low. The 2003 Ghana Demographic and Health Survey showed

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\(^4\) Ibid.
\(^5\) MOH/GHS, 2002.
\(^7\) Measure DHS (1998). Ghana Demographic and Health Survey.
that over 98% of currently married women and 98% of all women have heard of at least one modern contraceptive method. Similarly, 80% of women know where they could obtain a modern method of contraception and mention mass media as the most important source of information about family planning. Use of contraceptives, however, is low. In 2003 it was estimated at 19%. Meanwhile, unmet need for contraception among all ages is high, but higher among young people. It is estimated that of sexually active youth, 57% of 15 to 19 year olds and 41% of 20 to 24 year olds have an unmet need for contraceptives.

The Case for Integration

Traditionally in Ghana, the provision of Family Planning (FP) and Reproductive Health (RH) services has not included services for young people. The first FP programs started in 1967 by the Planned Parenthood Association of Ghana (PPAG) and focused only on married couples. Young people were excluded from the FP clinics’ services until 1994, when the 1969 Population Policy was revised. The spread of HIV/AIDS, the increasing reproductive health needs of young people, and the recommendations of the International Conference on Population and Development increased the urgency of addressing the SRH needs of young people.

The public sector health facilities alone cannot cope with all the SRH problems that confront young people. Therefore, all possible channels for the provision of SRH information and services to young people must be explored. Faith-Based Organizations (FBOs) can play a crucial role in addressing the SRH problems of young people if youth-friendly SRH services are integrated into their service delivery.

CHAG health facilities account for approximately 35-40% of healthcare delivery in Ghana. Significantly, most of CHAG’s facilities are located in rural, underserved communities. Therefore, by working with CHAG, AYA/Pathfinder could increase its program reach and sustainability and build on the trust developed by the local church facilities. Because more than two-thirds (69%) of Ghanaians are Christian, and are potentially using health services provided by Christian health organizations, AYA/Pathfinder felt that by integrating YFS into CHAG facilities, they would reach a vast portion of the population.

ASRH is a sensitive subject and can be difficult to discuss in public, let alone integrate into the health facilities of FBOs. It can be difficult for some Christians to accept that unmarried young Christians have sexual relationships. Some people feel uncomfortable about the provision of SRH services to unmarried people, particularly youth. In particular, there is opposition to condom distribution to young unmarried people. AYA/Pathfinder therefore has had to work within the sensitivities of the community in order to capitalize on the potential of FBOs to reach large numbers of youth with YFS, including the distribution of condoms and other contraceptives.

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102000 Ghana Population and Housing Census.
The Solution

AYA and the Window of Hope Project

In 2000, Ghana was selected as one of the four countries to benefit from funding from the Bill and Melinda Gates Foundation for the African Youth Alliance Program. Through the YFS component, AYA/Pathfinder worked with CHAG to integrate YFS into its service delivery system under the Window of Hope Project.

Youth-Friendly Services

YFS are defined as services that are able to effectively attract young people, respond comfortably to their needs, and retain young clients for continuing care. YFS involves a conscious and systematic effort to ensure that the provision of SRH information and services to young people is an integral part of the service delivery system.

Through its previous work, Pathfinder has developed a list of the key elements of YFS. Under AYA, these have been categorized into essential and supportive elements as presented in Box 1.

<table>
<thead>
<tr>
<th>Box 1: Characteristics of Youth-Friendly Services</th>
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<tbody>
<tr>
<td>Essential</td>
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<tr>
<td>• Convenient open hours;</td>
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<tr>
<td>• Privacy ensured;</td>
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<tr>
<td>• Competent staff;</td>
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<tr>
<td>• Respect for youth;</td>
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<tr>
<td>• Minimum package of services available;</td>
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<tr>
<td>• Sufficient supply of commodities and drugs;</td>
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<tr>
<td>• Range of family planning methods offered;</td>
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<tr>
<td>• Emphasis on dual protection/condoms;</td>
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<td>• Referrals available;</td>
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<tr>
<td>• Young adolescents (12-15 years-old) are served;</td>
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<tr>
<td>• Confidentiality ensured;</td>
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<td>• Waiting time not excessive;</td>
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<td>• Affordable fees; and</td>
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<tr>
<td>• Separate space and/or hours for youth.</td>
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<tr>
<td>Supportive</td>
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<tr>
<td>• Youth input/feedback to operations;</td>
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<td>• Accessible location;</td>
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<tr>
<td>• Publicity for YFS;</td>
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<tr>
<td>• Comfortable setting;</td>
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<tr>
<td>• Peer providers/counselors available;</td>
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<tr>
<td>• Educational materials available;</td>
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<tr>
<td>• Delay of blood test and pelvic exam, if possible;</td>
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<tr>
<td>• Partners welcomed and served;</td>
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<td>• Nonmedical staff oriented;</td>
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<td>• Provision of additional educational opportunities;</td>
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<td>• Outreach services available.</td>
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The AYA/Pathfinder approach to YFS focused on the following:

- Building on existing resources, using available facilities and service providers;
- Reaching young people through a variety of channels such as static clinics, outreach, peer education, and the private and commercial sectors;
- Establishing links with effective referral sites;
- Creating partnerships with other institutions to sustain efforts;
- Instituting a minimum package of youth-friendly SRH services, including:
  - Information and counseling on sexuality, safe sex, and reproductive health;
  - Contraceptive method provision (with an emphasis on dual protection);
  - STI diagnosis and management;
The process of integrating YFS into the health service delivery of CHAG can be categorized into three phases (Box 2). Phase one involved identifying both barriers and facilitators for integration. Phase two focused on dialoguing with key CHAG stakeholders, from the CHAG council to the local churches and communities. Phase three was the process of integrating YFS into existing RH service delivery.

**Box 2. Process of Dialogue & Integration**

**Phase 1: Identification of Barriers and Facilitating Factors**
- Identification of barriers and
- Identification of facilitating factors.

**Phase 2: Dialogue Process**
- Sensitization and negotiation with CHAG executive secretary;
- Sensitization and negotiation with the CHAG board;
- Sensitization of health coordinators and administrators;
- Selection of project implementation facilities; and
- Project design, approval by CHAG Board, and signing of contract.

**Phase 3: Integration Process**
- Facility assessment and development of quality improvement action plans;
- Training of service providers and orientation of all facility staff on YFS;
- Selection and training of peer service providers and nontraditional condom distributors on delivering nonclinical YFS;
- Refurbishment and other quality improvements
- Sensitization sessions with community, churches and mosques by providers from YFS facilities and peer service providers; and
- Monitoring and evaluation of the intervention.

**Phase 1: Identification of Barriers and Facilitating Factors**

Successful integration of YFS into mainstream health services requires careful identification of the barriers and facilitating factors for integration. The initial activities of the integration process therefore involved a thorough review of government and religious policies and documents and informal discussions with church groups.
**Barriers to Integration**

The barriers to YFS integration included resistance by some church leaders due to doctrinal issues and the perception that distributing condoms, especially to unmarried young people, is un-Christian. The conservative nature of some religious leaders, their interpretations of certain scriptures from the Bible, and church policies also created difficulties. At the community level, resistance was due primarily to community members’ socio-cultural beliefs, traditions, religious interpretation and misconceptions.

There was some resistance from community and local religious leaders, parents, and teachers to young people’s participation in the outreach component of the project. Certain community members argued that the project could encourage promiscuity.

**Facilitating Factors**

The process of building partnerships with FBOs to address ASRH required understanding the values, beliefs, vision, and mission of the groups involved. It was equally important for AYA/Pathfinder to have an in-depth knowledge of government policies on ASRH, HIV/AIDS, and the legalities of providing YFS.

In Ghana there are government policies and legal frameworks that support the provision of ASRH information and services, which facilitated the integration process. These included: the Revised National Population Policy (1994), Adolescent and Sexual Reproductive Health Policy (1999), The Reproductive Health Standard Policy and Protocol (Revised 2003), and the Constitution of Ghana (1992), among others. The documents suggest that young people have unrestricted access to all RH services provided at Ghanaian health facilities in the country, and thus served as an effective advocacy tool during the dialogue.

Further facilitating integration was the fact that the Ghana AIDS Commission was established in 2001, which vigorously supports (financially and otherwise) both government and nongovernmental agencies at the community, district, and national levels, and welcomes the involvement of influential religious leaders. In addition, leading members of the Christian Council of Ghana, including the then-general secretary of the council, and the current presiding bishop of the Methodist Church of Ghana, had been vocal in the fight against HIV/AIDS.
Phase 2: The Dialogue Process

The dialogue process was critical to the success of integrating YFS into the health service delivery of CHAG. As already noted, ASRH is a sensitive issue and many Ghanaian Christians can frown on public discussions about sex and provision of condoms to young people. Consequently, specific strategic approaches had to be used during the process, including strong negotiation skills, thorough understanding of CHAG and government policies and legal frameworks, and the Bible.

Sensitization and negotiation with CHAG executive secretary

The process began with discussions between the executive secretary and CHAG’s project manager. These discussions centered on the intentions of AYA/Pathfinder and the responsibilities of AYA/Pathfinder and CHAG in terms of the project. As part of the discussions the AYA/Pathfinder team explained the objectives of the project, made a presentation on the RH needs of young people in Ghana, explained the need to address the problems, and proposed some strategies to do so. AYA/Pathfinder stressed the minimum package of YFS and condom promotion was the cornerstone of the project’s implementation. AYA/Pathfinder explained their role, which included providing financial and technical support for the effective implementation of the project. During interactions with the CHAG management team, AYA/Pathfinder noted that government policies and legal frameworks support the provision of SRH services to young people. Handouts were distributed on the adolescent reproductive health profile in Ghana and YFS.

Sensitization and negotiation with the CHAG Board

Following the initial interactions between AYA/Pathfinder and the CHAG secretariat, the executive secretary held discussions with the CHAG board and recommended that the project be accepted for implementation. Some CHAG board members however, did not
feel comfortable with the condom distribution aspect of the program, and requested the executive secretary renegotiate that aspect of the package. The executive secretary understood that AYA/Pathfinder viewed the issue of condom distribution as non-negotiable and consequently, the negotiations stalled.

The stalemate in the negotiation process lasted for a period of about three months, with CHAG unable to agree to condom distribution and Pathfinder unwilling to remove one of the elements of the YFS minimum package and standard of care.

As the executive secretary searched for a way to proceed, he commented on the need for the project, stating to AYA/Pathfinder and board members, “We recognize the reproductive health problems of our young people. If you go to the rural and deprived areas where most of our facilities are located, one sees evidence of teenage pregnancies and teenage mothers. There is therefore a need to help the young ones.”

However, he did not have the mandate to proceed with the negotiation without the executive board of CHAG’s concurrence. He studied CHAG’s relevant documents in an effort to make a case for implementation of the project. In so doing, the executive secretary and other influential members of CHAG-affiliated religious denominations were able to counter arguments by CHAG members against the provision of condoms.

“I studied the Constitution of CHAG critically and evoked some relevant sections to support the need to implement the project, especially when there was a stalemate in the discussions and everything pointed to a rejection of the project by CHAG. I noted that a majority of the members supported the idea. I therefore cited Article 11, Section 5 of the CHAG Constitution11 to buttress my point,” said the executive secretary.

By quoting this section of the CHAG constitution and relevant governmental policies on ASRH, the executive secretary argued that members who were willing and able to implement the program be allowed to do so. He noted that the CHAG constitution enjoins him to help any member that requests his assistance. Furthermore, he noted that government policies support the provision of ASRH services to young people and referred to the relevant sections of the Revised National Population Policy (1994), Adolescent Sexual and Reproductive Health Policy, Reproductive Health Standards and Protocols, and the Constitution of Ghana, all of which provide for equality in services.

He referenced Article 2 of the association’s constitution on noninterference to buttress his point. Article 2 of CHAG’s Constitution states, “Provided that CHAG shall be in the realization of the aims and objectives of the association [and] not in any way infringe on the authority of governing boards of member institutions, nor of the appropriate policy-making committees of any of the organizations represented.”

11 Article 11 Section 5 describes the functions of the executive secretary as, “He/She shall formulate and recommend policies and procedures for adoption of the board.”
It was the reference to Article 2 of CHAG constitution that was the major breakthrough. Individual church health services have their own policies to govern their facilities. For example, the health facilities of churches belonging to the Christian Council of Ghana, the Pentecostal, and Charismatic Councils of Ghana are not against the provision of SRH services in their facilities, except abortion services. On the other hand, health facilities owned by the Catholic Church provide only selected sexual and reproductive health services, excluding abortion and modern contraceptive services. It was argued, therefore, that the CHAG policy of noninterference in the activity of individual members be evoked to provide avenues to implement the project.

Based on these arguments, the executive secretary proposed that the CHAG board present the issue to all its constituencies. The board agreed and requested that AYA/Pathfinder and the executive secretary make a presentation to the health coordinators and administrators at the association’s annual conference.

**Sensitization of health coordinators and administrators**

At the Annual Conference of the Health Coordinators and Administrators, the country representative of Pathfinder Ghana, and the executive secretary of CHAG, each made presentations advocating for integration of YFS into the health service delivery system. While AYA/Pathfinder addressed the issue from a social and medical point of view, the CHAG executive secretary looked at it from both the Biblical and policy angles, quoting extensively from the CHAG constitution, government policies, and legal frameworks to support his stance.

The AYA/Pathfinder presentation focused on adolescent reproductive health problems in Ghana and was supported by statistical data from research and surveys. A case was made to provide YFS information and services at CHAG health facilities, and included strategies to do so. The presentation appealed to all Ghanaians to support the efforts of the government in responding to the increasing reproductive health problems of young people. The AYA/Pathfinder team lauded the stance and active involvement of some religious leaders in the HIV/AIDS campaign, and asked for everyone’s support for the integration of YFS in CHAG facilities. In concluding, a passionate appeal was made to those gathered to review their position on provision of SRH information and services to adolescents.

In making a case for the provision of condoms to youth within CHAG health facilities, the executive secretary explained that though it is true that the Christian faith frowns on sex before marriage, it is also true that not all children of Christian parents automatically become Christians, or if they are Christians, they may not be able to abide by doctrine promoting abstinence until marriage and faithfulness to one’s spouse after marriage. It is undeniable that a large proportion of the youth, including those from Christian families, are sexually active, evidenced by record numbers being infected with STIs, including HIV/AIDS.
The executive secretary stressed that it would be naïve for Christian parents to think that their children are not sexually active and deny them SRH education and services. While emphasizing abstinence as the best preventive method for all youth, young people should also be exposed to alternative prevention and treatment options. “We must choose between having a young person well-informed about SRH issues...able to make responsible choices [and] a young person ignorant on SRH issues. Such a person is prone to and defenseless in the face of STI/HIV/AIDS, teenage pregnancy, and abortions and its social and economic consequences,” he further argued.

In all the discussions abstinence was identified as the best option, but it was argued that young people should know about the alternatives in case they are unable to remain abstinent.

In his argument, the executive secretary noted that the mission of CHAG, according to its constitution is, “To provide holistic spiritual and physical health services in fulfillment of Christ’s healing ministry to all people living in Ghana irrespective of race, color, religion and social/economic status.”

CHAG-affiliated health facilities are enjoined by their constitution to offer health services of all types to clients without discrimination. It was further stressed that both religious and nonreligious clients patronize the health facilities and it would not be fair to impose the Church’s beliefs on non-church-goers who use the health facilities. Doing so contradicts the mission of CHAG. As the policy of the Church urges affiliates to situate their health facilities in deprived areas of Ghana, service delivery in the mission health facilities should meet all the health needs of their communities without discrimination.

At the time of the negotiations, the Ghana AIDS Commission was pursuing a vigorous campaign at both the district and national levels. The involvement of governmental organizations and NGOs and the involvement of prominent religious leaders helped convince CHAG to integrate YFS into their mainstream health care delivery.

**Selection of project implementation facilities**

Following the discussions between AYA/Pathfinder and the executive secretary of CHAG and the presentation at CHAG’s annual health conference, health facilities that wanted to participate in the project were invited to indicate their interest. The willingness of a health facility to provide family planning, including modern contraception services, determined which facilities were selected. Ten health facilities of six member denominations (Methodist, Presbyterian, Salvation Army, Pentecost, Church of Christ, and the Seventh Day Adventist (SDA) agreed that their health facilities would implement the project.

Interactions with the health services directorates, priests, and some of the leadership of the participating CHAG facilities revealed that they were motivated to support the project because of the many reproductive health problems that face young people and the convincing argument made by AYA/Pathfinder and the CHAG executive secretary.
**Salvation Army**

The health coordinator of the Salvation Army Church in Ghana noted, “The Church does not have policies or norms or doctrines that limit social and medical work. In fact, the worldwide policy of the Army supports the provision of contraceptives.”

The leadership of the Church therefore willingly accepted the YFS concept. Prior to the project, the Salvation Army was involved in reproductive health programs and the Churches’ facilities were at the forefront of HIV/AIDS testing, care, and support in the country. The initial resistance to the program came from congregations who could not understand the involvement of a church facility in the provision of condoms to unmarried young people. After the worldwide policy of the church and the need to address ASRH had been explained to the congregation, the majority accepted and supported its implementation.

According to the health coordinator, the Salvation Army had integrated ASRH into other church programs such as the “Anidasofie Skills Training Centre” where young people are educated and exposed to the dangers of HIV/AIDS, teenage pregnancy, and unsafe abortion.

**Seventh Day Adventist Church (SDA)**

The SDA church supports provision of SRH services to young people, including the provision of contraceptives to young people under certain circumstances. During the interview with the health service directorate and the president of the central conference, they quoted excerpts of a press release by the Church’s headquarters to buttress the position of the church (Box 4).

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12 The Centre is based in Accra and trains street youth.
Furthermore, a book written by the SDA Church on “The Church Health Education” included a chapter devoted to family planning/reproductive health, including HIV/AIDS. The leadership had initial problems in convincing the congregations to support provision of services to youth. However, with the support of the Adventist Health Association (AHA), the church was able to persuade the local congregations to cooperate with the leadership in integrating YFS into the Church’s health services. The leadership’s position was bolstered by the Temperance Society, through which the Church’s health messages, or CELEBRATIONS, are disseminated to the congregations. The CELEBRATION messages support the YFS concept.

**Church of Pentecost**

Before the AYA/Pathfinder project, the Church of Pentecost was involved with the Government of Ghana/UNFPA Religious Project on Family Planning, so they had little difficulty accepting YFS. “All along we were only talking and teaching but now we are also providing the services. We opted for it in order to provide better and holistic service not only to church members but also to young people in the community,” noted the medical director of Alpha Medical Centre.

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13 Temperance Society is a group of laymen and health professional within the SDA Church, either working with or outside the Churches’ institutions who help explain and disseminate its health messages. The health messages are called “CELEBRATIONS,” an acronym for the various topical health issues areas covered by the Church.
In an address at the inauguration of the Alpha Medical Youth Centre, the director of the Pentecost Health Services recognized the reproductive health problems of young people and called for audience support toward addressing youth SRH issues. He noted, “The youth, as we all know, are the leaders of tomorrow and every effort at preparing them to face the challenges ahead must be commended and supported… Rev. Chairman, the HIV/AIDS pandemic and related sexually transmitted infections have been a big bother to the medical fraternity and Ghana as a nation for some time now. The debate on the best approach to addressing this still rages on, and targeting the youth, we (The Church) believe, is one of the best ways of sustaining the human race in light of the scary and ferocious manner in which the pandemic is affecting people. It is against this backdrop that management could not agree more with CHAG’s decision to include our hospital in the first ten facilities of Youth Resource Centers in Ghana. We are most grateful to the CHAG Board and the Executives of the African Youth Alliance. We are glad to mention that the hospital has embraced the project in high glee. Its high commitment is demonstrated in the amount of money it has so far committed to the project. To date, the hospital has spent over 23 million cedis ($2,875) from its internally generated funds, excluding the land on which the center sits, which is valued at about 60 million cedis ($7,500)."

**Project design, approval and signing of contract**

Following CHAG’s acceptance of the minimum package of YFS, AYA/Pathfinder and the management of CHAG collaborated on the development of the project document. It was eventually approved and in June 2002 AYA/Pathfinder and CHAG signed a contract for the implementation of the project in ten CHAG health facilities.

**Phase 3: Integration Process**

**Facility assessment and development of quality improvement action plans**

To institutionalize some of the YFS processes within the facilities, a core group of staff was trained to use the facility assessment tool developed by Pathfinder. The teams facilitated the assessments with technical support from AYA/Pathfinder. The team of assessors was composed of four people, including one young person. All ten CHAG facilities selected for the implementation of the project were assessed and reassessed to determine the youth-friendly status of these facilities. The findings of the baseline assessments were not different from what was found in the public health facilities. These include the following:

- Lack of separate hours for RH services for adolescents;
- An absence of separate space for serving adolescents’ RH needs lead to lack of privacy and confidentiality;
- Absence of service providers trained on adolescent needs;
- Ineffective capturing of service data – no disaggregation of data by age;
- Inadequate BCC materials; and
- Inadequate job aids.
Actions plans were developed based on the gaps identified. Action plans included a range of activities to improve the quality of services delivered to youth. Some activities, such as training and facility refurbishment, required significant financial and human resource investments. Other improvements, such as minimizing interruptions to increase privacy, required little financial resources.

**Training of service providers and orientation of all facility staff on YFS**

Ninety service providers and 610 other staff from participating facilities were trained and oriented on YFS by select service providers trained earlier by AYA/Pathfinder. The objective of the training and orientation was to make the staff at each health facility open to YFS and more approachable and receptive to young people.

**Selection and training of peer service providers and nontraditional condom distributors on delivery nonclinical YFS**

Outreach services were linked with all the health facilities. For each of the facilities, 10 Peer Service Providers (PSPs) and 10 Nontraditional Condom Distributors (NTCDs) were recruited and trained to provide services and refer young clients to the facilities. PSPs are youth who have been trained to provide reproductive health information and services to their peers. NTCDs are hairdressers, barbers, and other artisans who provide condoms to their clients and other youth. PSPs and NTCDs use one-on-one and group discussions to reach out to their clients. Two hundred youth (100 NTCDs and 100 PSPs) were trained and deployed in the catchment areas and linked with intervention facilities.

**Refurbishment and other quality improvements**

Refurbishment of all facilities was based on the findings of the various facility assessments. In general, the main gaps identified for refurbishment and addressed by the action plans included partitioning of counseling rooms to increase privacy, painting of facilities, changing of seating arrangements in consulting/counseling rooms, procurement and hanging of SRH posters for youth on walls, and rearrangement of waiting rooms and spaces to ensure privacy for youth and other clients. Additionally, some CHAG facilities procured and converted metal containers\(^{14}\) into youth clinics attached to their facilities to address the problem of space. At Assin Praso, Wiamoasi, and Alpha Medical Centre, clinic management renovated or constructed a new set of rooms for use as youth clinics and libraries.

In addition to the refurbishments, the facilities undertook other measures to reduce barriers such as improving client flow, increasing privacy by minimizing interruptions, improving the registration process to increase confidentiality, procuring job aids and BCC materials, and making condoms more accessible by locating them in various places like the dispensary, waiting areas, and registration tables. Facilities also erected signboards and used peers and outreach staff to publicize YFS. As a way of

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\(^{14}\) Metal containers are room-like structures constructed with fabricated metals and used as YFS centers in facilities where there is lack of space.
meaningfully engaging young people in the implementation of the program, facility management committees were established at each facility with two youth representatives on each committee. The committees served as a medium through which the views and concerns of young people were channeled for the consideration of management.

![Signboard](image)

*This signboard was erected as a means of publicizing YFS services.*

**Sensitization sessions with the community, churches, and mosques by providers from YFS facilities and peer service providers**

To win support for the project, facility and peer service providers organized regular community forums and talks at churches and mosques. Influential members of the community lobbied for the provision of ASRH information and YFS, especially condoms. These outreach efforts were instrumental in the mobilization of community support for the project. Some major challenges to the implementation of the project were encountered at the local church and community level. Socio-cultural and traditional practices are deeply rooted in rural settings, however, due to the project’s approach of always using local stakeholders as lead advocates, the barriers to implementation were overcome.

**Monitoring and evaluation of the intervention**

The partnership with CHAG had built-in mechanisms for effectively monitoring and evaluating implementation. These mechanisms were designed to ensure that quality standards were maintained and that the project was implemented as planned. The monitoring and evaluation plan included the design of collection tools that captured

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15 Although CHAG is a Christian organization, peer service providers conducted sensitization sessions at mosques in their communities as part of their outreach activities.
disaggregated data by age group, sex, and the service rendered, including services not previously recorded such as counseling. The plan also included quarterly and annual reporting, analysis of service statistics, and regular field visits to follow up on issues addressed in reports and for provision of technical assistance.

As mentioned earlier, facility assessments were done to determine improvements needed and as a way of establishing baseline information on monitoring indicators. Facility assessments were also undertaken at the midterm and end of project to serve as monitoring and evaluation tools. To ensure that clients’ needs were being met, mystery client studies were conducted at all the intervention facilities to identify areas needing improvement. Finally, regular meetings between AYA/Pathfinder and CHAG management were instituted to follow the project’s progress. Annual review meetings were organized for field staff as well as the project management team.

**Key Achievements and Results**

**YFS integrated into 10 health facilities**

YFS has been fully integrated into the service delivery of 10 CHAG health facilities, as planned by the project. Currently, the full range of YFS services (box 1) is provided by the 10 health facilities.

Following the success of YFS integration supported by AYA/Pathfinder, some churches have sought funding from other sources to integrate YFS into the health delivery system of their other health facilities: the Methodist Church has sought funding to integrate YFS into their facility in Wenchi, the Salvation Army has integrated YFS into the livelihood training institute in Accra, and the Pentecostal Church has established two youth centers at Teshie and Amasaman.

**Youth Served**

During the two-and-a-half years of project implementation, through the combined efforts of the outreach and static facility components, there were approximately 450,000 youth visits and contacts (table 1). Static facilities received fewer youth visits (62,619), than outreach services (333,214). At the health facilities, more female than male clients sought information and services on SRH. A total of 117,699 condoms were distributed to young people through the static and outreach components. The outreach component accounted for 88 percent of all condoms distributed to young people. Of the total number of condoms distributed through outreach, NTCD accounted for 54 percent.

<table>
<thead>
<tr>
<th></th>
<th>Youth Visits/Contacts</th>
<th>Condoms Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>62,619</td>
<td>11,887</td>
</tr>
<tr>
<td>PSP</td>
<td>201,389</td>
<td>48,502</td>
</tr>
<tr>
<td>NTCD</td>
<td>185,715</td>
<td>57,310</td>
</tr>
<tr>
<td>Total</td>
<td>449,723</td>
<td>117,699</td>
</tr>
</tbody>
</table>

**Table 1: Youth reached and condoms distributed through static and outreach outlets**
**Improved quality of SRH services for young people**

All 10 facilities now have an environment conducive to the provision of SRH information and services. A comparison of the baseline assessment and the reassessment of the 10 intervention health facilities shows improvement in the youth-friendly status of all the facilities (table 2).

**Table 2:** YFS status of the 10 health facilities (facility assessment and reassessment)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urbanaid Clinic, Maamobi, Accra</td>
<td>16</td>
<td>41</td>
</tr>
<tr>
<td>Alpha Medical Centre, Accra</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td>Assin Nsuta Presbyterian Clinic</td>
<td>25</td>
<td>42</td>
</tr>
<tr>
<td>Assin Praso Presbyterian Clinic</td>
<td>27</td>
<td>45</td>
</tr>
<tr>
<td>Church of Christ Mission Clinic, Kumasi</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>Kwadaso SDA Hospital, Kumasi</td>
<td>15</td>
<td>43</td>
</tr>
<tr>
<td>Onwe SDA Clinic, Kumasi</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Asamang SDA Hospital, Asamang</td>
<td>28</td>
<td>42</td>
</tr>
<tr>
<td>Salvation Army Clinic, Wiamoasi</td>
<td>27</td>
<td>45</td>
</tr>
<tr>
<td>Methodist Clinic, Amakom</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

The two mystery client studies conducted at the facilities also revealed that client satisfaction had improved.

**Commitment to and sustainability of YFS**

CHAG committed itself to working on ASRH, despite the sensitivity surrounding youth sexuality. The stakeholders of CHAG were motivated to implement the project because they realized the seriousness of RH problems facing young people in their areas of operation. All the participating member churches plan to continue the project to ensure the eventual integration of YFS into all health facilities under CHAG, thereby ensuring the sustainability of the project’s activities.

All participating health facilities made financial contributions and provided personnel, which facilitated the successful implementation of the project. For example, during the facility assessment at Assin Praso, it was agreed that the maternal and child health unit would be used as the youth center. However, after further evaluation, it became clear that the room would not be suitable for that purpose because it could not accommodate multiple activities and did not provide the privacy needed to serve young people. Therefore a structure needed to be built for the youth center. Since AYA was not designed to support construction projects, facility staff agreed to supplement funds allocated by the project for refurbishing of the facility. The management’s financial contribution covered the cost of roofing sheets, wooden boards, masons and carpenters’ wages, and the purchase of a generator. The estimated amount of the facility staff financial support was $12,600,000 ($1,575).
In addition, the following efforts were recorded at other CHAG facilities:

- The management of Alpha Medical Centre contributed ₳23,000,000 ($2,875), and a plot of land valued at ₳60,000,000 ($7,500) toward the construction of the youth center. Provisions for YFS have been made in the facility budget.
- The SDA health directorate asked for ₳75,000,000 ($9,375) from the SDA Church for the implementation of HIV/AIDS and ASRH activities in 2005.
- SDA hospital contributed ₳20,000,000 ($2,500) for the establishment of a youth center and hired one of the peer providers to manage the youth center.

At the dissemination of the reassessment findings of the ten CHAG facilities, participants committed themselves to the implementation of YFS into their overall health service delivery system. Some of the participants’ specific recommendations to sustain YFS at the current facilities have been summarized below:

**Box 5: Proposals to sustain YFS (Outcome of Facility Reassessment Dissemination Workshop)**

**Static Facility**
- CHAG secretariat will solicit funding from other donors in support of the 10 participating facilities;
- CHAG secretariat will ensure that the 10 facilities mechanize the salaries of all their staff in order to free some internally generated funds for YFS activities;
- All health facilities provide for YFS in their budgets;
- Core staff to forfeit all due allowances; and
- Matron to assign staff to work on YFS activities.

**Outreach**
- Solicit support from the district assemblies and from NGOs;
- Actively involve district and metropolitan assemblies in outreach activities;
- Market the concept of YFS and highlight its achievements;
- Make provisions in facility budget for outreach activities;
- Reduce allowances and meetings of peer providers by 50%;
- Consider either waiving or reducing consultation fees for peer providers who require ASRH services at the facility as an incentive. Currently, some of the facilities such as Kwadaso SDA Hospital, Assin Praso Hospital and Alpha Medical Centre provide this service free and others should be encouraged to emulate it; and
- Where possible, the facilities should engage in income-generating ventures by using the youth centers to sell souvenirs. The youth centers would also provide computer games and internet services for a fee.
Increased involvement of youth in the design, implementation, and monitoring of YFS

The project provided ample opportunity for young people to participate in a meaningful way by taking part in project development, implementation, monitoring, and evaluation. Young people were members of the facility assessment teams, served as mystery clients, and were representatives on all ten Facility Management Committees (FMCs). The involvement of youth in these activities ensured that the concerns of young people were adequately and swiftly addressed. For example, at Assin Praso Presbyterian Hospital, the financial support by the hospital management for the construction of a youth center was the outcome of lobbying and a proposal from the youth representative on the FMC. As a result, some internally generated funds were made available to support the youth center.

At Alpha Medical Centre in Accra, the youth representative on the FMC influenced the location of the facility’s youth corner. Many young people felt that the location initially proposed for the center was not discreet enough and would not encourage patronage by their peers. Consequently, the peer service providers took a vote at one of their biweekly meetings and mandated their representative on the FMC to present their views to the FMC. The committee accepted the concerns of the young people and the youth center was relocated to its present place.

Increased awareness and acceptance of the provision of ASRH information and YFS to young people by communities

Communities in which YFS interventions were conducted showed a generally positive attitude toward the project. Community leaders such as chiefs, religious leaders, and opinion leaders expressed commitment and support for the provision of ASRH information and YFS. It is worth noting, however, that a few community members still opposed the provision of condoms, but supported all other aspects of the program. A majority of leaders opposed the inclusion of young people between 10 and 14 years, stating that the focus for this age group should be abstinence, not condom use. Specific commitment and support by the community leaders included mobilizing the community to welcome the program, attendance at and chairing of some meetings organized by the project, and speaking positively to young people about the provision of ASRH information and YFS. Some of the members of the district assemblies have lobbied for ASRH issues to be put on the agenda of the assembly’s meetings. This high level support at the district and community level is significant in generating broad-based community support for the implementation of YFS.
Peer providers promoting condom use in their communities.

The activities of the peer providers have also helped create awareness and acceptance of the provision of ASRH information and YFS in the communities. A community leader in one of the intervention communities said the following about the activities of the peer providers: “They have conducted themselves very well and have put all of us to shame because we thought that their involvement in the project would spoil them. We also thought that they were going to teach our young people to be promiscuous by teaching them how to use condoms and also to chase young girls. We are witnesses to some changes that have taken place in the peer providers themselves. Some of the young people who used to be ‘very bad’ have changed completely.”

Most community leaders have been supportive of the peer providers’ outreach activities, in spite of the initial apprehension. Peer providers have created the necessary awareness of ASRH in the communities, and have influenced their peers and entire communities because they have conducted themselves well. The success of peer education tends to depend on the conduct of the peers in the communities, and could influence whether or not they are accepted.

**Monitoring and evaluation capacity built**

The CHAG members who participated in the project are now skilled at using the facility assessment tool, collecting and analyzing service statistics, and using mystery client studies to monitor and evaluate activities. All ten intervention health facilities have seen
marked improvement in data collection. In collaboration with facility staff, AYA designed a summary data collection tool that captured data disaggregated by five age groups. In addition, services such as counseling, which were previously provided by the facilities but not recorded, are now captured and reported in all ten intervention facilities. The CHAG secretariat was given a simple computerized management information system using the summary data collection tools to facilitate collation of data from the ten facilities. This drastically reduced the errors in reported service data and also improved timely reporting.

**Lessons Learned**

- The process of building a partnership with FBOs concerning the sensitive issue of integrating YFS into their health service delivery system required understanding of the values, beliefs, vision, and mission of the groups.
- Commitment of the CHAG management and other influential stakeholders was integral to the successful implementation of the project, especially during the dialogue phase.
- Identifying leading members of CHAG to facilitate and lead the lobbying effort, and identifying different groups within the membership for lobbying activities, facilitated the negotiation process.
- Extensive dialogue and compromise was required to reach consensus on programmatic components, such as the provision of contraception and support for sustainability.
- Commitment, flexibility, patience, perseverance and tact were essential during the dialogue process.
- Knowledge of government policies on ASRH and of the Bible and Koran served as facilitating factors in the negotiating process.
- Project managers should understand the religious values of FBOs and be able to use that information to overcome difficulties.
- It was important to have a team approach, in which everyone who mattered in the process was involved.
- Integration of YFS into mainstream health service delivery is a process.
- Active involvement of young people at every stage of the project: advocacy, design and implementation, and monitoring and evaluation, facilitated support for and implementation of the project.

**Challenges**

- The project was implemented in only 10 of the 152 CHAG health facilities. The challenge now is for YFS to be scaled-up so that all CHAG health facilities are covered.
- The Catholic Health Directorate plays a key role in health delivery in Ghana. The issue is how to get the Catholic Health Directorate and other health directorates that did not participate in the project to integrate YFS into their health service
delivery. One possible consideration would be to make less controversial services youth friendly (e.g., counseling, antenatal care, pregnancy testing, and STI treatment) and use this as an entry point.

- The health coordinators of CHAG were involved and played a key role in the negotiation and design of the project. They played a very small role however, in the implementation of the project. In the future, the office of the health coordinators should not only be involved in the design of the project, but also its implementation to ensure total support and sustainability.
- The outreach component at the various health facilities must be sustained after the project has ended.

**Conclusions and Recommendations**

Integration of YFS into the service delivery system of FBOs is of major importance in the field of ASRH. The AYA/Pathfinder partnership with CHAG in the Window of Hope Project was a major breakthrough in the field of ASRH and it is worth sharing the experience with others in the field. Although there were many challenges, tactfulness, patience, and respect facilitated a strong working relationship between AYA/Pathfinder and CHAG. In addition, knowledge of and respect for beliefs and values of the church and awareness of government policies on ASRH were essential for overcoming the sensitivities around ASRH. Involving all stakeholders at all levels in the implementation process solicited and guaranteed support and ownership of the outcome of the intervention. Furthermore, integrating the outreach program into the project extended the project’s reach.

It is recommended that to successfully integrate ASRH into FBO’s service delivery, absolute care should be taken to identify all barriers to integration and develop strategies to overcome them. Also, the facilitating factors must be identified. CHAG was able to integrate YFS into a small percentage of the 152 facilities under its jurisdiction, due to the coverage of the AYA project and the fact that not all the religious institutions agreed to participate in the project. Therefore, it is important for CHAG to develop a strategy to expand YFS to all CHAG health facilities. Since the government of Ghana is also trying to scale-up YFS within public sector facilities, the government and CHAG might consider collaborating to ensure that there is sufficient YFS coverage within the country.