DRAFT: NOT TO BE QUOTED

SEXUAL AND REPRODUCTIVE HEALTH POLICY FOR YOUNG PEOPLE IN GHANA

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1.0 PREAMBLE

Governments and international organizations have, over the years, shown interest in the well-being of adolescents and young people. The interest stems from a number of factors. First,the size of the group calls for attention as it is the fastest growing group in the world. Young people aged 10-24 years have consistently accounted for a third of the total population of the world and in the country in the last four decades. The current group of young people is also growing up in more interesting periods than the cohorts before them: more young people are attending and staying in school longer than their parents, are less likely to be affected by diseases associated with personal hygiene (e.g. yaws) and are exposed to alternative technological developments which are changing rapidly compared to the generation before them.

As a group they also face challenges as they transit into further education, the world of work, family formation, healthy living and citizenship, and the decisions they take today will affect them as individuals, their families and communities now and in the future. They also constitute the potential human capital for socio-economic development and to harness the potential inherent in the group, governments have come up with direct and indirect laws, policies and programmes to protect and promote their interest and to ensure their development.

In 1994, the Government of Ghana published its second National Population Policy in response to Article 37(4) of the 1992 Constitution which states that: *The State shall maintain a population policy consistent with the aspirations and development needs and objectives of Ghana.*Objective 4.3.7 of the 1994 National Population Policy states:*To educate the youth on population matters which directly affect them such as sexual relationships, fertility regulation, adolescent health, marriage and child-bearing, in order to guide them towards responsible parenthood and small family sizes (section 4.3.7).*Based on this article, a national Adolescent Reproductive Health policy was developed in 2000.

The National Population Policy and the Adolescent Reproductive Health Policy documents reflected the commitment of Governments over the years to the development of the total well-being of its citizens. For instance, through the Ministry of Health, Ghana has produced a National Health Policy titled *Creating Wealth through Health*, a National Adolescent and Young People's Health and Development Policy as well as guidelines and standards for health delivery. Thesealso complemented the Youth, Gender and HIV/AIDS and STI policies.

The policies, and the actions emanating from them, are manifestations of the endorsement ofGovernments of Ghana of various international recommendations and treatises. Among them are the recommendations from the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994and the post-conference meetings such as that of The Hague in 1999, ICPD +5 in New York, ICPD +10 in New York, ICPD +15 in Kampala, and ICPD+20, the Platform for Action of the Fourth International Women's Conference held in Beijing in 1995, Convention on the Right of Children (CRC), Convention on the Elimination of Discrimination Against Women (CEDAW), Protocol on the Rights of Women in Africa, the MDGs and the Sustainable Development Goals (SDG).

Fifteen years after the promulgation of the Adolescent Reproductive Health Policy (in 2000), the Government has found it necessary to revise the policy, taking account,the changing dynamics among young people, in the country and at the international level.

1.0 SITUATION OF YOUNG PEOPLE IN GHANA

1.1 Demographic profile

The population aged 10-24 years was 1,813,279 in 1960, and accounted for 27 percent of the total population. In 2010, the population in the age group was 7,849,520, and constituted 32 percent of the total population. In the 50-year period between 1960 and 2010, the population of young people increased more than fourfold, and the number is expected to increase to 8,955,000 in 2020.

For the first time in Ghana, the population in urban areas exceeded those in rural areas: 51 percent and 49 percent respectively. Thus, there is a shift in the rural-urban proportions of the population.Semi-urban and peri-urban areas have emerged as a result of shifts in population through migration and natural growth.With young people as a group with apropensity to migrate, the emerging shift in the spatial distribution of population will have implications for the allocation of resources and attention in the respective areas.

1.2 Sexual and Reproductive Health Profile of Young People

Living Arrangements

Results from the National Adolescent Study of 2006 indicated that among females aged 12-14 years, 42 percent lived with both parents while another 24 percent lived with themother alone. For the older adolescents (15-19 years), 39 percent lived with both parents and another 24 percent with themother alone. Among the males 49 percent of the 12-14 year-olds and 42 percent of those aged 15-19 years lived with both parents and 22 percenteach with themother alone. The slight difference in the proportions of males and females living with both parents is worth noting since such living arrangements have implications for protection and supportforeach of the sexes.

Pubertal Development

Although data on menarche (first menstrual experience) and menarche (first nocturnal emission or conscious ejaculation of boys) are patchy, the available evidence suggests that these ages have declined over the last half-century. One of the earliest reports on age at menarcheindicated that some females menstruated, on the average, at age 14 years, and this is now estimated to be between 12 and 13 years. Evidence also suggests that among females, 10 percent of those aged 12-14 years and 70 percent of those aged 15-19 years had reportedly experienced menarche at the time of the survey. For the males, 70 percent of those aged 15-19 years and 12 percent of the 12-14 year-olds reported experiencing semenarche. Thus, the few studies and anecdotal evidence indicate that ages at menarche and semenarche are decreasing in the country.

Initiation into sex

Data from the Ghana Demographic and Health Surveys (GDHS) indicate that age at sexual initiation has increased over the last two decades. Median age at first sex among females increased from 17.4 years in 1993 to 18.4 years in both 2008 and 2014. That of males

increased marginally from 19.4 years in 1998to 20 years in 2008 and 2014. So far, the evidence indicates that median age at first sex for females has stagnated at 18.4 years and that of males at 20 years in the last decade. Overtime, though, females are postponing theage at first sex, contrary to the general view that the current generation is initiating sex earlier than previous groups. In spite of the increase in the median age at first sex, the initiation of sexual activity for females still occurs in the adolescent period.

Entry into Marriage and Childbearing

One of the changes which has occurred in the last two decades is the postponement of marriage as a result of changes in societal demands for formal education, employment and self-actualization, especially for females. The available evidence indicates that the proportion of married females aged 15-19 years declined from 23.0 percentin 1988 to 5.4 percentin 2014, while for males the proportions were 1.8 percent in 1988 and 0.5 in 2014. In the 20-24 age group, the proportion of married females decreased from 72 percent in 1988 to 38 percent in 2014. For males, the decline was from 60 percent in 1993 to10 percent in 2014. However, at that age, some of the females were separated, divorced or widowed, while for the males they were separated or divorced. Among the females who were married at age 15-19 years, 16.8 percent were in polygyny in 1993, 6.8 percent in 2008, and 9.3 percent in 2014. The situation whereby young people aged 15-19 years are in polygyny presents a challenge to the rights of these women.

The age at which half of thefemales marry (median age at first marriage) increased from 17.9 years in 1988 to 20.7 years in 2014. For males, themedian age has hovered around 25 years over the period due to the generally high age at first marriage. The evidence is that both males and females are postponing marriage, and in particular, for females. The change is reflected in the proportion marrying at various ages. In spite of the increase in median age at first marriage, females still marry earlier than males due to societal norms on gender roles, which shape expectations on marriage for the two sexes.

Median age at first birth has also increased over the last 25 years: from 19.3 years in 1988 to 21.4 years in 2014 – an increase of 2.1 years over the period. From the Ghana Demographic Health surveys, the proportion of 15 year-olds who were mothers declined from 3.3percentin 2003 to 0.7 percentin 2008, but increased to 1.9 percent in 2014, more than double the proportion in the previous survey. For the 19-year olds,the proportion who were mothers was 24.8 percent in 2003, 28.9 percent n 2008 and 36.1 percent in 2014. The results indicate relatively high levels of pregnancy and childbearing among the 18-19 year olds.Furthermore, the rate of childbearing among married teenagers has remained at 60 percent, pointing to the practice of expecting childbearing immediately after marriage.

The decreasing age at maturation, vis-à-vis the increasing age at marriage has led to the emergence of what has been described as the bio-social gap. In the traditional system, marriage followed immediately after menarche and, therefore, the gap between physical maturation and marriage was short.During that time, especially for most women,first sex took place within marriage. Now, young women are menstruating early, and are expected to pursue further education, develop their careers, and by default, postpone marriage. The changing patterns, which also broaden avenues for social networking, have implications for sexuality education and the provision of information and services.

The lowest median ages at first sex, marriage and childbearing have occurred among females with only primary school education. Since primary schooling is not a terminal point in our

educational system, reporting only primary school education implies that the person was unable to achieve abasic education. The evidence suggests that the effect of formal education on sexual initiation, marriage and childbearing is felt with senior high school or higher.

1.3 Sexual Relationships and Partnerships

One of the features identified in reproductive health among young people is the nature of sexual relationships and partnerships. However, very few studies in Ghana have examined the sexual relationships and partnerships of young people. Some young people have reportedengaging in same-sex as well as heterosexual sexual relationships. About one percentof males and females aged 12–24 reported that they had ever had sex with a same-sex partner. Some studies have observed that among young people who had ever had sex, 67 percent of males and 55 percent of females aged 14–19 had their first sexual experience with someone of their own ageand who was either a boyfriend or girlfriend. Other studies have observed age mixing at sexual initiation. For instance, in the National Survey of Adolescent (NSA), the average age of first sexual partner for the males was 16.5 years and for the females it was 20.7 years. In the 2014 GDHS, 10 percent of the females aged 18-19 years were 10 years younger than their male sexual partners. For some of them, their first sex partner was with an older adult who gave them gifts, money or other items in exchange for sex. Two percent of the males aged 15-19 years old and four percent ofthe 20-24 year-olds among those who had sex in the 12 months prior to the 2014 survey reported paying for sex.

Results from the 2014 GDHS also showed that among females aged 15-24 years who had ever had sex, two percent reported two or more sexual partners in the 12 months before the survey. For the males, four percent and 14 percent respectively of those aged 15-19 years and 20-24 years reported two or more sexual partners within the last 12 months. Of those who had multiple sexual partners, 45 percent of the females and 64 percent of the males were in concurrent relationships. These are practices which have implications for the sexual health of young people.

Reasons for engaging in sexual intercourse ranged from pleasure through peer pressure to financial reasons. For some of the females, obtaining financial support and affection were the main reasons for starting a relationship. The financial support from boyfriends was an integral part of a relationship and was used for daily needs, including food, medical expenses, school fees and clothing.

1.4 Knowledge and Use of Contraceptives

Exposure to family planning messages among adolescents has been found to be mainly through radio and television. In the 2014 GDHS, 96.5 percent of married young females aged 15-24 years had heard of any contraceptive methods and the same percentage had heard ofmodern contraceptive methods. Although knowledge of contraceptives was high among married young females, usage was low. For instance, among females 15-19 years, 16.7percent were current users of modern family planning methods and of those aged 20-24 years, 24.8 percentwere using contraceptives at the time of the survey in 2014.

Analysis ofinformation from young females who were not usingany family planning method, revealed low contact with family planning providers. Data from the 2014 GDHS showed that only six percent of married females aged 15-19years who were visited by a health care provider in the 12 months prior to the survey had any discussion on family planning,while

fivepercentreceived family planning messageswhen they visited a health facility. Among females aged 20-24 years, 10 percent and 17 percent respectively received messages on family planning when a health worker visited them or when they visited a health facility.

1.5 Accessibility and Availability of Information and Services

Reproductive health services such as contraceptives, safe abortion services and reproductive health counselling services are not always available to the entire population. In places where these services are available, young people are unable to access them because of factors such as provider bias, restriction by law, fear of being branded as 'a bad boy or girl', distance to services, unfavourable opening hours, or simply lack of knowledge about the availability of such services. Provider bias has its roots in the social values, norms and culture. Reports indicate that some service providers feel reluctant to provide contraceptive services to young people for fear that they may promote promiscuity among them. Nonetheless, views on the provision of contraceptives to young people are changing, albeit slowly. In the 2014 GDHS, 53 percent of females and 58 percent of males aged 18-49 years supported teaching young people aged 12-14 years about condoms so that they could protect themselves against STI, including AIDS.

Services, where available, may not accord young people who visit these facilities the same respect and dignity that they would give to adult clients; may not be equitably provided in that it may be 'friendly' to some and not to others due to factors such as age, marital status or parity, rural-urban residence, residents of slums, migrants, marginalized groups such as commercial sex workers and persons with disability. Young people are known to be concerned with confidentially.

Reproductive health policy for young peopleaims at addressing disparities, concerns of and expanding access to the entire population of young people while dealing with the concerns of adults.

1.6 Gender and Age Differences

Disparities in attitudes to and expected behaviours in reproductive health between males and females are reflected in the ages at marriage, initiation of sex and childbearing. In general, the prevailing gender stereotyping is to the disadvantage of females. From this age, young males tend to exert their masculine influence on their female counterparts on decision-making in all aspect of life, including issues of sexual and reproductive health (e.g. use of contraceptives, abortion and sexual activity). Prevailing gender norms and sexual normative behaviours condones male multiple sexual partnerships but condemns such practices among females. The age difference between males and females in sexual relations also leads to dominance, and with females younger than their male partners in sexual relationships, they (the females) are less likely to negotiate the use of contraceptives. Additionally, feminization of poverty tends to disadvantage and disempower females in sexual relationships. Adolescents in sexual relationships are less likely to utilize reproductive health services, even where they are available, since they would like to keep such relationships secret. Thus, some of the normative gender beliefs and practices, which perpetuate discrimination and put one sex at a disadvantage,need to be addressed.

1.7 Situation with HIV, AIDS and STIs

Worldwide, young people account for half of new HIV infections. In Ghana, the overall mean prevalence of HIV infection peaked at 3.6% in 2003 and declinedto 1.6% in 2014. For those aged 15-24 years, mean prevalence has fluctuated over the period, with a reported 1.2% in 2013 and 1.8% in 2014. The increase in the prevalence rate among the15-24 age-group in 2014 occurred among both those aged 15-19 years and 20-24 years, but with a higher increase in the latter age group than the former. Althoughnearly all the respondents aged 15-24 years had heard about HIV, only 20 percent of the females and 27 percent of the males had comprehensive knowledge of HIV in the 2014 GDHS[1]. The results indicate inadequate comprehensive knowledge about AIDS in the face of high levels of awareness.

While various surveys have reported high levels of awareness on HIV and AIDS, knowledge about other sexually transmitted infections (STI) is low. In the National Survey of Adolescents, 28 percent of the males and 26 percent of the females aged 12-14 years had heard of any STI other than HIV and AIDS. For the older adolescents, 56 percent of the males and 49 percent of the females were aware of other sexually transmitted infections. Inthe 2014GDHS, eight percent of females and nine percent of males reported contracting a sexually transmitted infection in the 12 months prior to the survey. Since the behaviours and attitudes that increase young people's risk of contracting the AIDS virus are inextricably linked to those that result ininfection with other STIs, unintended pregnancy and unsafe abortions, it is important to address them together. Educating, protecting and preventing infection among this group could change the course of the AIDS epidemic in the country.

1.8 Building Skills among Young People

A number of young people are unable to take advantage of situations and facilities when they are available because they lack the necessary skills. These skills have been classified as practical self-care skills, livelihood skills, skills to deal with specific situations and have been defined to encompass adaptive and positive proficiencies which are used in personal life and interaction with others. These include decision making, problem-solving, creative and critical thinking, effective communication, positive interpersonal relationships, empathy, self-awareness, ability to cope with emotions, manage stress, act assertively as well as developing the ability to pursue goal-directed behaviour.

Studies have reported that young people lack negotiation and the necessary communicative skills to navigate themselves through life. For instance, some of them lack specific skills such as negotiating for the use of condoms and refusing to have sex with a husband who is known to have other sexual partners. In the 2014 GDHS, 18 percent of the married females aged 15-24years indicated that they would not be able to refuse sex with a husband who was known to have other sexual partners. Secondly, young people at this stage of development need various skills, which will be useful in the home, in the community, in the school system and in their interactions with peers and adults.

2.0 GUIDING PRINCIPLES

The policy, as conceived, is consistent with the extant legal framework, domestic legislation and the international conventions and the multi-lateral agreements that Ghana has ratified.

[1] This is defined as knowing that consistent use of condoms during sexual intercourse, having one uninfected faithful partner can reduce chances of infection, knowing that a healthy looking person can have the AIDS virus and two misconceptions that one could get infected through mosquito bite or supernatural means.

The guiding principles also take cognizance of the socio-cultural, ecological and economic conditions in Ghana. It, therefore, draws on a multi-sectoral and context sensitivity dimensions to address, co-ordinate and collaborate with all sectors from governmental and non-governmental levels. The policy is guided by ten inter-related principles, *viz*.:

First, development of young people underlies the promotion of positive sexuality and reproductive health: The sexual and reproductive health policy for young people should be an integral part of the overall development policies and programmes of the nation. It should be considered as a component of a continuum of information and services needed by young people in their transition to adulthood. Interventions that are most successful in promoting positive sexual and reproductive health behaviours invariably do address some developmental needs.

Second, adolescence is a period of opportunities and risks: A number of the decisions taken by young people influence their entire lifespan. Adolescence and the youth stages are associated with opportunities as well as risks including the development of a sense of identity, value systems among others. Interventions during this phase can therefore yield amplified benefits since their effects can be manifested throughout their lifespan.

Third, thebehaviour is influenced by socio-cultural and political environment: The multiple influences of one's ecology contribute to shaping one's behaviour and health outcomes. Environmental influences include relationships with parents and other family members, friends and other key adults such as school teachers, religious and opinion leaders; social attitudes and norms and policies. The influence of other social institutions such as the school, religion, economic and political conditions and the media are all key factors in the development of the worldview of young people. All these ecological influences affect the physical, sexual and mental health of adolescents and young people.

Fourth, the right to information is key to the realisation of the right to health of young people. Everyone has the right to the highest attainable standard of physical and mental health**.** Young people need accurate and reliable information about their sexuality, the physical changes taking place within them and the changing human relationships which take place at this stage. Also at this stage, young people are concerned with the nature of their relationship with parents, siblings and other adults in thehousehold as well as peers of the same sex and of the opposite sex. Therefore, they begin to make conscious plans about their future career, learn new skills and develop thecapacity to communicate with different categories of people on a wide range of issues. They therefore have the right to be informed about all matters relating to their health including the right to sexual and reproductive health information and services.

Fifth, right to services: Young people have the right to services on sexuality and reproductive health issues. Young people constitute a heterogeneous group with diverse and unique needs: there are those who are as young as 10 years, there are those who have had sex before but not married, those in special circumstances and those in casual or permanent sexual relationships. Therefore, there is the need for services such as counselling for those who are not sexually active and family planning services and counselling for those who are in sexual unions. Such services should be offered within the context of the mandate of the sector ministry or organization and in accordance with the socio-demographic background of the individual as well as the group or social milieu to which he/she belongs. To meet the needs and aspirations

of the clientele, the services should be comprehensive**,** reliable and user-friendly and responsive**.**

Sixth, gender issues: Gender is a socio-cultural construct defined by the sexual division of roles and dictated by social, cultural, religious and other values. Expectations of what it means to be a man or a woman, which is an integral part of the socialisation process, inform the actions of people, including their interactions with other people and how they perceive themselves, including how they deal with their health and other outcomes. Thus, gendered behaviours influence sexuality, vulnerabilities, male-female relationships, power relations and reproductive health decisions. Advancing gender equity and equality and other minority interests are, therefore, a prerequisite for the sexual and reproductive health of all people. While the focus of females has dominated gender issues for centuries because of their many disadvantages, attention on males have also taken centre stage in recent times due to their many challenges. It is in this regard that addressing the interest of both females and males is key to this policy.

Seventh, disability and other vulnerable groups need to be recognized: Advancing the interest of the physically challenged, minority and other vulnerable groups such as street youth, out-of-school youth, sex workers, men who sleep with men will contribute to the development of a just and equitable society. It is also imperative that the interests, needs and concerns of vulnerable and marginalised young people are considered in the provision of comprehensive, affordable and accessible sexual and reproductive health education and services. The health system should be oriented towards reducing risk factors, enhancing the general protection and providing services to marginalised and vulnerable young people on their sexual and reproductive health challenges.

Eight, active involvement and participation of young people in programmes: The policy recognises the need to actively involve adolescents and young people in the development of policies, services, programmes and decisions relating to their health status, treatment, care and rehabilitation. This will enable them to own such programmes and initiatives.

Ninth, progressive realisation of the right to sexual and reproductive health of young people is an obligation for all stakeholders: The policy acknowledges that the right of young people to sexual and reproductive health is a basic one. Sexual and reproductive health services should, therefore, be provided in a respectable, dignified and ethically appropriate manner without discrimination. The state, other state actors and the general population have an obligation to respond to their sexual and reproductive health needs within its available means with the view to achieving progressively the full array of rights, including adopting supportive legislative measures.

Tenth, bridging the spatial and socio-economic gap in thehealth-care delivery system: There should be a conscious effort to create practical health equality for young people in all parts of the country, irrespective of location, socio-economic background and other characteristics. Equal attention should be given to the health care delivery to all adolescents and young people to ensure theequitable right to sexual and reproductive health.

3.0 CONCEPTS AND DEFINITIONS

The World Health Organization defines adolescents as those in the second decade of life (i.e. 10-19 years), which is further broken down into early adolescence (10 to 14 years) and late

adolescence (15 to 19 years), the youth as people aged 15-24 years, young people as those aged 10-24 years and young adults as those aged 20-29 years. In this policy document the demographic definition for young people (10-24 years) is used to encompass young adolescents, older adolescents and those aged 20-24 years. In using the demographic definition, one is confronted with the heterogeneity within the group:in- or out-of-school, single, married, divorced or widowed, mothers or fathers, working or not working, living with disabilities or marginalized and living on the fringes of society. The 10-24 age cut-off is adopted for two reasons: to be consistent with standard definitions and to capture the group which consists of those entering, living withinit and at the threshold of leaving the five transitional phases of further education, theworld of work, family formation, healthy living and citizenship.

The concept of reproductive health is based on the ICPD definition;"a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity associated with all aspects of the reproductive system, functions and processes". The definition includes the ability to be able to have a responsible, satisfying and safe sex life and be able to decide when to reproduce and at what interval. All people, including young people, have the right to reproductive health information and services that are accessible, efficient, effective, affordable and acceptable and be able to make reproductive choices.

4.0 RATIONALE

4.1 Young People as an Asset

The future of any country depends on the investment it makes in the education, health and the opportunities created for young people. It also involves harnessing the potential of young people as part of the overall national strategy to promote gender equality and equity, female empowerment, healthy living and sustainable development. In Ghana, young people aged 10-24 years who account for a third of the national population, constitute an important asset for national development.

The processes of socialization, education, training and development of positive attitudes create two broad assets namely, social and human capital. Social capital involves the externalities of support available to the individual and groups. Human capital involves the range of knowledge, skills and capabilities needed for individual development as well as socio-economic transformation. Generally, the basic outlines of these two assets are acquired early in life, particularly in the pre-adult stage.

Available evidence suggests that when attention and resources are devoted to the education, health and wellbeing of young people, the age structure and other characteristics of the population are transformed. When managed properly, the changing age structure, can lead to decline in age-dependency ratio due to declining fertility and improved life expectancy, which then leads to what has been described as the 'demographic dividend'. This is a situation of increased personal savings and investment possibilities among the working population. Ghana needs to take advantage of this demographic dividend through judicious management of young people.

4.2 Population Management

The lifestyle of young people influences the future path of fertility and mortality of any country. The attitudes of young people towards family size, healthy living and reproduction, have implications for the future of the population of Ghana, which is estimated to be 45,213,000 by 2050. Creating a conducive, supportive and healthy environment for young people to learn about their own sexuality and that of the opposite sex will provide opportunities for them to develop healthy attitudes towards sexual and reproductive health. To this end, there is the need to provide all young people with age-appropriate, comprehensive education on values, self-esteem, and the provision of sexual and reproductive health services that cover family planning for those who will need them. This is especially important to empower young women to decide when and if they wish to become mothers.

Empowering young people will also imply assisting them to transit into further education, which will directly and indirectly contribute to delay in marriage and childbearing, and prepare them for the world of work. Some of these can be achieved through concerted efforts on the part of various stakeholders such as parents, community members, those who influence the life course of young people and the government through laws, policies and programmes.

Although the proportion of young people who are infected with HIV is low, considering the minimum period from infection to the stage of manifestation of the infection, it would appear that the majority of HIV+ females were infected when they were in their late teens or early twenties. Therefore, reducing the incidence of HIV infectionamong young people will have atremendous impact on the future trajectory of the epidemic. Furthermore, preventing RTIs, including HIV, among young people is less expensive than treatment.

4.3 Promoting Responsible Lifestyle and Living

At this phase of development, young people are responsive to new ideas and, therefore, it constitutes an opportune time to promote acceptable values, including good and healthy practices as part of the general education towards responsible living. This is a stage for inculcating positive behaviours patterns on aspects of life such as gender norms, attitudes to self, neighbours and people of the same and opposite sex and respect for the rights of others.

4.4 Situating the Policy in National Setting

The Government of Ghana has adopted various international and national conventions, policies and programmes which have implications for individuals, families and the nation, and some of which relate directly to young people. There are policies such as the national commitment to universal basic education, gender equality, equity and empowerment of females, wealth creation and employment programmes, which target young people. Meeting the objectives of these programmes will have implications for the size of the population of young people entering into the various transitions in the next decade.

The policy is also meant to complement a number of existing national policies and action plans which respond to the needs of the population and to young people. Among them are aspects of the Fourth Republican Constitution of 1992, The Children's Act, Human Trafficking Act, Ghana Shared Growth and Development Agenda (GSGDA), the National Population Policy, the National Youth Policy, the National HIV/AIDS and STI policy, the National Reproductive Health Policy and Standards, the National Health Policy (Creating wealth through health), Ghana Strategic Plan for the Health and Development of Adolescents and Young People: 2009-2015, as well as some of the national laws and bye-laws passed by

District, Municipal and Metropolitan Assemblies such as those that specifically target young people.

The enforcement of some of the laws and the implementation of the policies and programmes have implications for the life course of young people: they constitute investment in young people to enable them toachieve their potential as well as forthe development of the country

5.0 BENEFICIARIES

The policy targets two broad categories of people: Primary and Secondary. The first is the young people who are the immediate beneficiaries of the policy. The secondary beneficiaries all other people who provide services and/or interact with young people on regular basis and those who influence the lives (e.g. knowledge, attitudes and behaviour) of young people, either directly or indirectly.

5.1 Primary Beneficiaries

The primary recipients of the policy are young people aged 10 to 24 years. For this policy, the group is referred to as young people. Within this age group are various categories of young people including age (10-14, 15-19, 20-24), gender, those who are in- or out-of-school, married or unmarried, in rural, semi-urban and rural environments, those with special needs, vulnerable and marginalized populations.

5.1.1 In-school Young People

This category consists of young people in upper primary, junior and senior high schools, training institutions/colleges and other tertiary institutions. The school, as a socializing agency, provides an avenue for learning new skills and for the acquisition of knowledge and values including those on sexual and reproductive health. Pupils and students at all levels of the school system constitute a captive audience who can be easily reached with reproductive health information and services.

5.1.2 Out-of-school Young People

The out-of-school adolescents and young people include those who have never attended school, those who dropped out of school for various reasons, young people involved in anapprenticeship, the unemployed or home bound. It is a mixed group and they may be organized or not organized. Unlike those inschool, some of these young people are difficult to reach with reproductive health information and services. Therefore, it is important to identify and target these groups separately for sexual and reproductive health interventions.

5.1.3 Special Groups

The special groups category encompass a wide range of young people and they are identified separately due to their special needs. They can be married or unmarried, sexually active or inactive, residents of rural or urban areas, as well as young people in peculiar circumstances such as those involved in commercial sex work, homeless, persons with disability, young parents, persons living with HIV and AIDS, marginalized groups and females in ritual servitude (e.g. *Trokosi*) and young survivors of any form of abuse. The special groups have diverse sexual and reproductive health needs, and should be considered separately in the design and implementation of programmes and activities targeting young people.

5.2 Secondary Beneficiaries

Secondary recipients of the policy are the individuals and groups who influence the knowledge, attitude and behaviour of adolescents and young people; and/or are either directly or indirectly involved in the socialization process of young people. Understanding the secondary beneficiaries is important for designing programmes, which address their fears, and concerns about sexual and reproductive health needs of young people.

5.2.1 Family

In this category are parents, siblings, spouses/partners of adolescents, guardians and other immediate family members. These are people who have immediate and direct contacts with young people on regular basis. It is the unit that provides the immediate needs of young people. As members of the family of orientation, their values also become the building blocks for the subsequent behaviour of young people. The prevailing socio-cultural milieu and the socio-economic status of the unit also influence young people through the family.

5.2.2 Other Significant Actors and Institutions

This consists of individuals and actors in institutions, which provide services or interact with young people. These include teachers, health care providers, vocational trainers, traditional, opinion/community leaders, religious leaders, celebrities, policy makers, social workers, security personnel, media personnel, youth-related service providers and programme managers. The institutions consist of bothformal structures such as government establishments (Ministries, Departments and Agencies (MDA)), organized religious groups, community-based organizations and non-governmental organization, as well as informal structures such as associations and groups.

The mandate of an institution and the orientation of the actors also influence the nature, approach, and content of the programmes and activities developed and implemented by young people. Therefore, it is important for these institutions and the actors to be targeted in order to address their concerns and to provide opportunities for the sharing of experiences.

6.0 VISION, MISSION AND GOALS

The development of any country is tied to a knowledgeable and healthy youthful population achieved through enhanced and appropriate education. To achieve these objectives,young people require discerning guidance from adults and through enabling policies and in a supportive environment. These policies may be founded on ethics, the common good, the best practices in religion and some aspects of culture. The aim is to form women and men of conscience, who are competent and compassionate. Such a goal requires the formation of the human person, and educational processes that help the person as an individual and as a person-in-community to strive to achieve holistic development.

These areachievable when young people have the requisite knowledge andaccess to better, friendly, comprehensive and responsive health services, including sexual and reproductive health services in a conducive environment. Indeed, meeting the reproductive health needs of young people paves the way for healthy adults in the future.

6.1 Vision

To have young people who are well-informed about their sexual and reproductive health and rights, and are healthy.

6.2 Mission

To improve the knowledge and health status of young people in the country through education and the promotion of healthy sexual lifestyles within the context of accessible, affordable, efficient, quality, as well as sustainable, friendly and responsive health services, in a conducive and supportive socio-cultural and political environment and legal framework.

6.3 Goal

The overall goal of the policy is to mainstream sexual and reproductive health and rights of young people in the national health and developmental processes with the view to improving their quality of life.

7.0 TARGETS

The targets for the sexual and reproductive health policy are grouped into two broad areas namely, health and demographic and socio-economic.

7.1 Health and Demographic Targets

1. By 2020, provide a national database on 80 percent of key indicators of thesexual and reproductive health of young people and 100 percent by 2034.
2. By 2034, increase the proportion of females aged 15-19 years using modern contraceptive methods from 6 percent in 2014 to 38 percent and among those aged 20-24 years from 21 percent in 2014 to 53 percent.
3. By 2034, increase the proportion of married females aged 15-19 years using modern contraceptive methods from 17 percent in 2014 to 48 percent and among those aged 20-24 years from 29 percent to 57 percent
4. By 2034, reduce the unmet need for family planning among married females aged 15-19 years from 51 percent in 2014 to 37 percent and among those aged 20-24 years from 34 percent to 22 percent.
5. By 2034, increase the proportion of young males aged 15-24 years with 2 or more partners who used condoms in the last 12 months from 34 percent in 2014 to 66 percent.
6. By 2034, increase the proportion of females aged below 20 years who deliver with the assistance of a skilled provider from 72 percent in 2014 to 90 percent.
7. By 2034, reduce total induced abortion rate among females aged 15-19 years from 17 percent in 2007 to 5 percent and among those aged 20-24 years from 25 percent to 5 percent.
8. By 2034, reduce the incidence of unsafe abortion practices among young people by 80 percent.
9. By 2034, reduce new infections of HIV among young people aged 15-24 years from 59 per 100,000 in 2014 to 27 per 100,000.
10. By 2034, reduce the proportion of young people aged 15-24 years with sexually transmitted infection from 16 percent in 2014 to 5 percent.
11. By 2034, reduce the proportion of women aged below 20 years who give birth from 14 percent in 2014 to 5 percent.
12. By 2034, reduce the proportion of females who become pregnant at the JHS by 50 percent; and
13. By 2034, reduce the proportion of females who have first sex before the age of consent (16 years) from 25 percent to 10 percent and for males, from 17 percent in 2014 to 8 percent.

7.2 Socio-Economic Targets

1. By 2034, achieve universal basic and secondary school education for all.
2. By 2034, achieve gender equity in secondary and tertiary education.
3. By 2034, ensure that all in-school young people have access to age-appropriate, and culturally sensitive comprehensive sexual and reproductive health education.
4. By 2034, ensure that all in-school young people have access to counselling and other related services.
5. By 2034, provide 50 percent of out-of-school young people with accurate, age-appropriate, culturally sensitive and comprehensive sexual and reproductive health information.
6. By 2034, ensure that 50 percent of out-of-school young people have access to counselling and other related services.
7. By 2034, ensure that adequate sports and recreational facilities are provided in 80 percent of all basic and secondary schools.
8. By 2034, ensure that 50 percent of out-of-school young people have access to sports and recreational facilities.
9. By 2034, provide life-skills to 50 percent of in-school and out-of-school young people.
10. By 2034, introduce entrepreneurship skills to 50 percent of basic and secondary school students and out-of-school young people.
11. By 2034, ensure that the unemployment rate among out-of-school young people aged 15-24 years is reduced by 50 percent.
12. Secure ring-fenced budget allocation of 50 percent by 2025 and 80 percent by 2034 for sexual and reproductive health and rights programmes for young people.

8.0 OBJECTIVES AND STRATEGIES

The specific objectives of the Policy are to:

1. Promote conducive and supportive environment within which young people will understand and be able to exercise their sexual and reproductive health rights;
2. Strengthensexual and reproductive health education which inculcates in young people, the ideals of responsible living and mutual respect for people of the same and opposite sexes;
3. Strengthen the provision of accessible, innovative and effective communication channels and skills that will enable young people tomake informed decisions about their sexual and reproductive health and rights;
4. Strengthen programmes that improve access to quality, confidential, affordable, acceptable, equitable and sustainable comprehensive sexual and reproductive health services and rights to young people;
5. Facilitate research, monitoring and evaluation which will inform programmes and activities involving the sexual and reproductive health and rights of young people and for national development;
6. Strengthen the capacity of the National Population Council to co-ordinate programmes on sexual and reproductive health and rights of young people;
7. Strengthen the capacity of young people and other stakeholders on sexual and reproductive health and rights of young people;and
8. Facilitate the development of strategies for resource mobilization to support programmes and activities on thesexual and reproductive health of young people.

The objectives of the Policy shall be pursued through the following strategies:

OBJECTIVES	STRATEGIES
OBJECTIVE 1 **PROMOTE CONDUCIVE AND SUPPORTIVE ENVIRONMENT WITHIN WHICH YOUNG PEOPLE WILL UNDERSTAND AND BE ABLE TO EXERCISE THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS**	**STRATEGIES** • Advocate for amendments, where necessary, and the harmonization of existing legislation, strategies and guidelines on young people's sexual and reproductive health and rights; • Strengthen coordination and collaboration among key stakeholders (government establishments, NGOs and CBOs) to improve sexual and reproductive health and rights of young people; • Engage relevant stakeholders in the design and implementation of policies and programmes on sexual and reproductive health and rights of young people; • Empower parents, caregivers and school authorities to participate in programmes and activities on sexual and reproductive health and rights for young people, including vulnerable and marginalized groups; • Advocate for programmes which target parents, religious, opinion/traditional leaders as well as other influential persons to address their fears and concerns about sexual and reproductive health and rights of young people; • Engage political, religious and traditional leaders to support programmes and activities on sexual and reproductive health and rights for young people, including vulnerable and marginalized groups; • Involve all young people, including the vulnerable and marginalized in advocacy, to ensure the creation of conducive and supportive environments for programmes which meet their sexual and reproductive health and rights' needs; and • Advocate for the creation of spaces for young peoplewhere they can be assured of social, physical, psychological safety at home, inschool and in the community.
OBJECTIVE 2 **STRENGTHEN SEXUAL AND REPRODUCTIVE HEALTH EDUCATION WHICH INCULCATES IN YOUNG PEOPLE, THE IDEALS OF RESPONSIBLE LIVING AND MUTUAL RESPECT FOR PEOPLE OF THE SAME AND**	**STRATEGIES** • Advocate for regular review of in-school curricula on sexual and reproductive health and rights with the view to meeting the changing needs of young people; • Advocate for the harmonization and coordination of comprehensive sexual and reproductive health education that responds to the diverse and changing needs of out-of-school youth; • Strengthen the use of gendered perspectives and

OPPOSITE SEXES	rights-based approaches in the development and implementation of sexual and reproductive health education and programmes for in- and out-of-schoolyoung people; • Support the development of sexual and reproductive health education that responds to the needs of young people with disabilities and other vulnerable and marginalized groups; and • Facilitate the development of pre- and in-service education and training for teachers, facilitators, counsellors, parents and other care givers involved in sexual and reproductive health education for young people.
OBJECTIVE 3 **STRENGTHEN THE PROVISION OF ACCESSIBLE INNOVATIVE, AND EFFECTIVE COMMUNICATION CHANNELS AND SKILLS THAT WILL ENABLE YOUNG PEOPLE MAKE INFORMED DECISIONS ABOUT THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS**	**STRATEGIES** • Promote effective coordination of programmes among relevant stakeholders in the provision of comprehensive knowledge and wide range of life-skills on sexual and reproductive health and rights for young people; • Facilitate and promote evidence-based behavioural change communication campaigns that are age-appropriate, gender and culturally sensitive to improve and sustain positive sexual and reproductive health and rights of young people; • Strengthen traditional and modern channels, including art forms, for communicating information on sexual and reproductive health and rights to young people and other stakeholders; and • Facilitate programmes that raise the voices of young people at the local, regional, national and international levels.
OBJECTIVE 4 **STRENGTHEN PROGRAMMES THAT IMPROVE ACCESS TO QUALITY, CONFIDENTIAL, AFFORDABLE, ACCEPTABLE, EQUITABLE AND SUSTAINABLE COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND RIGHTS TO YOUNG PEOPLE**	**STRATEGIES** • Strengthen multi-sectoral collaboration in the design and implementation of sustainable programmes and services in sexual and reproductive health and rights for young people • Promote the provision of health facilities with youth-friendly and responsive sexual and reproductive health service corners; • Strengthen the provision of comprehensive sexual and reproductive health and rights services for young people; • Promote responsible sexual behaviour and small family- size norm through increased access to comprehensive information and services; • Promote sustainable programmes and services which seek to reduce unintended pregnancies and reproductive tract infections, including STIs and HIV;

	• Strengthen the provision of comprehensive abortion care; and • Support the provision of innovative information and services, which respond to the sexual and reproductive health needs of vulnerable and marginalized young people.
OBJECTIVE 5 PROMOTE RESEARCH, MONITORING AND EVALUATION WHICH WILL INFORM PROGRAMMES AND ACTIVITIES INVOLVING THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE AND FOR NATIONAL DEVELOPMENT	**STRATEGIES** • Strengthen structures for undertaking research and dissemination of research evidence; • Generate reliable and timely data as basis for formulating, implementing and reviewing policies and programmes on sexual and reproductive health and rights for young people; • Strengthen the capacity of young people to synthesize research output on their sexual and reproductive health and rights; • Liaise with relevant bodies to improve existing data banks to provide data to inform the development of key indicators for monitoring and evaluating programmes on reproductive health and rights of young people;and • Promote the scaling-up of good practices in planning and programme implementation on sexual and reproductive health and rights for young people.
OBJECTIVE 6 STRENGTHEN THE CAPACITY OF THE NATIONAL POPULATION COUNCILTO CO-ORDINATEPROGRAMMES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE	**STRATEGIES** • Strengthen the capacity of the Council to co-ordinate and link efforts of key players involved in all aspects of sexual and reproductive health and rights of young people; • Strengthen the capacity of the Council to enable it tomobilizeinternal and external resources for programmes on sexual and reproductive health and rightsof young people; and • Strengthen the capacity of the Council to enable it toensure effective and efficient use of resources for sexual and reproductive health and rights of young people**;** and • Strengthen the National Population Council to coordinate, monitor and evaluate programmes on sexual and reproductive health and rights of young people at the national, regional and district levels**.**
OBJECTIVE 7	**STRATEGIES**

STRENGTHEN THE CAPACITY OF YOUNG PEOPLE AND OTHER STAKEHOLDERS ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE	• Build the capacity of young through innovative approaches to enable them tocontribute to the conceptualization, design and implementation of programmes on their sexual and reproductive health and rights; • Train, re-train and re-orient professionals who work on sexual and reproductive health and rights of young people, including those who deal with vulnerable and marginalized groups; and • Build the capacity of the media in sexual and reproductive health and rights of young people
OBJECTIVE 8 **FACILITATE THE DEVELOPMENT OF STRATEGIES FOR RESOURCE MOBILIZATION TO SUPPORT PROGRAMMES AND ACTIVITIES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE**	**STRATEGIES** • Advocate for ring-fencing of a national fund, through budget allocation, for sexual and reproductive health and rights of young people; • Mobilize internal and external resources as well as technical support for programmes and activities on sexual and reproductive health and rights of young people; • Strengthen the capacity of organizations and individuals for effective and efficient use of resources; and • Engage Development Partners to ensure continuous support for programmes and activities in sexual and reproductive health and rights of young people;

9.0 IMPLEMENTATION FRAMEWORK

The complexity of sexual and reproductive health needs of young people requires multi-disciplinary and multi-sectoral approach. Therefore, achievinga comprehensive reproductive health care for young people proposed in this policy requires the involvement of government ministries, departments and agencies, non-governmental organisations, the private sector, development partners, civil society organisations, faith-based organizations, communities, families and individuals.

10.1 *Coordinating Body*

The National Population Council (NPC) shall be responsible for the coordination of the programmes under this policy at national, regional and district levels.The NPC shall:

- Ensure comprehensive dissemination of the policy to all stakeholders;
- Ensure periodic review of policies and programmes of ministries, departments and agencies, civil society organizations and other institutions involved in sexual and reproductive health of young people;
- Advocate for policies and laws that facilitate sexual and reproductive health pro-grammes for young people;
- Advocate for the rights of young people to sexual and reproductive health and rights information and services;
- Ensure the development of research agenda and protocols for monitoring and evaluating programmes on the sexual and reproductive health and rights of young people; and

- Mobilize resources as well as monitor their effective and efficient utilization for reproductive health and rights programmes for young people and advise thegovernment on same.

In the pursuit of the above functions, the NPC Secretariat, in consultation with the appropriate bodies, organizations and individuals, shall establish the following organs to support the implementation of the Policy:

- A National Steering Committee (NSC): There shall bea National Steering Committee on the Sexual and Reproductive Health and Rights of young people. Membership shall be representatives of key agencieswhose mandate involves aspects ofsexual and reproductive health and rights of young people and individuals in policy, programmes and academia. The Chair shall be appointed from outside the NPC Secretariat;
- A Co-ordinating Committee: This shall be composed of representatives of major agencies and organization implementing programmes in sexual and reproductive health for young people. The Committee shall be Chaired by the NPC Secretariat and shall report to the NSC; and
- Facilitate the formation of a coalition on thesexual and reproductive health of young people to assist in advocacy and other activities to enhance the implementation of policies and programmes.

10.2.1 Roles and Responsibilities of key State Institutions and Civil Society Organisations

To ensure themulti-sectoral approach to the implementation of this policy, a number of ministries, departments and agencies, organizations and institutions have been identified in the development and implementation of efficient and effective reproductive health programmes and activities for adolescents and young adults. The roles and responsibilities assigned to these ministries, departments and agencies align with their statutory mandate that established them.

10.2.2 *Ministry of Health and the Ghana Health Service*

The Ministry of Health and the Ghana Health Service are the main institutions directly responsible for the provision of health care in Ghana. These two institutions are among the major agencies currently providing sexual and reproductive health information and services to young people. The Ministry of Health and the Ghana Health Service shall continue to:

- Provide young people with responsive information and quality services such as counselling, family planning and STI, including HIV/AIDS management, to young people;
- Promote the training of health professionals in the provision of friendly and responsive sexual and reproductive health information and services to young people
- Provide training to other departments, agencies and civil society organisations; involved in young people's sexual and reproductive health in order to ensure that the services they provide conform to the standards and quality care set out in the Ministry of Health's reproductive health protocols and standards;
- Initiate and promote innovative interventions in sexual and reproductive health for young people;
- Undertake operations research and other scientific inquiry on young people's sexual and reproductive health and rights;

- Coordinate programmes and activities of departments, agencies, and civil society organisations involved in providing sexual and reproductive health information and services to young people;
- Advocate for periodic review of sexual and reproductive health policy for young people and recommend appropriate changes if need be; and
- Monitor and evaluate sexual and reproductive health services and programmes for young in the country.

10.2.3 *Ministry of Education and the Ghana Education Service*

The Ministry of Education and its agencies, the Ghana Education Service (GES) and private educational institutions are important players in the formulation and implementation of sexual and reproductive health policies and programmes for young people. Sexuality and sexual and reproductive health education in schools provide vital information for young people and prepare them for holistic life including being responsible members of society. The school environment also offers an opportunity to create and foster positive reproductive health behaviour among adolescent and young people thereby prepare them for ahealthy lifestyle in adulthood. Therefore, the Ministry of Education and the Ghana Education Service shall:

- Ensure that the school curricula at all levels have contents on learning about the developmental phases of life, sexual and reproductive health, relationships, gender equality and equity, respect for other people's rights and responsible adulthood;
- Ensure a healthy school environment for teaching and learning and the development of positive sexual and reproductive health attitudes and practices;
- Strengthen services, including primary health care, guidance and counselling in schools;
- Initiate and promote programmes that address gender-based biases in the curriculum and in the school system;
- Ensure gender equity in the allocation of resources in schools;
- Undertake periodic review of the school curricula which contain aspects of sexual and reproductive health and rights as well as those in the non-formal education curricula;
- Strengthen the sexual and reproductive health content in the curriculum of colleges of education;
- Provide in-service training to re-orient and upgrade the knowledge and skills of teachers in providing responsive sexual and reproductive health information, counselling and other services to students;
- Conduct periodic review and research on knowledge, attitudes, experience, values, needs and aspirations in sexual and reproductive health of young people as well as the teaching of topics; and
- Collaborate with other key sectors such as health, employment and social welfare, gender, youth and sports, religious groups and families to promote sexual and reproductive health for young people in their programmes.

10.2.4 *Ministry of Youth and Sports, the National Sports Authority (NSA) and the National Youth Authority (NYA)*

The Ministry of Youth and Sport shall support the implementation of this policy through the implementation of the National Youth Policy. The Ministry, the NSA and the NYA shall:

- Initiate and promote sexual and reproductive health for young people into their programmes;
- Strengthen the National Youth Authority to promote and co-ordinate sexual and reproductive health programmes for young people;

- Provide youth centres, recreation and sports facilities and other services for adolescents nationwide;
- Train staff who provide quality sexual and reproductive health information and services for young people;
- Provide employable skills to adolescents, especially, those in the identified special categories, in order to reduce their dependence on others and give them self-esteem;
- Promote sexual and reproductive health among out-of-school and special youth groups; and
- Liaise with other Ministries, agencies, department and CSOs to provide services and intervention that will promote healthy sexual and reproductive health among young people.

10.2.5 *Ministry of Communications and the Media*

Both traditional and social media play significant roles in the provision of information about sexual and reproductive health for young people. While the traditional modes are still useful and should be promoted, the social network platformssuch as Facebook and MySpace, which have become popular platforms for young people to share ideas and experiences, also need to be promoted. Young people are resorting to the new media to find and maintain relations, look for answers to their sexual and reproductive health challenges and to search for service. These new platforms, which provide anonymity and ready answers to questions, have become important resources for sexual and reproductive health education for young people. In this policy, it is expected that the Ministry of Communications, the Media Commission and both public and private media establishments shall:

- Promote and disseminate accurate, timely and reliable information on sexual and reproductive health for young people through traditional and social media;
- Develop programmes to sensitize people on harmful practices which affect the health of young people such as violence, abuse female genital cutting, servitude and neglect as well as highlight practices whichenhance gender equality and equity;
- Promote positive media images and appropriate role models for peers and adults of both sexes to young people;
- Develop appropriate guidelines for addressing and reporting on sexual abuse in collaboration with relevant authorities in order to protect and respect the rights victims and their families;
- Conduct research on sexual and reproductive health and rights-related issues of young people;
- Utilise appropriate traditionalfolk media to promote sexual and reproductive health and rights;
- Engage young people in the development of materials on their sexual and reproductive;
- Engage various secondary beneficiaries to develop materials which address their concerns on sexual and reproductive health of young people; and
- Sensitise families, individuals and communities on sexual and reproductive health issues of young people.

10.2.6 *Ministry of Employment and Labour Relations*

The Ministry of Employment and Labour Relations is responsible for the promotion of sustainable employment opportunities, management and vocational skills development, training, and re-training. The support of the Ministry of Employment and Labour Relations to the implementation of this policy shall be to:

- Promote the provision oflife longemployable skills to young people, especially, those identified in the special categories;
- Promote the rights and responsibilities of young people to decent work and encourage employers and other adults to respect these;
- Ensure that agencies within the Ministry incorporate sexual and reproductive health issues of young people into their programmes;
- Advocate for equal employment opportunities for young people of both sexes, persons with disabilities, and other marginalised and vulnerable young people; and
- Liaise with other Ministries, agencies, department and CSOs to provide services and intervention that will promote healthy sexual and reproductive health among young people.

10.2.7 *Ministry of Local Government and Rural Development*

Per its mandate, the Ministry of Local Government and Rural Development is responsible for the mobilization of resources, formulation, implementation, monitoring, evaluation and co-ordination of policies and programmes at the regional, metropolitan, municipal and districtlevels. It, therefore, has a special role in the promotion of youth-related programmes including those on sexual and reproductive health and rights. The Ministry and its agencies (metropolitan, municipal, and district assemblies) shall:

- Ensure that assemblies provide budget lines for sexual and reproductive health programmes and activities for young people.
- Engage in resource mobilisation at the local level to support sexual and reproductive health programmes and activities for young people.
- Monitor, in collaboration with the National Population Council, the activities of NGOs in their locality who areinvolved in programmes and activities on sexual and reproductive health for young people;
- Advocate for the promotion of sexual and reproductive health programmes for young people among community and opinion leaders as well as youth groups in their locality;
- Ensure the integration of sexual and reproductive health for young people in the development plans of metropolitan, municipal and district assemblies
- Promote gender equity in programmes in their areas of jurisdiction;
- Support research at the local level on sexual and reproductive health for young people and related issues;
- Liaise with traditional authorities to sensitize people on harmful practices which affect the health of young people such as violence, abuse female genital cutting, servitude and neglect as well as highlight practices which enhance gender equality and equity; and
- Coordinate sexual and reproductive health programmes for young people in their areas of jurisdiction in collaboration with relevant agencies and bodies.

10.2.8 *Ministry of Gender, Children and Social Protection*

The Ministry is responsible for the formulation of gender and child-specific development policies, guidelines, advocacy tools strategies and plans for implementation by MDAs, Private Sector Agencies, NGOs, Civil Society Organizations, and other Development partners. It also has the mandate to promote the social, economic and general well-being of children and young people, women and the vulnerable in society. As the government agency directly responsible for gender and social protection, the Ministry shall:

- Advocate for the formulation and implementation of programmes and activities that promote the welfare of young people, including reproductive health;

- Promote research on norms, beliefs and practices on sexual and reproductive health and rights which impact on the welfare of young people;
- Advocate for the strengthening of strategies which promote gender equality and equity, empowerment and rights of women, the girl-child and vulnerable groups on a wide range of areas including sexual and reproductive health of young people;
- Ensure that the sexual and reproductive health needs of young boys are also addressed in all programmes;
- Encourage and support organizations involved in youth-related activities to provide quality sexual and reproductive health services and programmes; and
- Liaise with other bodies and sector ministries to promote adolescent reproductive health

10.2.9 *Ministry of Chieftaincy and Traditional Affairs*

The Ministry of Chieftaincy and Tradition Affairs has the mandate to preserve, sustain and integrate regal, traditional and cultural values and practices into national development programmes. They also have the responsibility to create and sustain harmony as part of the total national development process. Therefore, the Ministry shall:

- Promote and preserve culture, norms, values and practices that ensure healthy reproductive health among adolescents and young people
- Ensure the promotion and packaging of culturally appropriate information on sexual and reproductive health of young people; and
- Ensure that traditional authorities discourage and prohibit cultural practices that are harmful as well as assist to preserve the positive ones, which can be used to enhance the sexual and reproductive health and rights of young people.

10.2.9.1 *Law Reform Commission*

As the national body charged with the review of laws in the country, the Commission has the mandate to ensure the protection of young people. With its mandate to revise existing laws and statutes as well as draft new ones, the Commission is expected to:

- Conduct periodic review of existing laws that relate directly or indirectly to young people, especially, those on adolescent sexual and reproductive health and bring them into conformity with changing situations.
- Initiate and promote laws that promote thesexual and reproductive health of young people in the country.
- Conduct research on laws and practices that affect the sexual and reproductive health of young people.

10.2.9.2 *National Commission for Civic Education*

The Commission's core responsibilities include the formulation and implementation to education and inculcate in Ghanaians an appreciation of their rights and obligations as free people to ensure equality in the population. In this regard, the Commission shall:

- Support the dissemination of this policy.
- Educate the general public on practices such as gender relations that have implications for the development of adolescents, especially females.
- Advocate for gender equity in all the programmes and activities under taken in the country and
- Monitor programmes and activities on sexual and reproductive health for young people.

10.2.9.3 *Private Sector and Non-Governmental Organizations (NGOs)*

The private sector and NGOs contribute in various ways to support government efforts in the provision of health and wellbeing for it people. In Ghana, there isa number of private sector institutions and NGOs involved in the delivery of reproductive health services and programmes in various geographical areas across the country. The private sector and NGOs, therefore, constitute important stakeholders in the promotion of sexual and reproductive health for young people. To support the implementation of this policy, the private sector and NGOs are encouraged to:

- Promote programmes in sexual and reproductive health for young people, especially for persons with special needs.
- Pioneer innovative programmes on sexual and reproductive health for young people.
- Mobilize resources to supplement government efforts in adolescent sexual and reproductive health.
- Assist to develop indicators for monitoring and evaluating sexual and reproductive health programmes for young people in the country.
- Train its members to provide quality adolescent responsive sexual and reproductive health services within the context of their mandate.
- Advocate for the need to put young people's sexual and reproductive health issues constantly on the development agenda of the country.
- Research into aspects of sexual and reproductive health among young people in their areas of operation.
- Maintain linkages with government agencies and the co-ordinating body and
- Develop effective networking among its members to promote the objective of providing quality sexual and reproductive health services for young people.

10.2.9.4 *Religious Bodies*

Most Ghanaians belong to one religious sect or the other. Therefore, religion forms an important agent of socialisation and has the ability to influence people's lives through the values, ideals, principles and moral tenets. In addition, a number of religious bodies have specific programmes that aim at improving the health of young people including their sexual and reproductive health. To support the implementation of this policy, religious bodies are encouraged to:

- Provide guidance and counselling to adolescents, young people, parents as well as the community on reproductive health that are consistent with the spirit of the policy.
- Promote the rights and responsibilities of adolescents and young people of both sexes among their congregation.
- Provide adolescent sexual and reproductive health information and services in line with the principles of this policy.
- Promote religious practices that promote health, sexual and reproductive health and discourage those that compromise health and human welfare.
- Education and sensitize their leaders and members on adolescent sexual and reproductive health issues, including gender-based discrimination and
- Conduct research on innovative ways of promoting reproductive health among adolescents and young people within their religious groups and in their catchment communities.

10.2.9.5 *The Family and Community*

Apart from the school, young people spend most of their lives with families and in the community. Therefore the families and communities into which children are born, live and grow are their primary agents of socialization and hence critical in their behaviour formation including sexual and reproductive health behaviour. For this reason, the family and the community have roles to play in the implementation of the Sexual and Reproductive Health Policy for Young People. In this respect, the families and communities are expected to:

- Create conducive environments in which children will grow to appreciate the benefits of responsible adulthood.
- Ensure that parents and young people receive reliable and timely information on adolescent sexual and reproductive health.
- Create conditions for parents, families and communities to interact with government departments and agencies, NGOs and private sector institutions that provide sexual and reproductive health for young people.
- Review community norms, practices and regulations in order to eliminate those, which have negative consequences on sexual and reproductive health.
- Educate parents and young people on their rights, roles and responsibilities.
- Assist communities to provide services such as counselling, family planning, and in-service training to parents, adolescents, young people and service providers and
- Ensure that families and communities are sensitized on sexual and reproductive health issues, including gender-based discrimination and violence

11.0CONCLUSION

Young people constitute the potential human capital for socio-economic development and should be provided withthe means to lead healthy and economically productive lives. Through the established structures and concerted efforts, it should be possible for state institutions and civil society organisations to meet the sexual and reproductive health needs of young people as part of an integrated nationaldevelopment plan. With an implementation plan, based on the objectives and identified strategies, the sexual and reproductive health policy shouldcontribute to the establishment of a society, which ensures healthy sexual lives, and promote well-being of young people. When managed properly, the potential of young people can be utilised to enable the country toachieve the demographic dividends.