# The Politics of Global Policy Frames: An Analysis of Reproductive Health in Ghana

Canadian Political Science Association Annual Conference

N01 Panel: Women, Gender, and Politics (Gender in a Global Context)

University of Regina
May 30-June 1, 2018, Regina, Saskatchewan, Canada

**By**

Candace Johnson
Professor
cajohnso@uoguelph.ca
&
Ebenezer Bossman Agyei
PhD Candidate
eagyei@uoguelph.ca

Department of Political Science
University of Guelph
Guelph, ON, N1G 2W1

**Abstract**

Over the past few years, relatively little attention has been paid to issues regarding adolescent and youth health. However, given the recent paradigm shift in global thinking, young people's health and well-being has gained uncommon traction. Multiple discourses surrounding global health are in vogue, and it is useful to identify and analyze how adolescent and youth health have been framed, and their implications for citizenship and reproductive health outcomes for young people. Drawing on the Ghana Adolescent Reproductive Health Programme (GHARH), we argue that an integrated ideational policy discourse, coupled with a strong sense of national government ownership and commitment, is critical to advancing and sustaining global and national policy initiatives aimed at improving young people's reproductive health and well-being.

**Keywords:** issue framing; global development agenda; adolescent health; policy implementation

## Introduction

Until recently, adolescent and youth health has largely been neglected or considered secondary in relation to women's and children's health, a development that has been attributed to the lack of understanding regarding the health and development challenges that confront young people, as well as the fragmented nature of global governance (Dehne & Riedner, 2001; Fatusi & Hindin, 2010; WHO, 2017). In retrospect, it is also widely acknowledged that the ardent commitment to fulfilling the targets set out in the Millennium Development Goals (MDGs) somewhat undermined the level of consideration in meeting the needs of young people (UNICEF, 2011).

In 2015, global leaders adopted the Sustainable Development Goals (SDGs) – a global policy agenda that established the framework for the consequent development of two adolescent-friendly protocols, namely (1) the updated Global Strategy for Women's, Children's, and Adolescents' Health (hereinafter "The Global Strategy"), and (2) the Global Accelerated Action for the Health of Adolescents (AA-HA!). Apparently, these global policy instruments account for the unprecedented elevation of young people's health into agenda prominence. But in what ways has the issue of adolescent and youth health been portrayed, and to what extent do global policy frames affect citizenship and reproductive health outcomes for young people? Drawing on the Ghana Adolescent Reproductive Health Programme (GHARH), this paper examines the complex dynamics of issue framing, and its implications for young people's reproductive health and well-being in the ever-changing context of globalization. Interestingly, while Ghana has taken advantage of recent global policy initiatives and opportunities, it remains unclear how the gains achieved can be sustained over time.

The politics of ideas and global discursive processes has long received scholarly thought, and continues to attract attention from scholars over the years (Beland & Cox, 2011; Johnson, 2010; Labonté, 2008; Schon & Rein, 1994; Shiffman &

Smith, 2007; Stone, 2012). However, much of the literature on health-related issues have mostly focused on agenda setting and health promotion, thus failing to capture the complex dynamics and ideational mechanisms that drive the implementation of global and national health initiatives. Yet this is an important consideration if global and national health policy arrangements are to yield fruitful and sustainable outcomes.

This paper, therefore, responds to the call for further research concerning the impact of issue framing on vulnerable and marginalized populations (Johnson, 2010). The paper seeks to identify and examine the core policy frames that have galvanized global action on adolescent and youth health development and, most importantly, their intersectionality with the trajectories of national politics. This undertaking will reveal the opportunities associated with the new development Agenda, as well as the potential hurdles that must be confronted to ensure the total transformation of the reproductive well-being of young people, within the broader context of adolescent health. By situating the discussion within larger debates in human rights and issue framing, we argue that an integrated ideational policy discourse, coupled with a strong sense of national government ownership and commitment, is critical to advancing and sustaining global and national policy initiatives targeted at improving young people's health, and more specifically, reproductive health and well-being.

There is general consensus among scholars that the success, or otherwise, of a policy frame is contingent on a number of factors – the power of ideas used to portray the issue, power resources of the actors, the character of the political or institutional context, among others (Johnson, 2010; Schmidt, 2008; Shiffman & Smith, 2007). The present paper is situated within this broader framework of understanding, but focuses particularly on the power of ideas and context, with the view to deconstructing the frames that provide substantive currency to adolescent and youth health development. In short, this paper provides a nuanced understanding of the complexities and politics of global frames, and how that translates at both the global and national level. Ghana merits attention because it is one of the few developing countries that have responded quite well in terms of comprehensive health programming that aligns with the current global Agenda, with adolescent reproductive health as a centerpiece of the development discourse. Needless to say, Ghana has been a leader in reproductive health and family planning across the West African sub-region over the past decades.

## Method

This paper is based on a qualitative research study conducted in Ghana from January – June 2017. The study draws on primary and secondary materials including, global and national health policy documents, published books, journal articles, local newspapers, and other relevant health reports. A series of semi-structured interviews were conducted with individuals centrally involved with the GHARH programme at the national, regional, and district levels. These respondents include officials at the National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA).

Interviews were also conducted with leading officials of the Palladium Group (formerly Futures Group Europe), who constitute the primary implementing and oversight body of the GHARH Programme. Lastly, interviews were held with Non-Governmental Organizations (NGOs), including MAP International, as well as young people aged 10-24 years. Overall, these interviews were helpful in gaining rich information about respondents' perspectives, expertise, and experiences regarding the GHARH intervention. The study area for the research was the Brong Ahafo region.[1] Interviews were, however, also conducted with Palladium and government officials in the Greater Accra region of Ghana.

The remaining sections of the paper are structured as follows: The first section provides a brief overview of the trajectory of adolescent health within the global policy landscape, leading to the adoption of protocols that have animated the discourse on young people's health. Following, is a critical analysis of the core frames embedded in the SDGs, Global Strategy, and the AA-HA! Framework, which provides deep insight into the complexities and analytical tensions surrounding the framing of adolescent health. After this, the next section sheds light on the adolescent health landscape in Ghana, with particular focus on the policies and programmes that have been adopted over time to deal with the health challenges faced by young people. The next three sections of the paper will discuss the GHARH programme, findings from the research, and a focused analysis that provides a conceptual understanding of the intricacies of an integrated ideational policy discourse. The final section weaves the discussion together, with some concluding thoughts on framing and adolescent reproductive health development.

## Health in the Global Context: The Case for Adolescent and Youth Health Development

The past decade has been punctuated with opportunities but also enduring challenges as well, so far as the health of young people is concerned. While significant investments have been made in several areas of global health over time, it has been widely recognized that the adolescent and youth cohort have been shortchanged in terms of social policies and programme interventions; they have been neglected or ignored. As keenly observed by WHO (2002), adolescents are generally perceived to be healthy due to the low death rates of this age group vis-à-vis the child or adult population. However, this misperception has been dispelled in light of new evidence that urgent response is required to confront the horrendous challenges and health inequities faced by the adolescent and youth population (WHO, 2017).

Although the MDGs delivered tangible progress in terms of meeting global and regional targets, empirical evidence proves that the benefits were unevenly distributed across the global community (UN, 2015). More specifically, a wide category of marginalized, disadvantaged, and vulnerable people had been left behind in the development discourse. This worrying reality, therefore, created

[1] Ghana is composed of ten administrative regions.

momentum and set the global stage for policy action on adolescent and youth health. Obviously, the global policy window for adolescent and youth health opened after the adoption of the SDGs, with its landmark slogan, "leave no one behind." SDG #3 specifically captures the adolescent and youth population, and speaks to the need to ensure and promote healthy lives and well-being for all at all ages. As a significant departure from earlier global development commitments, the adolescent, women and children population have been strategically positioned at the forefront of the global development agenda. In line with this reasoning, the Global Strategy (2015) proposes that, "the survival, health and well-being of women, children and adolescents are essential to ending extreme poverty, promoting development and resilience, and achieving the SDGs"(p. 12).

Against this backdrop, the Global Strategy was launched in September 2015 by the United Nations Secretary-General, Ban Ki-moon, to complement the SDGs in the global effort to improve the health and well-being of young people. Deliberations on the Global Strategy at the 68th World Health Assembly (WHA) by delegates from all WHO Member States, complemented by input garnered from the youth and other major stakeholders, resulted in the development and subsequent adoption of the AA-HA! Framework. This policy framework was designed to accelerate action for the health and well-being of adolescents, based on the three core defining principles of the Global Strategy – Survive, Thrive, and Transform.

## Making the Case: Framing for Adolescent Health

The Sustainable Development Goals (SDGs) are generally agreed to constitute an improvement over their predecessor, the Millennium Development Goals (MDGs) for two main reasons. First, they are more broadly conceived and focused on underlying causes of poverty, disease, and inequality, rather than on specific indicators and their measurement. And second, they are articulated in global terms and not directed exclusively at developing countries. As noted, adolescent health is captured by SDG #3, "Ensure healthy lives and promote well-being for all at all ages." The topic addressed in this paper, reproductive health for adolescents, is also the focus of SDG #5, "Achieve gender equality and empower all women and girls." Each goal identifies a number of problems, some intractable and others more amenable to change, and provides evidence of either progress toward the goal or barriers to its achievement. All goals adopt the language and perspective of human rights, which is to say that they acknowledge universal, global norms and standards to be fundamental to development. However, the goals also try to reconcile this foundation with the need to pay close attention to context and cultural differences. To some extent, this produces frame conflict between the metacultural human rights frames and the various action frames for development (Schon & Rein, 1994), although the main argument that we are advancing in this paper is that frames should not compete with each other; rather, framing strategies should be integrative and multiple. We also want to emphasize that we understand frames to constitute both cognitive predispositions (Schon & Rein, 1994) and political strategies (Stone, 1989).

The first frame that gives shape to global initiatives for adolescent health is human rights. This is evident in the SDGs, as noted above, and also in the Global Strategy and AA-HA! Framework. Regarding progress toward SDG #5, the UN reports that, "Gender inequality persists worldwide, depriving women and girls of their basic rights and opportunities"(https://sustainabledevelopment.un.org/sdg5). The 2017 progress report for SDG #3 emphasizes that "Preventing unintended pregnancies and reducing adolescent childbearing through universal access to sexual and reproductive health care is crucial to the health and well-being of women, children and adolescents." While the former makes explicit reference to women's rights, the latter suggests the need for universal access to "sexual and reproductive health services," which is itself framed in politically charged, controversial language. Reference to "sexual and reproductive health" represents a discursive shift away from longstanding (and less politically controversial) commitments to maternal and child health (see, for instance, Johnson 2016: 6-10; more on this below). In any case, the 2017 SDG reports for goals #3 and #5 provide consistent evidence of the same universalist, human rights frame. Human rights are embedded in the SDGs as standard commitments to UN sponsored activities. In other words, they are not *employed* by UN agencies so much as they are *fundamental to UN consciousness* and therefore serve as a metacultural narrative. However, there is also a strategic, action-oriented dimension to the linking of development goals and human rights commitments. The human rights frame signals individuals' rights to a minimum standard of living, dignity, gender justice, and self-determination at the same time that it highlights states' responsibilities to their citizens.

The WHO's Global Strategy also states that human rights are of paramount importance in achieving health goals. In its updated strategy document, it indicates that, "This Global Strategy is much broader, more ambitious and more focused on equity than its predecessor. It is universal and applies to all people (including the marginalized and hard-to-reach), in all places (including crisis situations) and to transnational issues. It focuses on safeguarding women, children and adolescents in humanitarian and fragile settings and upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances" (www.wec-globalstrategyreport-200915.pdf , p. 11). Further, the introduction makes clear that, "The updated *Global Strategy* includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda. By helping adolescents to realize their rights to health, well-being, education and full and equal participation in society, we are equipping them to attain their full potential as adults" (p. 5; see also fuller articulation on p. 37). However, this commitment is significantly different from the SDG commitment to human rights. The Global Strategy develops a three-pronged approach to addressing women's, children's, and adolescent health. The approach is structured with three objectives: Survive, Thrive, and Transform. The first element, "Survive" attends primarily to the standard concerns of maternal and neonatal health and survival. The final two – Thrive and Transform – are more clearly focused on adolescents.

The second predominant frame is that of development. In the documents under consideration here, development is conceived in both cultural and economic terms. Regarding the former, attention to cultural specificity is a challenge to the

human rights frame, as cultural differences and their practice either contradict human rights guarantees outright, or merely frustrate their realization in practice. Regarding the latter, "sustainable development," refers to both economic growth and the strengthening of financing mechanisms for health care. All three global initiatives, the SDGs, the Global Strategy, and AA-HA!, combine cultural and economic elements in their development frames. The SDGs are the most expansive in their approach to development, and integrate well development and human rights considerations. The SDGs identify the specific underlying causes of inequality and premature death and make these preconditions to development the focus of the global initiative. In other words, the SDGs do not just pay attention to gender inequity, poverty, child marriage, FGM as development-related issues, rather the SDGs are themselves commitments to these socio-cultural phenomena.

The SDGs articulate the goals of reducing poverty, improving health, reducing child and maternal deaths, empowering women, and so on, without justifying them in economic terms. The goals are stated as independent imperatives, intrinsically worthwhile, and not of instrumental value (i.e., worthy of pursuit because they will improve economic performance). Workforce participation and economic growth are included as a separate goal (#8), and not directly connected to all other goals. However, the goal of poverty alleviation is central to the Agenda and is highlighted in the preamble to the 2030 Agenda for Sustainable Development: "The importance of context cannot be overstated: the specific details of each action in different settings will depend on political environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviour among women, children and adolescents." (https://sustainabledevelopment.un.org/post2015/transformingourworld). In short, the language of development is broadly presented throughout the SDG Knowledge Platform. Interestingly, the Global Strategy and AA-HA! initiatives were developed in response to the SDG agenda, yet both interpret that agenda in different ways.

The SDGs are the most directly concerned with the cultural dimensions of development, namely the contextual factors that contribute to high rates of adolescent pregnancy, domestic violence, FGM, child marriage, and HIV infection. These are acknowledged in both the Global Strategy and the AA-HA! document, although both tend to focus preponderantly on economic rather than cultural dimensions of adolescent health (ill health as the basis for multi-level, multi-sectoral action). For example, concerning cultural factors, the Global Strategy emphasizes that, "the importance of context cannot be overstated: the specific details of each action in different settings will depend on political environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviours among women, children and adolescents" (Global Strategy, p. 48). However, there is consistent and equally forceful reference to the theme of economic development. To this point, the Global Strategy report states, "If countries in demographic transition make the right human capital investments and adopt policies that expand opportunities for young people, their combined demographic dividends could be enormous. In sub-Saharan Africa, for example, they would be at least US$500 billion a year, equal to about one third of the region's current GDP, for

as many as 30 years" (Global Strategy, p. 20). The entire second chapter of the Global Strategy is dedicated to the theme of investment as one of the primary benefits of improving the health of women, children, and adolescents. This may raise some red flags concerning the existence of neo-liberal predicates, which is to say that the strategy directs itself to adolescent health not as a matter of fulfilment of human rights but as a means of bolstering preparedness of future adults/ productive citizens for participation in the market. Further, the report resolves to, "Identify context-specific needs—including barriers to realizing rights—and promote access to essential goods, services and information. Expand age-appropriate opportunities for socioeconomic and political participation. Ensure that these activities are funded in country plans and budgets" (Global Strategy page 59, point 2).

The Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation – Summary (hereinafter "the AA-HA! document"), is similarly dedicated to economic justifications for development. This document does not make extensive reference to human rights (for brief mention exceptions, see pages 4 and 18). There is an acknowledgment on page 4 that "Adolescents have the fundamental right to health," although this is cast as a reason for "investing" in adolescent health. Further, the document is not primarily focused on development, although it does describe its purpose as achieving the SDGs (vii) and aligning with Global Strategy commitments. To be sure, the AA-HA! document is an implementation guide rather than a grand visioning strategy. Therefore, it is more oriented toward practice (in the realms of both development and health administration), which is dependent on robust partnerships with constituents (adolescents), communities, government stakeholders and decision makers from different sectors, technical support agencies, and donors.

In the AA-HA! document, the imperative for attention to adolescent health is framed as an investment that brings "a triple dividend" (p. 4, 17, and throughout the document). The health benefits that will accrue from improved attention to adolescent well-being and survival include benefits "for adolescents now… for adolescents' future lives… [and] "for the next generation" (4). In addition, the document claims that "investments in adolescent health reduce present and future health costs and enhance social capital" (4). The language of investment is both admirably pragmatic and dubiously instrumental. The language of investment is a sound strategy for convincing governments, political leaders, and policy makers to fund health programs for adolescents. Because revenues and funding sources are limited, it is important to advocate, in whatever language resonates, for the prioritization of vulnerable and often excluded or invisible groups (such as adolescents). However, as Prentice (2009) explains, the economic reframing of complex social justice issues often "sidesteps the problem of social inequality" (p. 692). Moreover, "the business case [for childcare or health care] builds an ideological/ conceptual bridge to contemporary wealth production, not to social transformation" (2009: 693). In other words, the case for investing in adolescent health focuses on future economic returns and minimizes the complexities of persistent socio-economic inequalities, endemic poverty, and patriarchy.

The third frame to be considered here is that of adolescent health. While this seems to be a simple descriptive branding of an important policy focus, it is more complex than that. The shift in focus on maternal and child health to adolescent health as a separate but related health domain, is a strategic rhetorical shift, which might or might not possess any potential for change in health outcomes. There is longstanding criticism of the maternal and child health commitments. These criticisms are well explained elsewhere (Johnson, 2016; Robinson, 2014; Shiffman & Smith, 2007; Tiessen, 2015). Suffice it to say that the focus on maternal health rather than women's health or sexual and reproductive health suggests a pronatalist, conservative bias toward protecting women as mothers. Further, maternal health conveniently tends to ignore the important yet politically divisive issue of abortion (Haussman & Mills, 2012). And finally, maternal and child health seem fused in ways that further emphasize the pronatalist bias and thereby marginalize both women and children as independently vulnerable populations.

The focus on adolescents is both much needed and somewhat mystifying. Both the Global Strategy and the AA-HA! document provide compelling justifications for the isolation of adolescents as a group of particular concern. The SDGs speak directly to the need to focus on adolescents as a vulnerable group. For example, SDG #3 mentions the distinct sexual and reproductive health needs of this population, and SDG#5 speaks to the challenges of achieving gender equity and empowerment for girls, whereas SGD#8 emphasizes the labour rights violations and employment needs of adolescents. In the introduction to the Global Strategy, it is stated that, "for the first time, adolescents join women and children at the heart of the Global Strategy. This acknowledges not only the unique health challenges facing young people, but also their pivotal role alongside women and children as key drivers of change in the post-2015 era. By investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this "SDG Generation" to transform our world" (11). Similarly, the AA-HA! document makes clear that, "adolescents are not simply old children or young adults. This deceptively simple observation lies at the heart of the Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation – which reflects the coming of age of adolescent health within global public health" (foreword, iv).

However, despite the apparent uniqueness of adolescents as a population, there might be more intergroup variation than the updated focus suggests, much of which is still attended to by other global frames. The clearest example of this is the domain (and frame) of maternal health, an area of concern that does not abate in significance under the new frameworks. The SDGs and Global Strategy make abundantly clear that maternal health, related to a wide variety of causes from child marriage to lack of access to medical care, is a major health threat for all women. The AA-HA! document, which is focused exclusively on adolescent health, reveals that the leading cause of death for girls from 15-19 years of age is "maternal conditions" (6), which indicates the precarity of both age and gender. It is possible, given the emphases on maternal health in all three sets of global commitments, that

the rhetorical framing of "adolescent health" will necessitate continued attention to the more conventional action frame of "maternal health."

While we have isolated these three frames – human rights, development, and adolescent health – for analytical purposes, the documents and strategies themselves suggest an integrated approach. We endorse this suggestion, but caution that without explicit and careful attention to individual frames and their components, the political and policy implications of integrated initiatives are obscured. We agree with the admonition of the Global Strategy, which declares that, "Only a comprehensive human rights-based approach will overcome the varied and complex challenges facing women's, children's and adolescents' health. To succeed, countries and their partners will have to take simultaneous action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multisector action; humanitarian and fragile settings; research and innovation; and accountability" (p. 48). The complexity of this endeavor cannot be overstated. It is enormous, and deserving of increased global resources and attention. It is our intention in this paper to demonstrate this position through the case of adolescent health and multi-level initiatives for adolescent reproductive health in Ghana.

## Contextual Overview of Adolescent and Youth Health in Ghana

Before examining the GHARH programme, a brief overview of the Ghanaian health policy landscape is in order. Ghana has demonstrated a significant level of commitment to improving adolescent and youth health over the past few years. Although gaps and challenges remain, the state recognizes the youth as critical assets in the development agenda, which is certainly a good first step towards sustainable prioritization of their needs. To begin with, the Directive Principles of State Policy, as enshrined in the 1992 Constitution, enjoins the State to "seek the well-being of all her citizens" (Article 35, Clause 2). This directive encompasses elements such as human rights, health, education, and economy, among several others. In line with this objective, several policies and programmes have been established across space and time to confront the peculiar challenges faced by young people.

Examples of such policies, programmes and strategies include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), National Population Policy, National Health Policy, National Reproductive Health and Service Policy and Standards, National Youth Policy, Ghana Adolescent Reproductive Health Policy, National Gender and Children Policy, Adolescent Health and Development Programme (ADHD), National Condom and Lubricant Strategy (2016 – 2020), Ghana Family Planning Costed Implementation Plan (2016 – 2020), and more recently, Adolescent Health Service Policy and Strategy (2016 – 2020).

While these policies, programmes and strategies have varied objectives and goals, they share certain commonalities. A significant point of convergence is the goal towards enhancing the general quality of life of young people, which ultimately boils down to effective policy delivery within an enabling environment that

facilitates their smooth transition towards productive adulthood. As noted in the Adolescent Reproductive Health Policy, effective health programming could help to "avert the wasting of the lives of young people" (Section 4.1). More broadly, these national policies, programmes and strategies harmonize under the understanding and recognition of health as a human right issue, the advancement of which leads to empowerment, wealth creation, and overall well-being.

**The Ghana Adolescent Reproductive Health Programme (GHARH)**

Ghana is signatory to several global treaties and conventions that recognize the right to health, and this mechanism, to a great extent, has been instrumental in pushing young people's reproductive health issues and rights to the forefront of the national policy agenda. The GHARH programme is a three-year DFID-funded project (£11.3 million UK aid) implemented by the Palladium Group (international NGO), in partnership with the Government of Ghana (GoG) and other relevant partners (Jan 2014 – March 2017).[2] Through a multi-sectoral approach, the project was instituted to improve reproductive health and educational outcomes for adolescents and youth in all 27 districts in the Brong Ahafo region, with support from four significant collaborative national agencies – National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA). Five selected non-governmental organizations (NGOs) were also engaged as implementing partners for the project – Hope for Future Generations (HFFG), Map International, Planned Parenthood Association of Ghana (PPAG), Women in Law for Development in Africa (WiLDAF), and Institute of Social Research and Development (ISRAD).

Broadly speaking, the GHARH programme specifically aimed at improving national efforts towards the fulfillment of MDG #5 (i.e., improving maternal health), with the ultimate goal of reducing adolescent birth and maternal mortality rates among young people aged 10-24 years in the Brong Ahafo region of Ghana. Perhaps the most striking aspect of the programme is its adaptation to the exigencies of the global policy environment, specifically in relation to the adoption of the SDGs, the Global Strategy, and the AA-HA!, which ultimately served as the overarching framework for policy intervention. Certainly, this 'layering' mechanism profoundly shows the dynamic character of Ghana's policy landscape. In the context of the GHARH initiative, the Brong Ahafo region was selected as the focal point of intervention due to the high rates of adolescent pregnancy, as well as recognized gap and demand in sexual reproductive health services among young people across the region.

Against this backdrop, the expectation was that the programme would help minimize the adolescent pregnancy burden, sexually transmitted infections (STIs), and school drop-out rates (Smith, Pereira, & Bishop, 2016). Also, the GHARH

[2] The Department for International Development (DFID) is one of Ghana's key bilateral donors. DFID has supported the nation with millions of aid towards eradicating poverty and improving social infrastructure over the past decades.

programme sought to strengthen the government's capacity in terms of efficient implementation, management, and effective delivery of adolescent sexual and reproductive health programmes. While the GHARH programme draws on global ideational protocols, it is worth noting that it also rests on existing national policies and strategies – an arrangement that illustrates how the success of global policy frames are dictated by national politics and legitimation mechanisms.

## Implementing the GHARH Programme: Opportunities and Constraints

Findings from the research suggest that although significant strides have been made in relation to improving adolescent reproductive health and well-being in Ghana, challenges still remain. While the full impact of the intervention in terms of reduction in adolescent pregnancy rates is yet to be ascertained, there are aspects of the programme that showcase the virtues of the GHARH initiative. The one-year extension of the programme to the Ashanti region (i.e., Kumasi metropolis) by GoG and DFID, for instance, is a testament to the gains achieved in the Brong Ahafo region, especially considering that the extension was not part of the original contractual arrangement. As noted by the Team Leader, Palladium surpassed most of their targets, hence the vote of confidence by the government and DFID to expand the program.[3]

A key feature of the intervention speaks to the concept of strategic partnership and multi-sectoral implementation. Arguably, this approach constitutes the bedrock of the GHARH intervention. Palladium served as the main implementing body of the project, and through sustained engagement with DFID, NPC, GHS, GES, NYA, NGOs, and other relevant stakeholders and implementing partners, a comprehensive strategy was adopted to guide the implementation of the programme. Of course, the need for concerted action across multi-level governance establishments has gained significant currency in policy and health discourses over the past few years, particularly in response to the complex challenges of modern governance (Lindquist, 2006; Rantala, Bortz, & Armada, 2014; WHO, 2008). As such, the wave of ideational protocols, as discussed above, reinforces the partnership dictum as a symbolic device for advancing adolescent health within the broader context of the new Agenda.

In relation to the GHARH programme, the NPC was engaged because it constitutes the highest statutory body mandated to advice Government on population-related issues and, therefore, served as the coordinating unit for the GHARH intervention. The GHS, GES, and the NYA are also government agencies that work in diverse capacities to enhance the general well-being of the adolescent and youth population. Engaging in-school and out-of-school adolescents was made possible through this joint partnership, and particularly with the help of NGOs and other relevant institutional bodies. Most importantly, the partnership with DFID secured the necessary financial resources to execute the programme.

[3] Interview with Mr. David Logan, Ghana, March 13, 2017.

To be sure, Ghana has undertaken several health programmes involving partnership with other agencies and institutional bodies. Therefore, the concept of multi-sectoral implementation is nothing new. Nonetheless, the GHARH programme seems to offer some useful lessons for future interventions – the elements, structure, quality, and depth of partnership is critical to the successful implementation of adolescent reproductive health initiatives. Indeed, evidence shows that the preceding Adolescent Health and Development programme (ADHD) failed to yield the expected outcomes due to poor understanding of this mechanism (GHS, 2014), a lapse that Palladium sought to rectify through the lens of the Global Strategy and other related protocols.

The GHARH programme, as revealed by the research, has achieved quite a number of successes on many fronts. It is estimated that Palladium provided services for almost over 153,000 young people across the 27 districts in the Brong Ahafo region.[4] As a result, uptake of family planning, maternal and antenatal care was positively impacted. In line with the provision of services, technical support and training was provided to the aforementioned government agencies and other relevant institutional bodies and implementing partners – NPC, GES, GHS, NYA, service providers, peer educators, youth facilitators, among others. In many ways, capacity building was essential to ensure that all individuals, agencies, and institutions engaged were equipped to effectively deliver on the goals of the GHARH programme.

Given the failings of the prior ADHD programme, emphasis was placed on the need to take capacity building more seriously at the national, regional, and district levels. As expressed by a senior policy advisor:

> The ADHD program didn't receive much of the needed support … Sometimes, they assign just a general practitioner to handle adolescent issues, which is not really acceptable. Because adolescent health is not like any general health practitioning; it's a specific specialized area (Field Interview, 2017).

A technical consultant at Palladium also corroborated this point. According to him, building the requisite individual and institutional capacities for adolescent and youth health should be considered a precursor to intervention. He noted, "… *In many areas in many institutions, it just becomes an afterthought*."[5]

The GHARH intervention was also embedded with awareness creation, sensitization, and community mobilization. This allowed for information empowerment among the adolescent and youth cohort in the region. It is estimated that not less than 400,000 young people were reached across the region. About 600 school health clubs were also established across the region to provide education and counseling services to young people. Importantly, Palladium's flagship investment relates to the adolescent health corners. These adolescent-focused health centres were established specifically to provide "safe spaces" or adolescent-friendly services

[4] Interview with Mr. David Logan, Ghana, March 13, 2017.
[5] Interview with Mr. Jacob Larbi, Ghana, Feb. 08, 2017.

to young people in the region. Overall, 54 adolescent health corners were established across the region, with two facilities in each district (this comprises new and refurbished centres). Although the preceding ADHD programme championed the concept of health corners, evidence suggests that most of the established corners were fraught with functionality and integrity issues. Arguably, Palladium's reinvention of the health corners can be interpreted as a symbolic effort at shifting the discourse on adolescent pregnancy from the sphere of intentional cause to institutional responsibility.[6]

Generally, these corners provide counseling services, STI diagnosis, family planning, psychiatric care, antenatal and post-natal care, as well as comprehensive abortion services and referrals for young people. Available data, as well as field visits to some of the health corners shows that young people in the region have, to a significant degree, patronized the services being offered. Overall, it is estimated that about 51,426 young people were reached with sexual reproductive health (SRH) services and information by the GHARH-supported corners (Palladium, 2016). Notably, these corners have been furnished with recreational games such as scrabble, checkers, ludo, cards etc. that are designed to sustain the interest of young people who visit the health corners. Interestingly, the field research revealed that some of the young people frequent the health corners merely to play, and this generates opportunities for the health practitioners to educate them, as well as gradually introduce them to the health services offered at the facilities.

Another innovative idea introduced by Palladium is the television drama series entitled 'You Only Live Once' (YOLO). This educational programme is designed to help young people make sound reproductive health choices, and has been a great attraction among the youth since its introduction. Perhaps by harnessing the power of the current technological revolution, Palladium was able to engage a broader section of the youth population through interactive media platforms such as Facebook, Twitter, Youtube, etc. It is worth emphasizing that while television programmes such as 'YOLO' is not new to the Ghanaian media landscape, it is unique in terms of its packaging as part of a broader interventionist programme and linkage with the adolescent corners.

Overall, an interesting takeaway from the study is that when young people are effectively and meaningfully engaged, they respond positively to health interventions targeted at them. Not surprisingly, this observation somewhat challenges the pre-existing notion that young people today are recalcitrant and indifferent to interventions aimed at improving their reproductive health and well-being. Although it is not clear whether or not the intervention has been successful in reducing the adolescent pregnancy burden, the patronization of services and information by adolescents and youth offers a reflective opportunity space that should not be overlooked. Indeed, these novel ideas for engaging young people hold significant implications for policy making – the future direction and competitiveness of adolescent and youth health programmes rest increasingly on continuous

[6] See Deborah Stone, *Policy Paradox: The Art of Political Decision Making* (New York: W.W. Norton & Company, Inc, 2012).

innovation and improvement, especially within the context of a rapidly globalizing world.

While significant gains have been made, it is also important to note that challenges still remain in the effort to advance adolescent reproductive health in Ghana. The research revealed that the GHARH intervention faced a number of difficulties, which to some extent, affected implementation and program delivery. These include, bureaucratic delays in establishing adolescent health corners, foot-dragging by some GoG partners, delays in releasing money from MDAs (i.e., Ministries, Departments, and Agencies) to implementing partners, and in some cases, delays on the part of partners in transmitting the proper documentation.[7] As a result, the programme, which was supposed to be about 3 years in duration (Jan 2014 – March 2017), was limited to just about 2 years of activities.[8]

Following from the above difficulties, a critical issue that demands urgent attention is the apparent disregard for the new socio-political identity of young people, particularly at the local and district level; adolescent health is still subsumed under women's and children's welfare in some communities. Ironically, while the global frame of inclusion has been invoked at the national level, young people's political and social citizenship is yet to be fully recognized, broadly speaking. During the implementation of the GHARH project, it was noted that outreach programmes were particularly challenging for NGOs due to wavering support from the GHS. In order to attract the necessary attention from the health personnel, the NGOs had to consistently align their programme of activities to fit with the GHS outreach schedule for child welfare clinic. As lamented by an NGO official:

> Working with GHS is sometimes a challenge because they have their itinerary that they're working with … When embarking on the mobile clinic outreach, you need these health workers to work with. Sometimes, it becomes quite challenging getting access to them… So our activity is fed into the child welfare clinic; both the child welfare clinic and youth clinic are held concurrently. So you have to do it that way before you get them. This makes planning quite difficult sometimes because you want to achieve a specific goal within a specific time frame, but you'd have to wait till their activity is due before you're able to go. It's quite challenging.[9]

From an economic standpoint, the GHS strategy may perhaps translate in Ghanaian parlance as "killing two birds with one stone." To be sure, this cost-benefit approach may seem to offer immediate or short-term financial relief, but the long-term impact on the reproductive health of adolescents is worth keeping in mind. Indeed, we argue that such thinking is misguided, counterproductive, and severely

---

[7] Interview with Mr. Bashiru Adams (Overall Monitoring and Evaluation Coordinator on the GHARH project), Ghana, May 10, 2017.

[8] Interview with Brong Ahafo Regional Co-ordinator of the National Youth Authority, Mr. Pascal Edwards, Ghana, May 10, 2017.

[9] Interview with Team Leader of Map International, Mr. Gilbert Asante, Ghana, May 09, 2017.

compromises the reproductive health and well-being of young people. Of course, this phenomenon also signals a new analytic perspective when understood within the constructivist paradigm (i.e., the framing of adolescent health). As indicated earlier, the coupling of maternal, child and adolescent health holds implications for public policy and adolescent health interventions.

Ironically, young people still risk being left behind in the new development agenda even though the new global development frame seeks to rectify the historical discourse and practices that have accounted for the long-standing neglect and marginalization of the adolescent and youth population. Women and children's welfare vis-à-vis adolescent health are closely related concepts, yet distinct from each other. To treat adolescent health as subsidiary to maternal and child health is dangerous, and threatens the unique political, moral, and social identity accorded to young people. Indeed, this phenomenon somewhat challenges the efficacy of the Global Strategy and AA-HA! in structuring the location of adolescent health as an independent action sphere.

Another major challenge identified from the study relates to the financial sustainability of the GHARH programme. In the words of a district health officer:

> When you talk about adolescent health and understand the whole concept well, you would want to have an arrangement where there is some kind of permanency, or a permanent structure that keeps adolescents well-oriented all the time[10]

As discussed earlier, the GHARH programme was a three-year project solely funded by DFID. Given that the funding period is exhausted, questions remain about how the gains achieved over time can be further consolidated. As articulated by a senior policy official:

> It should actually be us funding our own programs, not relying on another government; … adolescents are our future; they're the future of the country (Field interview, 2017).

In a similar vein, a Palladium official noted:

> If there's a sustainability plan such that when GHARH or Palladium folds up from this region and Ashanti, the investments that have been made will not just be left to be a white elephant and continues to be operational, then that can be helpful.[11]

This dicey situation obviously raises a fundamental question relating to financing – how can adequate resources be mobilized to advance and sustain adolescent and youth focused health programmes, and from whom?

A broad range of social and cultural factors further compounds the complexity of the issue. On the one hand, cultural norms tend to shape how

[10] Interview with Mr. Owusu Asante, May 09, 2017.
[11] Interview with Mr. Bashiru Adams, May 10, 2017.

reproductive health interventions are perceived on the ground. On the other, migration appears to work against health interventions. Interestingly, the research revealed that young men in some communities resist sensitization programs, as it challenges their masculinity and ease of access to develop sexual relations with young girls and women in the locale.[12] Perhaps this challenge may, to some extent, help explain why young women and mothers are sometimes targeted with interventions in some districts or communities to the neglect of others. In fact, the interviews revealed that some peer educators were in constant fear of being chased out or mobbed by the young men in some of these communities. Obviously, this development, in some measure, reflects the character of gender-based obstacles to adolescent reproductive health. The central question, therefore, remains: how can effective and equal empowerment opportunities be created for young men and women in the face of prevailing patriarchal norms and ideational resistance to social change? This is important if the discourse on gender equality is to gain ground in national and global politics.

Scholars have noted the challenge of early child marriage as a barrier to sound maternal health (Jensen & Thornton, 2003; UNFPA, 2014; Walker, 2012). In the case of Ghana, the study revealed that migration from the Northern part of the country to the South accounts for the increased adolescent pregnancy burden in some districts, particularly the communities inhabited by the migrants. The Northern region remains disproportionately poor compared to other regions in the country (GSS, 2015; UNICEF, 2016). Due to the North-South divide, young and old people alike tend to migrate to the South in search of better opportunities and life prospects. However, these migrants also carry along their cultural beliefs, which includes the practice of early marriage. As pointed out by a health practitioner, *"early marriage is normal to them, and most of our teenage pregnancy records are from there* [migrant communities]*"* (Field Interview, 2017). Given the short duration of the GHARH programme, it is currently difficult to ascertain whether the project has been successful in dealing with these cultural forces; a longitudinal study might be more fruitful in this endeavor.

To be sure, the challenges associated with implementing the GHARH programme are not unique to the Ghanaian context. Nonetheless, Ghana's experience suggests that adopting a proper ideational perspective to the issue is imperative to strengthening, advancing and sustaining adolescent reproductive health initiatives.

## A Discursive Agenda: Towards An Integrated Ideational Policy Discourse

As already noted, the GHARH intervention draws extensively on international instruments, and the analysis above underscores the intersubjective reality that reproductive health intersects with the global regime of human rights. To better understand the dynamics and utility of an integrated ideational policy discourse,

[12] See Adomako Ampofo (2001) for an excellent gendered analysis of the Ghanaian society. "When Men Speak, Women Listen": Gender Socialization and Young Adolescents' Attitudes to Sexual and Reproductive Issues. *African Journal of Reproductive Health, 5(3), 196-212.*

which we propose in this paper, it would be useful to first situate the discussion within the broader context of debates in human rights and issue framing. In advancing our key argument, we maintain that Ghana's prior ADHD programme failed in large part due to the lack of a unifying global frame, and consistent appeal to the human rights ideology.

Since the adoption of the Universal Declaration of Human Rights in 1948, the immanent authority of the ideology of human rights has been strongly embraced by virtually all states across the globe, and continues to structure important issues and debates in modern politics. As Elliott (2007) explains, the expansive power and impact of the ideology is perhaps rooted in the conceptualization of the individual as "sacred and inviolable" (p. 343). Today, the language of human rights is often used as a strategic leverage to push for political and social goals embedded in principles of social justice, equity, and human dignity (Bawa, 2012; Johnson, 2011).

However, the notion of human rights is a highly contested concept. Indeed, the universal applicability of human rights has been increasingly called into question by human rights scholars, leading to what has become popularly known as the cultural relativism and universality argument (Donnelly, 2007; Fox, 1998). While the universalist claim of human rights rest on the theory of global policy convergence, relativism is rooted in normative notions of human rights that underscore the need to appreciate cultural context, and more specifically, cultural differences (Donnelly, 2007).

The key concern among some scholars speak to the idea that the notion of a contextually-based human rights approach has often been used as a pretext to legitimize harmful cultural traditions and practices that violate, degrade, and posture women as 'second-class citizens' (Andreopoulos et al., 2014; Bawa, 2012; Fox, 1998). Despite the difficulty in reconciling these debates, it is clear from the literature that contemporary scholars in both theoretical camps agree on one point – that is, the need to adopt a human rights culture that upholds individual and collective identity, dignity, equality, liberties, and self-determination. We endorse this point of view, but also argue for the need to push the conversation beyond these ideational boundaries. Indeed, the complexity of the human rights ideology cannot be limited to the cultural argument, but should be expanded to also encompass the political, legal, and broader institutional framework within which these rights are articulated.

To advance understanding on how ideational frames can facilitate or constrain policy direction and delivery, we posit that it is imperative to adopt a multidimensional approach that takes into account the dialectic value of individual frames. Over the past few years, a number of studies have been conducted in relation to the impact of global frames. A critical review of these studies draws attention to interesting and important debates in the literature. On the one hand, it has been argued that global discourses have positive impacts on policy design, policy options, and overall quality of life (Austin, 2001; Johnson, 2010; Yamin, 2010). On the other, it has also been suggested that global frames are nothing more than a rhetorical instrument for advancing particular interests, and hence ineffective in producing tangible benefits or outcomes (Johnson, 2010; Labonté, 2008).

Connecting these theoretical debates, it has been expressed that while global policy frames can be considered instrumental to shaping political priority, their impact is limited by the lack of resonance, political context, institutional barriers, as well as the specific nature of the problem (Shiffman & Smith, 2007). According to Labonté (2008), the type of frame deployed by the global policy community determines the nature of impact. For instance, the securitization of health may privilege some diseases over others, thus leading to disproportionate funding towards certain illnesses and health inequities; health as a global public good could engender free riding and social injustice; health as a human right could become a burden onto itself due to the lack of enforcement and multiple interpretations. In essence, although each frame is potent in itself, they affect the "problem" in different and perhaps contradictory ways.

Central to the present discussion is the normative advancement of human rights protocols within the context of global development and national health discourses. While the utility of the human rights frame is beyond question, scholars have also argued that it may not necessarily be an effective ideational instrument in addressing the rising tide of reproductive injustice, inequality, and poor maternal health outcomes (Bradshaw, 2006; Cornwall & Molyneux, 2006; Cornwall & Nyamu-Musembi, 2004; Gideon, 2006; Johnson & Das, 2014). A case in point is Ghana's national ADHD programme, which was established in 2001 to improve the general health and well-being of young people, with particular focus on sexual and reproductive health.

It is worth pointing out that a critical evaluation of the ADHD programme resulted in the GHARH initiative, which has been thoroughly discussed in earlier sections of this paper. According to the evaluation report, the ADHD programme faced a broad range of difficulties from the outset including: minimal financial support from the national government; lack of information, education, and communication (IEC) materials from the GHS; lack of regional support for the programme, among several others, thus affecting the overall impact of the intervention (GHS, 2014). Yet Ghana has various resolutions and policies such as CEDAW, National Reproductive Health and Service Policy and Standards, National Health Policy, National Youth Policy etc., which are all remarkably inspired by, and grounded in the human rights ideology. In fact, this outcome is not surprising, especially given that sexual and reproductive health in itself is defined and approached in the Ghanaian context with a rights-based framework, as reflected by Ghana's National Reproductive Health and Service Policy and Standards (MOH, 2015).

If the above ideational premise is flawed, then we argue that the rights-based approach is not enough. Indeed, privileging the human rights frame constrains broader discourses around which policy action can be crystallized. The GHARH programme, for instance, demonstrates the utility of drawing on multiple frames in advancing reproductive health and well-being. As noted by the Team Leader of Palladium:

> The world has changed now; young people are seen as having great potential to impact their own life and the life of their community. I

> think we didn't encourage young people to be empowered enough to know that these rights are theirs, and that they can champion it themselves.[13]

On a different but related subject, he also argued:

> Adolescent pregnancy also has a lot of social dimension – that is, issues surrounding parenting, poverty, gatekeepers etc. So yeah, it was critical for all of our partners to understand those dynamics at the outset: this is not just a health intervention, there's a social side, as well as community-driven side to it. We had to sell that point quite a bit.[14]

In a similar vein, a district health officer who was privy to the implementation of the preceding ADHD programme also expressed:

> The ADHD programme was flawed due to the absence of technical direction. If our authorities had sat down and understood, or had been advised deeply into this demographic dividend alone, it could have strengthened the economic argument and allowed for greater resources and mobilization.[15]

It is clear that the above observations capture an integrated discourse that reinforce the power of the human rights ideology, but also underscore the multi-dimensional character of reproductive health. While it is clear from the literature that multiple factors impinge on the impact of policy frames, there is also a shared understanding among scholars that the framing and reframing of policy issues could yield desired effects insofar as the frames deployed neutralize dissension and appeal to broad sentiments. As Schon and Rein (1994) metaphorically demonstrate in what they call "design rationality," the designer (collection of actors) is constantly engaged in a discursive conversation with his or her materials (policy object and external environment), a complex political process that leads to new opportunities or problems, as well as strategies (p. 167). In line with this reasoning, and in the broader context of adolescent health, we posit that an integrated ideational policy discourse can be used to make a difference in terms of how reproductive health is conceptualized in both the global and national spheres. The central point here is that, a single frame is insufficient in itself to make meaningful impact if the ambitious global objectives surrounding adolescent health and well-being is to be attained. In consonance with the Global Strategy, we maintain that a single frame may not fully capture the complexity and multi-dimensionality of the health problem, and could perhaps undermine policy delivery or result in misguided policy action.

---

[13] Interview with Mr. David Logan, Ghana, March 13, 2017.
[14] Ibid., 13.
[15] Interview with Mr. Owusu Asante, May 09, 2017.

So, if the language of rights, development, partnership, inclusion, among others, are to translate into meaningful and '*real*' change on the ground, a variegated ideational lens cannot be overemphasized. Rather than privilege the human rights frame over other substantive health ideologies, an integrated ideational policy discourse provides a multidimensional language that allows state and non-state actors to draw on multiple policy tools to produce transformative social change, while appreciating contextual environmental realities and constraints. Of course, a one-size-fits-all ideational platform raises critical and legitimate questions about potential competition between frames. But to assume that every context presents equal or similar challenges is unwarranted, if not misleading. Indeed, what one may consider as competing frames in one context could present opportunities in a different venue. It goes without saying that conflicting frames are not immune to resolution (Schon & Rein, 1994). The challenge, then, for policy makers, health programmers, and other stakeholders is to figure out innovative strategies of combining the strengths of the various substantive frames without sacrificing the core values of adolescent health.

To be sure, this is not an attempt to downplay the issue of competing frames as conceptualized more broadly by ideational scholars. Rather, the goal is to underscore the fact that a multidimensional ideational approach offers a more fruitful pathway for sustainable initiatives aimed at improving adolescent reproductive health and well-being within the broader context of the development Agenda. By invoking an integrated discursive exchange, policy makers are not only able to see the broader picture, but also have access to an array of policy options, networks and resources that allow for deeper and constructive appreciation of the issues. Ultimately, the frames that animate the SDGs, Global Strategy, and AA-HA! generate a series of puzzles, yet can be considered complementary, and provide theoretical tools for better understanding of the power of ideas to shaping the trajectory of global and national politics.

## Conclusion

Our study has shown that global ideational frames lie at the heart of adolescent health and development. The aim of this paper has been to advance understanding on how global discourses affect citizenship and reproductive health outcomes at both the global and national levels. Drawing on Ghana's experience with the GHARH programme, it is clear that reproductive rights, gender equality and empowerment remain central to the adolescent health project, an endeavor that has benefited from strategies adopted by Palladium, together with other collaborative agencies and implementing partners.

Despite the gains achieved, the analysis presented suggests that a number of challenges remain to be addressed. A comprehensive analysis of specific policy instruments and instrument settings relevant to addressing these challenges is, however, beyond the scope of this paper. Nonetheless, the difficulties and uncertainties surrounding the implementation and sustainability of the GHARH programme brings to the fore (1) the need for an integrated ideational policy

framework rooted in a sustainability discourse, which simultaneously takes into account the properties of individual frames; (2) the crucial element of government ownership and commitment to adolescent and youth focused programmes; and (3) the need for more focused attention on inclusive citizenship and entitlement for young people, more broadly.

As we have tried to show, frames hold significant currency in terms of reconstructing policy problems, but could also translate as rhetorical instruments that hold empty promise. Therefore, the need to consider the dimensionality of the policy frame, as well as the nature of the contextual environment, and how they may facilitate or constrain social change cannot be overemphasized. To our mind, while the GHARH programme offers useful insights into the impact of global policy frames, we see that it also encourages thinking beyond agenda setting to include elements of policy implementation, and most importantly, policy sustainability.

**References**

Andreopoulos, G., Arat, Z. F. K., Holzhacker, R., Johnson, C., Das, S., Fulmer, A. M., . . . Pruce, J. R. (2014). *The Uses and Misuses of Human Rights: A Critical Approach to Advocacy* (G. Andreopoulos & Z. F. K. Arat Eds.). New York: Palgrave Macmillan.

Bawa, S. (2012). Women's Rights and Culture in Africa: A Dialogue with Global Patriarchal Traditions. *Canadian Journal of Development Studies, 33*(1), 90-105.

Beland, D., & Cox, R. H. (2011). Ideas and Politics. In D. Beland & R. H. Cox (Eds.), *Ideas and Politics in Social Science Research*. New York: Oxford University Press.

Bradshaw, S. (2006). Is the Rights Focus the Right Focus? Nicaraguan Responses to the Rights Agenda. *Third World Quarterly, 27*(7), 1329-1341.

Cornwall, A., & Molyneux, M. (2006). The Politics of Rights - Dilemmas for Feminist Praxis: An Introduction. *Third World Quarterly, 27*(7), 1175-1191.

Cornwall, A., & Nyamu-Musembi, C. (2004). Putting the 'Rights-Based Approach' to Development into Perspective. *Third World Quarterly, 25*(8), 1415-1437.

Dehne, K. L., & Riedner, G. (2001). Adolescence - A Dynamic Concept. *Reproductive Health Matters, 9*(17), 11-15.

Donnelly, J. (2007). The Relative Universality of Human Rights. *Human Rights Quarterly, 29*(2), 281-306.

Elliott, M. A. (2007). Human Rights and the Triumph of the Individual in World Culture. *Cultural Sociology, 1*(3), 343-363.

Fatusi, A. O., & Hindin, M. J. (2010). Adolescents and Youth in Developing Countries: Health and Development Issues in Context. *Journal of Adolescence, 33*(4), 499-508.

Fox, D. J. (1998). Women's Human Rights in Africa: Beyond the Debate over the Universality or Relativity of Human Rights. *African Studies Quarterly, 2*(3), 3-16.

GHS. (2014). *Family Health Annual Report*. Ghana Health Service.

Gideon, J. (2006). Accessing Economic and Social Rights Under Neoliberalism: Gender and Rights in Chile. *Third World Quarterly, 27*(7), 1269-1283.

GSS. (2015). *Ghana Poverty Mapping Report*. Ghana: Ghana Statistical Service.

Haussman, M., & Mills, L. (2012). Doing the North American two-steps on a global stage: Canada, its G8 Muskoka Initiative, and Safe Abortion Funding. In G. B. Doern & C. Stoney (Eds.), *How Ottawa Spends 2012-2013: The Harper Majority, Budget Cuts, and the New Opposition* (pp. 242-260). Montreal and Kingston: McGill-Queen's University Press.

Jensen, R., & Thornton, R. (2003). Early Female Marriage in the Developing World. *Gender and Development, 11*(2).

Johnson, C. (2010). Framing and the Politics of Public Health: An Examination of Competing Health Narratives in Honduras. *Global Public Health, 5*(1), 1-14.

Johnson, C. (2011). Framing for Change: Social Policy, the State, and the Federación de Mujeres Cubanas. *Cuban Studies, 42*, 35-51.

Johnson, C. (2016). *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. New York: Routledge.

Johnson, C., & Das, S. (2014). The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment? In G. Andreopoulos & Z. F. K. Arat (Eds.), *The Uses and Misuses of Human Rights: A Critical Approach to Advocacy*. New York: Palgrave Macmillan.

Labonté, R. (2008). Global Health in Public Policy: Finding the Right Frame? *Critical Public Health, 18*(4), 467-482.

Lindquist, E. (2006). Organizing for Policy Implementation: The Emergence and Role of Implementation Units in Policy Design and Oversight. *Journal of Comparative Policy Analysis, 8*(4), 311-324.

MOH. (2015). *Ghana Family Planning Costed Implementation Plan (2016-2020).* Retrieved from http://www.npc.gov.gh/images/Ghana-FP-CIP.pdf.

NPC. (2014). *NPC Policy Brief No.II*. National Population Council, Ghana.

Palladium. (2016). *Building Local Capacity in Ghana's Adolescent Health Sector: Handover Ceremony*. Retrieved from http://thepalladiumgroup.com/who/news/Building-local-capacity-in-Ghanas-adolescent-health-sector-handover-ceremony

Prentice, S. (2009). The "Investable" Child and the Economic Reframing of Childcare. *signs, 34*(3), 687-710.

Rantala, R., Bortz, M., & Armada, F. (2014). Intersectoral Action: Local Governments Promoting health. *Health Promotion International, 29*(S1).

Robinson, F. (2014). Discourses of Motherhood and Women's Health: Maternal Thinking as Feminist Politics. *Journal of International Political Theory, 10*(1), 94-108.

Schmidt, V. A. (2008). Discursive Institutionalism: The Explanatory Power of Ideas and Discourse. *Annual Review of Political Science, 11*, 303-326.

Schon, D. A., & Rein, M. (1994). *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books: Hardper Collins Publishers.

Shiffman, J., & Smith, S. (2007). Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality. *Lancet, 370*, 1370-1379.

Smith, E., Pereira, S., & Bishop, M. (2016). *Adolescent Sexual and Reproductive Health in Ghana: What Do the Data Tell Us?* : Palladium, Ghana.

Stone, D. (1989). Causal Stories and the Formation of policy Agendas. *Political Science Quarterly, 104*(2), 281-300.

Stone, D. (2012). *Policy Paradox: The Art of Political Decision Making*. New York: W .W. Norton & Company, Inc.

Tiessen, R. (2015). 'Walking Wombs': Making Sense of the Muskoka Initiative and the Emphasis on Motherhood in Canadian Foreign Policy *Global Justice: Theory Practice Rhetoric, 8*(1), 1-16.

UN. (2015). *The Millennium Development Goals Report*. United Nations Retrieved from http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG 2015 rev (July 1).pdf.

UNFPA. (2014). *The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the Future. State of World Population*.

UNICEF. (2011). *The State of the World's Children. Adolescence: An Age of Opportunity. United Nations Children's Fund*. Retrieved from

UNICEF. (2016). *The Ghana Poverty and Inequality Report: Using the 6th Ghana Living Standards Survey*. United Nations Children's Emergency Fund.

Walker, J.-A. (2012). Early Marriage in Africa - Trends, Harmful Effects and Interventions. *African Journal of Reproductive Health, 16*(2).

WHO. (2002). *Adolescent Friendly Health Services: An Agenda for Change*. World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/67923/1/WHO_FCH_CAH_02.14.pdf.

WHO. (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf.

WHO. (2017). *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation*. Retrieved from http://apps.who.int/iris/bitstream/10665/255415/1/9789241512343-eng.pdf