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# Considering Culture and Countering Mistrust: Organisation Perspectives for Adapting Comprehensive Sexuality Education in Ghana

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## Abstract

**Introduction** Comprehensive sexuality education (CSE) is heralded as an effective solution to reduce acute sexual and reproductive health (SRH) issues, particularly for young people. In Ghana, from 2019 to 2020, a co-ordinated campaign against implementing revisions to the CSE curriculum by national and international parties generated a polarising debate resulting in government pull-back from actioning the revisions. Whilst mainstream reporting predominantly focuses on political voices that either promote or discredit the CSE curriculum, formally documented perspectives of those working within service delivery are limited in Ghana.

**Methods** To address this gap, in February 2020, an exploratory qualitative study was conducted using 16 key-informant semistructured interviews with practitioners from organisations delivering SRH in Accra, Ghana, to answer the question: *In what ways might CSE be adapted to enhance SRH education delivery for young people in Ghana?* Participants were asked their perspectives on the barriers and enablers of CSE implementation in Ghana.

**Results** Utilising a rights-based approach as a theoretical frame for analysis, a hybrid thematic analysis approach revealed three overarching themes: (1) "It's not anything strange": The need to normalise young people's sexual wellness; (2) cultural considerations and countering mistrust; and (3) suggested adaptations.

**Conclusions and Policy Implications** Key informants described seeing the need for CSE in Ghana alongside cultural resistance to content within the curriculum. They called for CSE implementations to consider engaging multiple stakeholders in training to develop content clarity and suggested pathways for incremental delivery and adaptations at government and community levels to continue addressing issues of sexual wellness for the country's growing youth population.

**Keywords** Sexual health · Culturally responsive · Africa · Adolescent · Youth · Community · Programmes

## Introduction

In Ghana, sexuality education is commonly referred to as sexual and reproductive health (SRH) education (Awusabo-Asare et al., 2017). The inception of formal sexuality education in Ghana can be traced to the 1950s and has evolved considerably in terms of content, methods, and policy (Amo-Adjei, 2022). Sexuality education plays a critical role in improving the health outcomes and overall wellbeing of young people in the country, including, but not limited to, delaying sexual debut (Tenkorang et al., 2021); reducing unintended pregnancies, gender-based violence (GBV), sexually transmitted infections (STIs), and HIV/AIDS (Amo-Adjei, 2021); amplifying the use of SRH services (Aninanya et al., 2015); and increasing the likelihood of contraceptive use (Seidu et al., 2022).

Young people in the West African nation face immense challenges meeting their sexual health needs. One in five people are aged between 10 and 19 years, and many encounter acute SRH issues such as unintended pregnancy, early marriage, unsafe abortions, gendered violence, and STIs,

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including HIV/AIDS (Opollo, 2019; Performance Monitoring & Accountability, 2020; Wangamati, 2020). It is common for adolescents to engage in sex early, with many not using contraception, resulting in unplanned pregnancies and other unintended consequences. The 2014 Ghana Demographic Health Survey, which is nationally representative, estimated that 12% and 9% of adolescent females and males, respectively, debut sex before the age of 15 (Awusabo-Asare et al., 2017). This is concerning in a context where SRH services and resources are underutilised and barriers to access for specific populations exist (Awusabo-Asare et al., 2017).

Sexuality education has been characterised differently and taught in various ways. Historically, sexuality education was the responsibility of parents and took place in homes, but today, it is mainly provided in schools (Nyarko et al., 2014). Such classes primarily focus on pregnancy and STI prevention. UNESCO (2019) has provided a broader perspective on sexuality education and offers comprehensive sexuality education (CSE) as a more holistic approach. CSE is a "curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality" (p. 1). According to UNESCO, the aim of CSE is to provide children and young people with knowledge, skills, attitudes, and values that will enable them to realise their health, wellbeing, and dignity; develop respectful social and sexual relationships; consider how their choices affect their own and others' wellbeing; and understand and protect their rights throughout their lives. One feature that distinguishes CSE from sexuality education is that it takes a rights-based approach—moving away from "problematising sex among teenagers" towards a more balanced view of sex and sexuality as both pleasurable and risky (Haberland & Rogow, 2015).

The CSE curriculum provides age-appropriate SRH and rights-based education in an incremental manner, catering to knowledge levels of younger children through to older adolescents. Existing evidence and research studies on CSE describe it as an evidence-based programme aiming to empower young people to develop healthy interpersonal relationships and realise their agency in sexual-health decision-making (Opollo, 2019; Tenkorang et al., 2021; Wangamati, 2020). Many systematic reviews have indicated that successful CSE programmes build self-efficacy, increase knowledge, and positively change attitudes towards gender and social norms, whilst also increasing contraceptive use and delaying sexual debut (Gallant & Maticka-Tyndale, 2004; Haberland & Rogow, 2015; Kirby et al., 2006; Panchaud et al., 2019; UNESCO, 2015). The CSE curriculum provides a first step in offering a consistent supply of accurate and nonjudgemental SRH information that can improve protective factors for adolescents. For instance, it reduces the need to seek out unsafe, inaccurate information such as pornography (Amo-Adjei, 2022). Instead, CSE imparts accurate, evidence-based skills and values to young people that are relevant, age appropriate, and culturally sensitive (Amo-Adjei, 2022). Finally, implementing CSE within Ghana has the potential to improve public health outcomes locally whilst working towards achieving the United Nations Sustainable Development Goals and the broader Agenda 2030 (Miedema et al., 2020).

When CSE is appropriately implemented, it can instil better decision-making involving sex and relationships and educate young people about GBV, empowering them to challenge cultural narratives normalising violence (Opollo, 2019; Wangamati, 2020). Unfortunately, most Ghanaian adolescents still lack access to comprehensive SRH education covering abortion and GBV—pertinent issues not taught in most educational settings (Awusabo-Asare et al., 2017; Boateng, 2017; Gbagbo, 2020).

Components of CSE were first offered in Ghana as part of civic and hygiene education, encompassing features of the human body, personal hygiene, and civic responsibility (Amo-Adjei, 2022). Over the last few decades, Ghanaian schools have adopted various approaches, integrating concepts of CSE into some of the compulsory and elective subjects such as integrated science, biology, social studies, religious and moral education, and management and living (Awusabo-Asare et al., 2017). Additionally, standalone cocurricular programmes were developed such as the school health education programme (Amo-Adjei, 2022). However, the topics covered were narrow in scope, focusing on the "ABC" dimensions (abstinence, fidelity, and condom usage) of HIV prevention (Tenkorang et al., 2021) and a fear-based negative attitude towards sexuality (Awusabo-Asare et al., 2017).

The main underlying causes for the narrow approach to sexuality education stem from a nexus of cultural and religious opposition. For decades, religious and cultural discourses have made sexuality a highly taboo subject, making sexual education difficult. Adding to the complexity, many Ghanaians are religious and strive to follow the moral precepts of their religion, believing sexuality education promotes immorality (Nyarko et al., 2014) by encouraging youth not already engaged in sexual behaviours to begin sexual experimentation and to engage in premarital sex.

Prevalent perceptions and cultural norms in Ghana also present challenges to implementing CSE. Sex is a sensitive topic in Ghanaian society (Nyarko et al., 2014); young people have limited opportunities to discuss sex-related topics with their parents or teachers, as it is considered bad conduct (Boborakhimov et al., 2023). In addition, the attitude of parents and teachers has played a vital role. Some parents believe children are too young and oppose sexuality education for students in primary school. For example, the majority of parents (58%) from Nyarko et al.'s (2014) study were against sexuality education at primary level and refused to discuss sexuality

education with their daughters because they considered the issue embarrassing.

Despite cultural, social, and religious contestation, there is still support for CSE in Ghana—mainly influenced by international documents such as Abuja and Maputo Declarations to which the country is a signatory (Keogh et al., 2018). In this regard, Ghana's national government launched policy initiatives that paved the way for a more holistic and comprehensive approach to sexuality education in the country: the advocacy for the inclusion of age-appropriate SRH education in the school curriculum within the national HIV and AIDS and STI policies in 2013 and the revision of SRH policy in alignment with the national standards, as outlined in UNESCO'S *International Technical Guidance on Sexuality Education* in 2015. These revisions covered topics such as gender roles, sexual rights, and reproductive health (Adomako, 2022), aimed at providing students with the knowledge, interpersonal skills, and values needed to develop a positive perception of their sexuality (Tenkorang et al., 2021). Another significant step was the development of a guideline for CSE in schools in collaboration with the Ministry of Education and the Ghana Education Service in September 2019. This revision called for the implementation of CSE across all age groups (6–18) and grades (1–12) (Amo-Adjei & Tenkorang, 2022).

Although the policy direction was promising, in early 2019, steps taken in Ghana towards making existing sexuality education more comprehensive, in conjunction with the Ghanaian Health Service advocating for its introduction into the school curriculum, sparked moral panic and a concerted anti-CSE campaign (Martínez et al., 2021), prompting a national-level debate and stalling its formal rollout. Whilst opinion pieces have been widespread in newspapers and online media since the debate began, there is limited research documenting how people working in SRH services perceive the possibilities for implementation of revised CSE in schools or communities. The purpose of this article is to first lay out the foundations of the campaign against the CSE implementation in Ghana as well as the proposed benefits and challenges to its implementation. Next, drawing from data collected in 2020, we present the perspectives of those delivering SRH services in Ghana on whether implementing the CSE curriculum is an endeavour that will succeed or fail in their context. These Ghanaian perspectives may inform decisions on CSE implementation and adaptations in countries where similar political, social, and religious discourses continue to influence sexuality education through the limiting lens of reproduction and heteronormative discourse.

## The Campaign Against CSE

At the centre of the campaign against the CSE is the promotion of abstinence along with heteronormative ideas of gender, sexual orientation, and accepted sex-related practices (Amo-Adjei, 2022). Political and religious leaders criticised the revised sexuality education guidelines after they were leaked just before the start of the academic year (Amo-Adjei & Tenkorang, 2022). One major objection was that the guidelines would distort Ghanaian accepted sexual norms and invite students to embrace LGBTQIA+ (lesbian, gay, bisexual, transgender, questioning, intersex, asexual, or other sexually and gender-diverse identities—also known as rainbow or LGBTQ) identities and values which are largely stigmatised in the nation (Amo-Adjei & Tenkorang, 2022). Faith-based and anti-LGBTQIA+ groups perceived the promotion of CSE guidelines as a Western agenda, part of the colonisation endeavour, and a threat to Ghanaian cultural norms and practices on human sexuality (Martínez et al., 2021). These groups utilised the World Congress of Families (WCF) 2019 summit which convened in Accra, Ghana's capital, as an avenue to come together and spread their argument against the CSE curriculum and LGBTQIA+ rights more generally (Martínez et al., 2021).

Guided by strong anti-LGBTQIA+ sentiments, the WCF summit concentrated on four main areas to oppose CSE (Martínez et al., 2021): (1) the notion that nonnormative sexual orientations and gender identities are disorders, (2) the idea that Western colonisers have forced an LGBTQIA+ agenda on the country as a plan to depopulate Africa and create havoc in the country, (3) the belief that CSE is an immoral war on children that undermines the (heterosexual, patriarchal) family and challenges God's law, and (4) the belief that Ghana is at the centre of plans to spread homosexuality within the continent. Voices of oppression spread beyond the summit to social and traditional media. Platforms such as WhatsApp, Facebook, and YouTube were used to generate a misinformation campaign, circulating false claims and inaccurate information, fake news, videos, and links (Martínez et al., 2021). For example, disinformation claimed young people interacting with the CSE curriculum risk being exposed to sexually explicit content in textbooks that might encourage them to be gay. Further misinformation was spread by using out-of-context phrases from the CSE recommendations for schools, claiming that the CSE encourages inappropriate sexual activity in young people, especially children.

Allah-Mensah and Osei-Afful (2017) noted that, in their campaign, Ghanaians opposing CSE and other gender-related issues employed popular global strategies such as framing issues as anticultural and antireligious. These sentiments promoted a moralistic and homophobic atmosphere, and its advocates presented themselves and their agenda as protecting children as well as African culture and values (Martínez et al., 2021). Influenced by the campaign, a prominent politician and leader from prominent churches called for immediate withdrawal of

the CSE guidelines. Consequently, the government pulled back from implementing the new curriculum and guidelines "never saw the light of day" (Griffith, 2020, p. 2). The campaign may possibly have contributed to the formulation of legislative bills such as the Property Rights of Spouses Bill, sometimes referred to as the Family Bill 2021. Claiming to protect society and maintain the nation's sovereignty, the Family Bill not only restricts LGBTQIA+ rights but also criminalises gender and sexual diversity whilst placing prohibitions on media, education, and advocacy for homosexuality (McEwen, 2022).

## Challenges to CSE Implementation in Ghana

Ghana's political, cultural, religious, and social contexts present various challenges to properly adopting CSE. Several studies show that challenges to implementing CSE occur at multiple levels (i.e., ideological, institutional, teacher, parent, and student levels; Keogh et al., 2018; UNESCO, 2019). A central, decades-old argument is that implementing the CSE curriculum will sexualise young children, increasing sexual experimentation and promiscuity, thereby diminishing gains made by abstinence-based programmes (Amo-Adjei, 2022). This argument persists, despite gains acquired through upscaling SRH initiatives and adequate global evidence demonstrating abstinence-only education is harmful.

Tenkorang et al. (2021) argued that the opposition to CSE in schools stems primarily from the misconception held by many sub-Saharan Africans that CSE is a Western agenda to promote sexual norms such as abortion care and LGBTQIA+ rights, which are "alien" to African cultures. Sharing a similar view, Amo-Adjei and Tenkorang (2022) noted that a common understanding of CSE amongst Ghanaians is that it is unfit for Ghana because it conflicts with cultural norms and practices about human sexuality and accepts sexual expressions outside heteronormative ideals. Local and international religious organisations have severely impeded the implementation of CSE in Ghana. For example, some Catholic bishops view CSE as a vehicle to promote homosexuality in children; this underlies the Ghana Pentecostal and Christian Council's allegation that CSE is a "satanic" movement that promotes the LGBTQIA+ agenda (Shamrock & Ginn, 2021, p. 631). As such, opponents push the narrative that the need for CSE comes from forces outside Ghana. However, Ghanaian youth from a study by Amo-Adjei (2022) expressed their desire for sexuality education that is broad in scope. They indicated aspirations to learn about topics such as hygiene, pregnancy prevention, healthy relationships, STIs and control, reproductive physiology and maturation, gender differences and sexual orientations, and sexual pleasure and pain. These topics align with the broad agenda of CSE, although some were not included in the proposed guidelines for implementation.

Implementing CSE in Ghana is also challenged by the capacity and willingness of those charged with delivering the curriculum. Research indicates that Ghanaian teachers tend to be unequipped for educating adolescents on matters of SRH (Adu-Gyamfi, 2014). In a study by Challa et al. (2018), 15- to 24-year-old research participants shared that their teachers exuded judgement and discriminatory attitudes and provided students with biased information. This may be influenced by the educators' discomfort with CSE topics or their inability to distance themselves from their innate attitudes (Singh et al., 2021). Ocran (2021) also acknowledged that sexuality education was hindered where teacher attitudes to the subject prevented free-flowing participatory communication. Adding to this, international research has demonstrated that young people are consulted on the development of CSE but rarely on implementation. Panchaud et al. (2019) described the haphazard involvement of young people in processes that have direct impacts on their sexual agency as generating a dichotomy between the needs and aspirations of young people.

These factors perpetuate an atmosphere that restricts CSE adoption and promotes abstinence programmes as an approach to sexuality education in Ghana. Abstinence programmes discourage premarital sex and do not include information about safe sexual behaviours, condoms, and other contraception (Ocran et al., 2022) and pay minimal attention to teaching teenagers issues of consent (Awusabo-Asare et al., 2017). In contrast, with a focus on human rights, gender equality, and empowerment, the CSE curriculum acknowledges that sexual activity can occur during adolescence and attempts to provide students with information and the ability to make informed and safe choices about sex and sexuality (Awusabo-Asare et al., 2017).

The CSE far outweigh any outcomes of abstinence-only programmes (Ocran et al., 2022). When provided with age-appropriate CSE, students do well in terms of safe sexual practices, lead productive lives, know more about health problems, and are more equipped to deal with HIV/AIDS and STIs as well as unwanted pregnancies and GBV (Amo-Adjei, 2021; Nyarko et al., 2014). CSE has demonstrated a more significant impact than abstinence-only programmes on SHR outcomes, advancing SRH-related knowledge, improving self-confidence and self-esteem, shifting positive attitudes towards gender and social norms, strengthening decision-making and communication skills, developing self-efficacy, and increasing the use of condoms and other contraceptives (Awusabo-Asare et al., 2017; Ocran et al., 2022). In fact, globally, abstinence-only programmes are noted as being exclusionary (Elia & Eliason, 2010), violating adolescent rights whilst reinforcing harmful gender stereotypes and promoting unscientific information (Santelli et al., 2017).

Given the prevalence of SRH issues in Ghana, a more comprehensive approach to sexuality education is vital. Like many other countries with similar characteristics, the average

age at which children have sex for the first time is 16 years (Amo-Adjei & Tuoyire, 2018), suggesting young people need CSE at an early age to safeguard themselves and others from dangerous sexual and reproductive decisions. However, critics of CSE have argued that what makes a sexuality education programme comprehensive can vary considerably, as "comprehensive" is a continuum (Miedema et al., 2020).

Miedema et al. (2020) highlighted another critique of CSE: its application as a single model for achieving sexuality education when its goals reflect universal natural ideals and progressive secularism. They noted that implementing CSE will leave some political views sidelined whilst advancing others (Miedema et al., 2020), but CSE is not politically neutral. Miedema et al. made several recommendations for moving forward with CSE implementation. Most prominent was the need to modify CSE content to better fit local contexts and sensitivities to help counter some of the ideas and fears that opponents of CSE harbour, which are barriers to logical, rational progress.

Diverse opinions about how CSE is implemented in Ghanaian schools are allowed to coexist. However, moralising, ill-informed, discriminatory opinions have detrimental effects on young people's sexual health and wellbeing. This brief review highlights that both SRH disparities and challenges to local understanding and cultural ways of supporting SRH concerns necessitate exploration. Greater insights into locally proposed solutions are needed to move forward.

## Methods

### Study Design

The data reported in this is article are one part of a larger exploratory qualitative study from November 2019 to May 2020 (Chubb, 2023). Young people's insights about access to, uptake, and understanding of the SRH services and resources available to them were used to inform the interview schedule to explore practitioners' views on sexuality education and services in Ghana. Our team of researchers sought to learn from practitioners working with organisations and young people on what would make SRH programmes and services more culturally and contextually responsive to the needs of youth.

### Study Participants, Recruitment, and Ethical Procedures

The findings presented in this article focus on a subset of that data—conversations with 16 key informants who were practitioners working in a variety of organisations that deliver a form of SRH programme, service, or education in Accra, Ghana. These included community-based, and non-governmental, national entities and international nongovernmental organisations (NGOs) based in Ghana. For the purposes of this analysis, distinctions between their roles are not stated in the findings as the lines between them in state and nonstate organisations are often blurred.

Ethical approval was obtained through the human participant ethics committees at the University of Alberta (approval number: Pro00095724) and the University of Ghana (approval number: ECH073/19–20). The district chief in Jamestown and the Ghana Health Service, a public service body responsible for health under the authority of the Ministry of Health in Ghana, formally approved the project before researchers contacted practitioners inviting their participation. Participation was voluntary, and written informed consent was obtained from all key informants before the interviews.

### Participants and Sampling

Purposive sampling was used to recruit practitioners with expertise in SRH services and programmes in Ghana. Participants were identified on public websites or databases in accordance with their professional affiliations, positions, and work experience and then invited to participate via email and telephone. The technique secured suitable practitioners, ensuring that the data collected were relevant and informative. Seven key informants were female and nine were male (see Table 1) and spread across national government and NGOs as well as international NGOs.

**Table 1** Demographic characteristics of participants

| ID | Sex | Type of organisation |
|---|---|---|
| P 1 | Female | National government organisation |
| P 2 | Male | Ghanaian NGO |
| P 3 | Male | Ghanaian NGO |
| P 4 | Male | International NGO |
| P 5 | Male | Ghanaian NGO |
| P 6 | Female | Ghanaian NGO |
| P 7 | Female | International NGO |
| P 8 | Female | National government organisation |
| P 9 | Male | International NGO |
| P 10 | Female | National government organisation |
| P 11 | Male | Ghanaian NGO |
| P 12 | Female | International NGO |
| P 13 | Male | International NGO |
| P 14 | Male | Ghanaian NGO |
| P 15 | Female | International NGO |
| P 16 | Male | International NGO |

*NGO* nongovernment organisation

## Data Collection

Sixteen, 1-h, face-to-face, individual semistructured interviews were conducted by the Ghanaian member of the research team (the second author) and a second Ghanaian research assistant to ensure key informants could speak in the language with which they were comfortable. The research sought to answer the question: *In what ways might CSE be adapted to enhance SRH education delivery for young people in Ghana?*

All interviews were conducted in a private location considered convenient for the participants (e.g., room in their workplace and over the telephone), and an interview guide based on literature about CSE in Ghana was shared with participants prior to the interview. All interviews were audio recorded and transcribed verbatim, then translated to English where necessary. To ensure accuracy and reliability of translation from Twi or Ga (local Ghanaian languages used in the interviews) to English, a process of back translation (Sutrisno et al., 2014) was followed on a sample ($n=4$) of the interviews. This involved the process of back translation illustrated in Fig. 1 whereby two Ghanaian research assistants proficient in English Ga and Twi first translated the original research questions from English to Twi or Ga and then back to English. This process ensured intended meanings were the same regardless of the language in which they were asked. The same back-translation process was performed on data collected in Ga or Twi.

## Data Analysis

Data from interviews were analysed using a hybrid thematic analysis approach that utilises both deductive and inductive reasoning (Fereday & Muir-Cochrane, 2006; Swain, 2018). The hybrid approach is a flexible method of thematic analysis that combines searching for theoretically driven codes (i.e., a priori codes) and data-driven codes (posteriori codes) in the analysis process to move to overarching themes in the data (Fereday & Muir-Cochrane, 2006). In line with Swain's (2018) framework, we applied both types of coding approaches concurrently and moved back and forth between inductive and deductive coding as needed.

**Table 2** List of a priori codes

| A priori codes |
|---|
| • Curriculum relevance |
| • Training and capacity |
| • Cultural and religious nuances |
| • Stigma and taboos |
| • Gender dynamics |
| • Local terminologies |
| • Right to accurate information |
| • Right to accurate information |

First, a priori codes were developed based on the research question and the theoretical lens of a rights-based approach to SRH (see Table 2). As such, interviews were coded deductively based in the research question and to highlight the intersection of four factors underpinning a rights-based approach to sexual wellbeing: (1) acknowledge that people have sexual rights; (2) broaden the aims of sexuality education programmes beyond minimising unplanned pregnancies and STIs; (3) expand curriculum content to include issues such as gender norms, sexual orientation, expression and pleasure, violence, and individual rights and responsibilities in relationships; and (4)

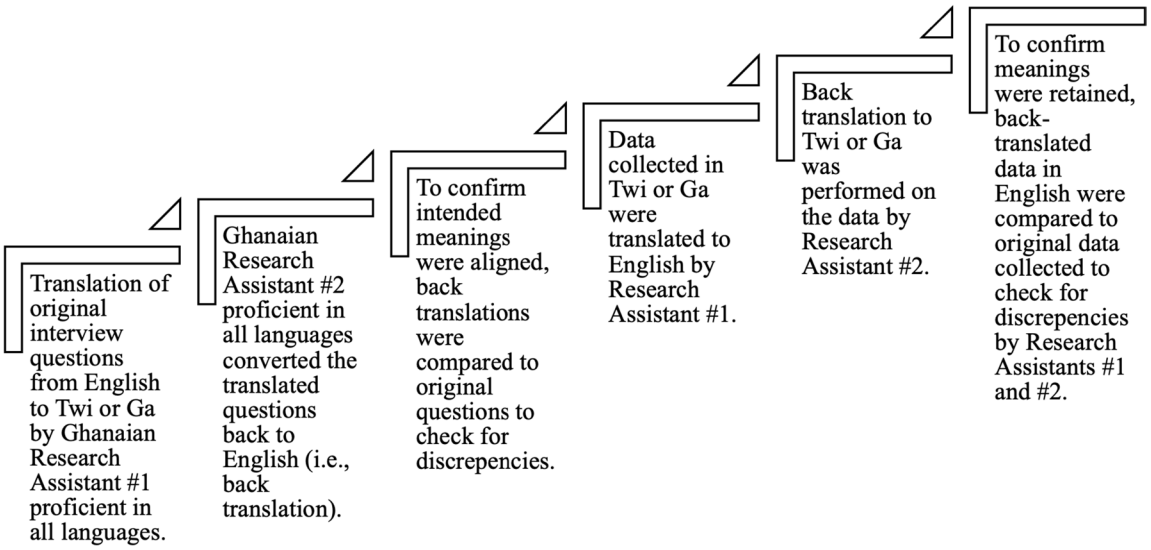


**Fig. 1** Steps in back translation of interview data

adopt a teaching approach that engages students in critical thinking about sexuality and sexual choices (Amo-Adjei & Tenkorang, 2022).

To validate the a priori codes, three of the 16 transcripts were selected by two authors to assess their relevance to the raw data. After comparing results, no adjustments to the a priori codes were necessary, and we applied the codes to distil meaning units of representative text. Next, posteriori codes were generated through inductively reviewing the transcripts (see Table 3) before we worked on summarising data and identifying initial themes.

Given the cross-cultural nature of the team and one member's capacity to translate local Ghanaian languages used by some key informants, we sought to establish intercoder confirmability during the inductive portion of the analysis. This meant we all familiarised ourselves with the data and individually began coding the transcripts, eventually organising the codes into larger themes by focusing on context linking SRH discussions to CSE. Once this content was isolated in NVivo 12, we shared organising themes and then came together to share, revise, and rearrange codes to produce three final themes representing dominant ideas answering the question: *In what ways might CSE be adapted to enhance SRH education delivery for young people in Ghana?*

1. "It's not anything strange": desire to normalise young people's sexual wellbeing.
2. Countering religious and culturally influenced mistrust of CSE.
3. Staying sensitive, whilst staying safe: making considerations for culture.

**Table 3** List of posteriori codes

| Posteriori codes |
|---|
| • Traditional routes of sexuality education not always sufficient |
| • Old enough to know |
| • Normalising adolescent sexual health wellness |
| • Sex is still taboo |
| • Misinformation |
| • Binary conceptions of gender |
| • Getting the messaging right |
| • Science framing |
| • Evidence-based sexuality education |
| • Engaging with the content of CSE, enhancing familiarity with conten |
| • Parental tools to talk with their children |
| • Listening to communities |
| • Deeper involvement of communities in SRH solutions |
| • Walking alongside communities as they learn about SRH |

## Results

### "It's Not Anything Strange": Desire to Normalise Young People's Sexual Wellbeing

The need to broaden conceptualisations of what SRH means beyond reproductive anatomy and abstinence was noted across the interviews. A "comprehensive package" was touted to supplement or build on traditional sexuality education largely lost in the contemporary Ghanaian context:

> *But one thing is very critical that runs through all of these [policies, CSE curriculum, SRH services or programmes] - the fact that in whatever form that we choose as a country . . . we need to provide some basic information to children . . . Traditional sexuality education did not really include things like how to teach a girl to be assertive . . . sexual and gender-based violence, child marriage, all those things. So, when all those things come together you have a comprehensive package. (P 4)*

Another key informant raised the need for young people to know about SRH and be up to date on information:

> *As for the impact [of implementing CSE], it could be positive, it could be negative. The positive aspect is times are changing . . . and there's a need to be abreast . . . with things that are happening in and around us. (P 8)*

Adding to this, all key informants acknowledged that young people have sexual rights and are old enough to know and that the CSE curriculum is incremental, accounting for introduction of content in an age-appropriate manner:

> *There was a video somebody sent . . . 5-year-old children and sex, we are teaching this, and I was saying not when it comes to CSE, it must be age appropriate. . . Young people are now getting raped and being introduced to sexual activity at a very early age. Right from when the child starts kindergarten you have to plan. All the things that they [those revising guidelines to CSE implementation] had written for 5-year-olds are the things the child already does. (P 14)*

In addition, a desire to prioritise and normalise adolescent SRH rights and needs within the community was expressed:

> *Yes. We just want everyone to understand adolescent health is not anything bad. It is not anything strange. It's just any ordinary day activity just giving health information and helping them to access health more easily. Giving them the priority. (P 1)*

## Countering Religious and Culturally Influenced Mistrust of CSE

All participants referred to Ghana being in the throes of a contentious debate over the viability and responsiveness of implementing CSE. Whilst most participants framed CSE implementation positively, they also echoed concerns highlighted in the literature about existing barriers to successful uptake—namely, the ideas of sexuality education being misaligned with cultural beliefs and values and the presence of misinformation campaigns. Key informants repeatedly acknowledged the taboo nature of SRH-related discussions: *"Sex issues, that's always been an issue... a taboo" (P 5).* Several participants described the taboos present in the organisations and communities, evidencing how some are not ready for the expansion of curriculum topics:

> *Even at the Sunday school level—I remember I wanted to teach sexual and reproductive health and my husband was like, "No, no. You can't go and teach the children about such things." (P 8)*

Participants stated there is recognition that SRH information is needed, but abstinence is promoted ahead of more controversial topics covered within the CSE curriculum. This key informant wove together conflicting narratives about the place of contraception and of abstinence within religious and cultural traditions, showing the challenges to broadening the aims of sexuality education beyond decreasing unplanned pregnancies or avoiding STIs:

> *What exactly is being taught there, it's on safe sex and abstinence . . . to prevent someone from getting pregnant you use contraception. We teach them those things . . . but most of the time, because of how our culture is . . . we stress abstinence . . . because of the way of life of . . . the people in Ghana . . . Whether we like it or not, religion plays an important role in the life of Ghanaians. Talk about African traditional religion, talk about Islam, talk about Christianity—which takes the major percentage of the population. African traditional religion stresses abstinence. (P 6)*

Key informants also described how conforming to cultural beliefs about SRH that present risks rather than utilising evidence-informed services and resources were common to avoid ostracisation by family members:

> *With the cultural aspect we had a big challenge. Like some of the communities if you go and talk about family planning or even early child marriage, they will tell you that in their community they are not against those things. I don't blame them because . . . it's lack of education . . . The cultural aspect is really affecting people who accept the family planning, and it is causing us a lot of headaches. (P 3)*

This cultural resistance to confronting SRH issues spills over into educational and domestic spaces, creating opposition to expanding curriculum content, where some are completely against the notion of family planning, making organisation workers' jobs difficult:

> *You had a whole hullabaloo about the comprehensive [sexuality] education in Ghana, and we are implementing it for out of school . . . some of the parents were actually against us educating them, talking about family planning and all of these things. (P 5)*

Some key informants acknowledged their willingness to broaden the scope of sexuality education but felt discouraged by others who strongly disapproved of the subject matter:

> *We were given the flashcards to educate the youth on issues of sexual and reproductive health. I didn't mind, and I was doing it . . . following what I was supposed to do. But I have colleagues who said "no, this is foreign to our culture." (P 8)*

Several key informants referenced CSE misinformation campaigns as a barrier to implementing CSE, stating "*they think we are teaching children about promiscuity in the communities, so currently that's why the programme [CSE] came to a halt*" *(P 13).* They also mentioned the assumption that overseas influences were pushing political and policy agendas that conflict with Ghanaian cultural beliefs and values, through implementation of CSE. This was perceived as one of the main challenges to implementing CSE:

> *People of Ghana are up in arms against CSE because they think it's a foreign agenda because the resources are coming from somewhere. That's how we [Ghanaians] are interpreting it. Right or wrong, I don't know, but we must also recognise that whether we like it or not, we are part of the global community, and the LGBT agenda is making waves and our young people need to be empowered with the right information, not so they become one [LGBTQIA+] but so they can safeguard their own [wellbeing] . . . But are we ready to invest as a country into that? (P 14)*

Even individuals working in the SRH field were confused about what the revised CSE guidelines called for, sharing their traditional ideas around binary divisions of gender, which complicate the expansion of the CSE curriculum to include diverse gender norms:

> *I hate that the sexual and reproductive curriculum being introduced last year was an agenda to push foreign culture on the Ghanaian population. That's*

*what I heard. Because according to things that we saw, there were aspects that say that a child is at liberty to express his or her sexuality. It's like, . . . if your daughter walks up to you and says, "Hey, mummy, I'm a woman, I have a vagina, but I feel I am not a woman, I'm supposed to be a man," then such a child can go ahead and then have a surgery done to become a man. Well, that's what I heard, but I don't know if it is true though. (P 8)*

Confusion about what CSE entails signals a need for clarity of content to develop trust in the curriculum. In contrast, the next key informant's statement shows shock and frustration with the infiltration, buy-in, and spread of CSE misinformation:

*The thing about CSE which people couldn't understand was that there is CSE in the US which is seen as being used to spread the issue about LGBTQ. So, people thought that it was the same thing. As usual, Ghanaians don't like reading . . . I was very shocked when that guy was on radio saying that we want to teach 5-year-olds how to use a condom, which was not the case. (P 9)*

Another key informant flagged misinformation concerns around the CSE curriculum:

*I think most of the people's position stems from a misconception about what CSE is—whether it's going to promote LGBTQ in the country. I mean before that, we had some level of reproductive health education in the educational sector from time immemorial . . . It's a challenge and it's quite unfortunate. (P 16)*

This sentiment demonstrates a lack of understanding around how the CSE curriculum is meant to teach young people to think critically about sexuality and sexual choices.

## Staying Sensitive, Whilst Staying Safe: Making Considerations for Culture

Key informants suggested several adaptations of CSE curriculum worth adopting, but expressed that the process required sensitivity and criticality for the process. They highlighted the necessity for messages that are responsive to culturally accepted norms and practices of sexual learning in Ghana:

*It's like teaching geography, every country in the world teaches geography . . . But if you go to Norway then you have snow and stuff, so their textbooks would be more . . . about how snow is formed, glaciers and stuff, OK? In Ghana maybe we have more harmattan [dry dusty wind from the Sahara Desert], so we would be looking more at harmattan. We might share, "Oh, there's something like snow which exists and its falls," but we are not going to go into the details that Norway would go because each country is very specific in . . . what their culture allows et cetera, and what you can use to teach. Honestly, I think we just didn't read the [CSE] document well. I've realised there's nothing in it per se [against culture]. And I think we need to have a proper evaluation of the thing itself and even find out . . . what those anti-CSE were trying to communicate to the people . . . because for me, when I found out some of the things in there, I didn't really find it problematic. (P 14)*

Despite the notions of the CSE being unproblematic, another key informant cautioned against cultural loss resulting from engaging in SRH discussions that transpire too quickly. Instead, they highlighted the need to walk alongside community members as people make sense of SRH rights from their cultural standpoint:

*There are these contentious aspects we are quite conscious of in terms of reproductive health, that is the gay rights, bisexuals, and such issues. Our communities are very sensitive; they are very religious and traditionally inclined. So, with those areas, discussing them, we are highly practical, we appreciate that everybody, in every individual case, possesses some form of right. But over here, looking at the environment that we live in, if you don't take time, you will end up promoting your organisation's needs and subconsciously lose the freedom of association with the community. (P 15)*

Getting the messaging right was also deemed important. One key informant described hiring a consultant to determine what the people wanted in terms of naming the CSE to align more with the context of SRH in Ghana:

*In Ghana we had an option not to call it CSE. When the consultant finished the work, he proposed about four or five names: "What do you want to call it that will better suit us?" The meeting people there decided on CSE. That's how we became CSE. And he even recommended, . . . he knows that in some countries when you use CSE it brings a lot of . . . assumptions about what is and is not being taught . . . it was a national validation so people, at the end of day, they voted CSE and that was what was put on the document. (P 14)*

One key informant described the power of training in CSE as important to building an educator's capacity for dispersing SRH knowledge more broadly amongst the community, thinking critically about content and embedding intergenerational knowledge of SRH:

*It was through our training that some of those—how do I even put it?—challenges were broken. The difficultly to even mention "vagina" or talk about penis or talk about sex, it's like a taboo, even at their level as counsellors. And so that was the other way that we tried to bridge that gap and make sure there's a continuous and consistent flow of information and interaction between these people and their students. So that as those students also engage with them, they pick up knowledge and then they also share with their peers, and we keep on spreading the knowledge. (P 11)*

A few key informants pointed out that lack of parental involvement presents a challenge that needs to be addressed through building community capacity to hold sex-related dialogues with young people:

*The basic reason is you [parents]can only give what you have. So, if you don't have that knowledge and the skills, how are you going to pass it on to your child? (P 4)*

These sentiments reflect the need for parental education as one aspect to raise general comfort with broaching sex-related topics in conversations with their children. Key informants indicated a joint effort is required to dispel parents' misinformation about the CSE curriculum:

*What we [health practitioners] realise, normally we select areas to work on based on the hotspots. For instance, if they have high teenage pregnancy et cetera, and our initial baseline study will indicate what are the causation factors . . . For some of them we realised that the dialogue and the misconception are a problem. We look at the factors causing these, and we say"what can we use to address some of these issues?" So together [health practitioners and individuals from the community] we say "OK, we need to have the parents more open or understanding and so why don't you do an activity which will address that?" (P 14)*

The specific types of knowledge parents require to engage meaningfully in conversations with young people were discussed by several key informants, with one reiterating the need for science to support such educational messaging:

*We are implementing it [CSE] for out of school . . . and some of the parents were against us educating them, talking about family planning and all these things. But sometimes what we do . . . in our orientation meetings, we use evidence to try and break some of this resistance to our programmes. What is the evidence saying in terms of adolescent pregnancies? Even at the district level we are working . . .how many girls are getting pregnant? How many of them are dropping out of school? So, you show them the statistics. (P 5)*

Another key informant echoed the need to use science as a frame of exposure to SRH-related information, stating:

*It would have been a very good platform for them to be exposed to very scientific information. And we were going to do it age appropriate, so that by the time the child gets to secondary school the child will be prepared. (P 9)*

One key informant suggested that a manual providing parents the tools to talk about health-related knowledge could enhance skills:

*One of the things that we need to intensify is adolescent–parental communication . . . It is one of the things that we are not doing well . . .We suggest that there should be something like a manual that will guide parents to be able to effectively communicate with their children on SRH. That is lacking and I've not seen any document like that. (P 5)*

Several informants mentioned the importance of being more responsive when implementing CSE by involving communities and listening to their wants and solutions:

*[In] everything we do, we involve the communities. If you go to the community and they tell us that we don't want this kind of intervention, then there is no way we would go ahead with the intervention. In all our programming, we involve the community. (P 6)*

Some key informants noted that workers in the field were using stakeholder meetings to encourage others to engage in discussions about adapting and adopting CSE components:

*During these stakeholder meetings is where we also try to encourage people to not stigmatise adolescents . . . issues of sexuality shouldn't be a taboo. These are things that need to be talked about. Even in the field . . . volunteers are . . . encouraging discussions and engaging with adolescents in the community . . . encouraging parents to ensure that their children are protected . . . from unsafe practices. (P 7)*

One key informant shared an example of regional implementation of CSE in which both parents and young people were given a stage to express concerns and questions concerning sexual wellness.

*We initially did not have parents in mind, until the CSE debate. So, we're currently doing what we call a parent/child platform. We started in the two regions where we now have that programme running, where we do a quarterly meeting with parents, more like the way they do the PTAs [parent–teacher associations]. (P 9)*

Those working on the frontline in SRH services had ideas for adapting and adopting CSE curriculum content which

countered the extremes of the debate and offered initial solutions for navigating community concerns in ways that suited Ghana's cultural contexts.

## Discussion

Whilst there is much literature on CSE and its implementation globally, very few sources document the voices of people working within local and international organisations who are responsible for actioning the curriculum in schools or running community programmes that foster knowledge of SRH and safe practices for adolescents in Ghana. During the interviews, key informants made several references to CSE. They described grappling with the desire to implement CSE for young people whilst still honouring their personal views and cultural realities of being Ghanaian—a dichotomy evidenced strongly at the national and international levels by organisational reports, policies, political debates, advocacy groups, and the media (Amo-Adjei, 2022; Awusabo-Asare et al., 2017; Boateng, 2017; Martínez et al., 2021; Miedema et al., 2020; UNESCO, 2019; Wangamati, 2020).

The Ghana Health Service (2017) reported that CSE, as an integrated and universal approach to equip adolescents with a broad range of knowledge to improve their SRH, is "delivered piecemeal", especially to those outside the school system or in remote and rural areas. This sentiment was echoed by key informants in our study who shared culturally specific adaptations to the CSE as a way forward for improving young people's sexual wellness by (a) aligning the contents of CSE with current cultural belief and sexual norms of young people, (b) developing tools to talk about sex-related issues for teachers and parents, and (c) enhancing community comfort with CSE through a cautious and caring approach.

Amo-Adjei (2022) found that contrary to what adults and SRH stakeholders believe, young people are knowledgeable about sex and sexuality topics and older adolescents have expectations of having pleasurable sexual experiences. Whilst culturally sensitive adaptation was viewed as important by key informants in our study, they also acknowledged young people are old enough to know—a pertinent finding in the Sub-Saharan African countries of Kenya, Tanzania, and South Africa (McLaughlin et al., 2012). Whilst there is certainly room for a more culturally sensitive iteration that accounts for local traditions and cultural norms, key informants stated the age-appropriate levels that already exist in the incremental delivery design of the CSE need to be clearly delineated and communicated to CSE critics but also that the incremental nature of information might need to be revaluated to align better with a young person's age, which may not be being translated into practice. This idea was also suggested by Amo-Adjei (2022) who stated that such an action will show the content is evidence based and designed to guide learners into healthy SRH practices as they age. Further research investigating the impact of culturally responsive programming on SRH outcomes of Ghanaian young people will be required.

Key informants advised that those directly involved in health conversations, such as parents and teachers, should be provided with the tools to talk about SRH with the provision these tools align with Ghanaian cultural value systems. They highlighted that communities might have gaps in their knowledge about SRH education through the CSE curriculum and be vulnerable to misinformation tactics. Key informants also acknowledged that work needs to be done on the ground to understand what works for Ghanaian communities. This insight was supported by Shamrock and Ginn (2021) who advocated for the Ghanaian government to engage religious groups to increase the likelihood of accepting CSE within the education system. Additionally, research by Amo-Adjei (2022) highlighted that a reliance on foreign evidence alone can exacerbate mistrust due to colonisation and the historical politics contributing to sexuality education reform within Ghana. An implication of our findings is that parent–child platforms for having dialogues about SRH might be used to depolarise positions hindering consensus building at the community level, necessary for finding a middle ground between cultural values and accurate health information to implement CSE.

Where misinformation is spread about CSE, others (e.g., Wangamati, 2020) have also suggested the government unify stakeholders supporting SRH initiatives to dispel myths and fears, as suggested by our participants. For example, external financing for education has been crucial to the delivery of SRH programmes, but it creates a complex environment where international donors hold significant power in deciding what SRH services to finance and how those services will operate (Duah et al., 2020). Key informants voiced similar concerns regarding donors and support for rainbow rights that some viewed as directly conflicting with cultural beliefs and accepted gender norms. These findings highlight the often-perceived mismatch between CSE as an approach to SRH for young people and the cultural ideologies concerning sexuality education in Ghana. A practical implication of our findings calls for engaging several stakeholders to adapt the curriculum content. Miedema et al. (2020) offered similar insights in revealing how critics and proponents of CSE often share similar end goals and should be willing to discuss shortcomings within the proposed CSE model. As they stated, all sexuality education moralises—how it does is determined by when and where content for SRH education is generated and by whom. Similarly, a report conducted by Joint United Nations Programme on HIV/AIDS (2021)

argued for investigating what is available in the context already to inform delivery of CSE in a sensitive manner.

Participants in our study echoed sentiments about adaptation of CSE requiring a more sensitive approach that considers factors such as culture, religion, social norms, and values as important (Boborakhimov et al., 2023; Goldfarb & Lieberman, 2021; Miedema et al., 2020; Nyarko et al., 2014). Nyarko et al. (2014) highlighted that this also means not disregarding rich components of culture, such as the decency and humility that morality provides to the culture, which was similarly highlighted by participants. For the Ghana context, this may mean acknowledging the dominant religious view and educating people on religious leaders' misconceptions about CSE. Such misconceptions are based on assumptions and opinions rather than empirical data as noted by our participants. These findings are similar to Nyarko et al.'s review of 48 studies in the USA on CSE, which demonstrated substantial evidence that the curriculum did not lead to sexual activities but increased the use of condoms and contraceptives. Based on our findings, a practical implication to consider in future iterations of CSE would be the need to develop trust in the curriculum and reduce confusion over ideas in the CSE.

Key informants in our study emphasised the need for local adaptation of the CSE curriculum specifically. These findings align with those of Boborakhimov et al. (2023) who suggested another way of achieving cultural sensitivity in CSE implementation is to weave a country's diverse cultural, geographical, ethnic, and gendered values and other important characteristics into the CSE curriculum. Successful integration of CSE necessitates developing sensitivity to diverse forms of moralising and collaborative conversations between various stakeholders to unpack misinformation (Miedema et al., 2020). Key informants stated that SRH strategies must consider the local culture to be effective, noting it would be prudent to use culturally specific language and examples in approaching contentious CSE topics such as gender or sexual pleasure. These views reiterate the complexity and conflict generated by the role of culture and tradition in shaping Ghanaians' understandings of sex and sexuality previously noted in literature (Panchaud et al., 2019; Shamrock & Ginn, 2021). Amo-Adjei (2022) similarly found that certain ideas and teachings within CSE do not fit the local context. For instance, omitting religion, kinship networks, culture, and spirituality from CSE denies the central place of these elements in the lives of Ghanaian young people.

Whilst there is agreement that SRH education is needed in Ghana, most notably for young people, key informants pointed out that a campaign to clarify the specific content taught in CSE is necessary, specifically concerning the goals of teaching LGBTQIA+ content in the curriculum and the assumption of critics that it encourages promiscuity. This is supported by Palmer and Hirsch (2022), who cautioned that the current emphasis on biological aspects of SRH education underemphasises the importance of the social and emotional aspects that contribute to the development of a young person's sexual citizenship and determine their ability to navigate relationships. It is imperative to remember that Ghana is not alone in this challenge. Issues of sex and sexuality, especially those pertaining to LGBTQIA+ populations, are also challenging in many Global North countries. SRH education policies are integral to supporting young people in their development of self-worth, body agency, sexual rights, and maintenance of physical and emotional wellbeing. Arguments have been made that the introduction of sexuality education into the early years of schooling is important as it reaches many young people at a time when education is still mandatory (Tenkorang et al., 2021). Amo-Adjei's (2022) study also showed that young people who started learning about SRH earlier had increased knowledge of all CSE components. This may give younger learners an advantage and lead them to make better SRH choices or exhibit positive behavioural changes. Such policies should endeavour to reflect the diversity of issues young people encounter and offer a supportive structure that ensures those implementing CSE feel confident and comfortable through appropriate training and awareness of community services that can further assist youth. A practical implication of our findings emphasises the need to conduct purposeful consultations on how culturally specific norms and beliefs might be used to adapt the curriculum for a local lens.

## Conclusions

Key informants acknowledged CSE implementation in schools and community programmes as a challenging endeavour, but they also recognised the potential value of the curriculum. These findings add to limited formally documented perspectives on CSE from those working in health organisations that deliver SRH services in Ghana. Key informants pointed to a need for more locally generated evidence in terms of what works well for young people, what does not, and what they identify as their specific needs, to ensure CSE-related policies and content are more culturally and contextually responsive. However, future research will need to further investigate how culturally specific norms and beliefs might be used to adapt CSE for Ghana. Participatory approaches that involve participants as coresearchers may be a prudent strategy. Furthermore, assessing the impacts of such culturally responsive programming for improving SRH outcomes for young people, once it is developed, will also be a pertinent area for future research.

Despite noting the shortcomings of the current CSE curriculum, findings from this study demonstrate that some aspects of the guidelines are considered valuable to

improving overall adolescent SRH. Moving forward, it might be beneficial to regard CSE as a harm-reduction approach that can contribute to the minimisation of SRH risks. A cultural review of CSE that would adapt the curriculum to fit within community norms and beliefs about sex and sexuality is a means to reach a middle ground on this highly polarised issue. Purposeful consultations on how culturally specific norms and beliefs might be used to adapt the curriculum locally are required.

It is essential to remember that health and wellbeing do not just belong to healthcare providers and policy makers. SRH impacts everyone and is an important component of overall health and wellbeing that is often neglected. Local and international entities working in the SRH space in Ghana must seize the opportunity to advocate for and create culturally responsive programming. Key informants in this study offer parent–child platforms as one solution for depolarising positions that hinder the progression of consensus building at the community level; future research might explore the effectiveness of such platforms.

The nation is currently on a precipice where next steps will determine the shape of adolescent SRH for decades to come. It is unclear whether the Ghanaian government will accept CSE in its entirety, develop an adapted version in consultation and collaboration with communities, or dismiss it altogether. However, workers in organisations delivering SRH in Ghana reiterate the need for ongoing, nuanced conversations, alongside extensive community commitment, to design responsive resources and curriculum to enable a cultural shift in SRH education for the benefit of future generations.

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**Availability of Data and Material** It was opted out in the survey option during the Submissions process for two reasons. The approved ethics also says the data can only sit with the principal investigators of the study and must be destroyed after six years. Secondly, other aspects of the data are still be analysed and written up for further and future publications.

**Code Availability** Approved ethics states the data can only sit with the principal investigators of the study and must be destroyed after six years.

## Declarations

**Competing Interests** The authors declare no competing interests.



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