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Knowledge of Sexual and Reproductive Health among Adolescents in a Ghanaian Municipality: A Mixed-Method Approach

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Authors' contributions

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ABSTRACT

Introduction: Sexual and Reproductive Health (SRH) is an essential aspect of the physical, mental, social, and emotional well-being of adolescents who are generally known to be the most vulnerable group in this aspect of health.
Aim: This study was designed to explore the sexual and reproductive health knowledge of adolescents in the Central Region of Ghana with Komenda as the case study.
Methodology: A mixed method with a case study design was adopted through quantitative survey and focus group discussions among 95 adolescents in the Komenda community.
Results and Discussion: The study revealed that most respondents had an idea about what SRH is all about, what contraceptives are with condom being known by all of the study respondents but were not willing to use contraceptives during sex. Most respondents also knew of STDs including

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HIV and their mode of transmission even though a significant number of the respondents (for example, 34% of survey respondents) were also found to hold misconception that STDs can be transmitted through witchcraft. The school was found to be the most source of SRH information for the respondents and place they will prefer to learn about SRH. Who to best discuss SRH issues with was found to depend on the type of SRH issue to be shared even though parents followed by peers and health professionals were found to be the entities survey respondents generally would prefer to share SRH issues with.

Conclusion: This study revealed that even though respondents had knowledge on SRH, most of them held some misconceptions about SRH which is likely to affect their understanding and tolerance of the topic. This can lead to poor SRH outcomes such as high prevalence of HIV/AIDS. There is therefore the need for effective education among adolescents in the study community by the Ghana Health Service and relevant stakeholders. Moreover, the school should be used as an important vessel for educating adolescents on SRH issues.

Keywords: Sexual and reproductive health; knowledge; health information; adolescents; mixed-method; and Ghana.

1. INTRODUCTION

The World Health Organisation (WHO) has defined adolescence as the age range of 10 to 19 years. It is the period between childhood and adulthood, marked by physical growth, attainment of a mature structure, learning of physical characteristics, mental maturation and the development of secondary-sex characteristics. There are 1.2 billion adolescents representing 16% of the world population [1].

While adolescents generally enjoy good health compared with other age groups, adolescent sexual and reproductive health (ASRH) constitutes a major component of global burden of ill-health and therefore needs special attention. Adolescents face particular health risks, which may be detrimental not only for their immediate future but for the rest of their lives. High prevalence of HIV, teenage pregnancy and unsafe abortions are challenges faced by many countries especially in Sub-Saharan Africa [2]. Research has shown that many of the health problems that arise are due to a lack of general basic understanding on "reproductive biology and prevention methods" [2]. The health of adolescents and particularly their sexual and reproductive health (SRH) are of particular concern for a number of reasons: adolescents account for 23% of the overall burden of disease (disability-adjusted life years) because of pregnancy and childbirth [3]. WHO estimated 16 million births annually occur to young women aged 15 to 19 years, representing 11% of all births. Almost all (95%) of adolescent births take place in developing countries. 18% and 50% of births annually in Latin America and sub-Saharan Africa respectively occur during adolescence. Approximately 2.5 million births occur to girls aged between 12 and 15 years in low-resourced countries each year of which around a million births occur to girls younger than 16 years in Africa. Early childbearing is linked with higher maternal mortality and morbidity rates and increased risk of induced mostly illegal and unsafe abortions. Maternal deaths constitute the leading cause of death among adolescent females [4]. Of the estimated 22 million unsafe abortions that occur every year, 15% occur among young women aged between 15 and 19 years. An estimated one million young people aged between 15 and 24 years are infected with HIV every year representing 41% of all new infections among those aged 15 years and older. Most of these conditions, deaths and illnesses can be avoided. Gender-based violence is also too common a reality for many adolescents, especially girls [3]. What is even alarming is that whilst mortality rate is consistently reducing from all regions; it is still escalating and highest in Africa, increasing the global mortality in adolescents [5].

A number of initiatives have been undertaken in Ghana since 1980 culminating the launching of the National Adolescent Health and Development (ADHD) programme in 2001. A seven-year (2009-2015) National ADHD Strategic Plan was developed in 2009 which sought to provide a multi-sectorial support to every young person living in Ghana with education and information that will lead to the adoption of a healthy lifestyle physically, sexually, psychologically and socially [6]. Although many gains have been made over the past decades as a result of such initiatives, for example, the rate of new HIV infections among 15 to 19-year-old adolescents has

decreased by 40%. The proportion of females aged below 20 years who deliver with the assistance of a skilled provider increased to 72 percent, however, birth rate among adolescents aged 15 to 19 remains high. Central region consistently ranked as the second region with highest prevalence rate in teenage pregnancies in Ghana, for example, recorded more than 13,000 teenage pregnancies in 2016 [6]. Again, 2020 data from GHS depict that teenage pregnancy is still a big challenge in Ghana. According to GHS, Ghana recorded 109,888 teen pregnancies with the lowest girls to be put in the family way being ten years old. Per the data, girls between the ages of 10 and 14 account for 2,865 in pregnancies recorded in 2020 whilst another 107,023 girls between the ages of 15 and 19 were impregnated within same year [7]. This infers that in every one hour, there were 301 teen pregnancies in 2020. Ashanti Region was the region with the highest number of teen pregnancies (17,802), followed by Eastern Region (10,865).

Central Region, the focus of this study was the third region with the highest number of teen pregnancies (10; 301). Analysing the data from case to population ratio makes the region the highest with teen pregnancies in Ghana. KEEA Municipality for which Komenda is one of the circuits is one of the hot spot areas in the region where most adolescents face these challenges [8]. However, researches examining knowledge of adolescents on sexual and reproductive health in the area are non-existent. Moreover, studies that have investigated the problem in other parts of the country have largely used a quantitative approach. This is problematic since these studies are unable to present a deep understanding of the problem which can be best revealed with the triangulation of methods. It is against this background that this study sought to examine the sexual and reproductive health knowledge of adolescents in Central Region of Ghana using Komenda in the Komenda Edina Eguafo Abirem Municipality in the Central Region of Ghana as a case study. Hence this study empirically aims at:

(i) Assessing the knowledge of adolescents on sexual and reproductive health in Komenda community in the Central Region and

(ii) Identifying the mechanisms or sources of sexual and reproductive health knowledge among the youth of Komenda community in the Central Region of Ghana.

2. MATERIALS AND METHODS

The study employed the mixed-method approach with a descriptive study design. The population for this research constitutes adolescents in Komenda community in the Central Region of Ghana. The sample used for this study was drawn from a pool of adolescents in the Komenda community. A total of 60 adolescents agreed to respond to the questionnaires. As a part of the qualitative design, the sample size was determined by using the principle of saturation. Guest et al. [9] refer to it as having become 'the gold standard by which purposive sample sizes are determined in health science research. The principle of saturation was used to reduce repetitiveness of respondents' responses and the collection of large responses that did not add up to what had been collected [10]. A total of 35 respondents were therefore invited for focus group discussions. The convenience sampling approach was used to recruit participants since there was no sampling frame to allow for randomisation.

Questionnaires and in-depth focus group discussion guides were used as the instruments to assess knowledge and the experiences of adolescents on sexual and reproduction health. Sixty questionnaires were purposefully and randomly distributed among the adolescents who met the inclusive criteria in all the sixteen electoral areas of Komenda Community. Again, seven focus groups made up of five respondents of same sex each were also held in different electoral areas in Komenda Community. In all, 35 adolescents comprising of 20 females and 15 males were involved in the focus group discussions. At the end of each focus group discussion, study respondents were given an opportunity to ask questions related to the discussion. Each group discussion lasted for an average of one hour, and thirty minutes. Discussions were held in both "Fante" (local language of the people) and English. A semi-circular sitting arrangement was planned to ensure good communication between the study respondents and the researchers. Data collection took place between April and May 2021.

Very conscious of the ethical issues and guidelines for research on sexual and reproductive health involving minors [11], permission was sought from the authorities of University of Education, Winneba where the researchers are affiliated to, leaders of Komenda

community where the research was conducted and the KEEA Municipal Assembly.

Data collected from the questionnaires were analysed using SPSS software (version 19) and Microsoft excel. Descriptive data were presented as simple frequencies and percentages whilst data analysis from the focus group discussions commenced with transcribing, translating, reviewing and coding of interview excerpts. This enabled the development of key themes and patterns emanating from the data.

3. RESULTS

3.1 Demographic Characteristics of Respondents

Ninety-five (95) respondents participated in the study. Sixty (60) of them were made to respond to the questionnaires whilst the remaining thirty-five (35) were used for the focus group discussions. The mean age of the respondents was 16.9 whilst the median age was calculated to be 17 with 18 being the modal age. The standard deviation for the distribution of the ages was found to be 1.61. The demographic characteristics of the respondents have been presented in Table 1.

3.2 Knowledge on Sexual and Reproductive Health in General

As Table 2 and Table 3 depict, 60 out of the 95 study respondents who responded to the items on the questionnaires' knowledge on general SRH were explored. When asked to respond whether they were conversant with the term SRH, 52 respondents representing 86.7% of the respondents responded "YES" whilst the remaining 13.3% responded "NO". To further test their assertions, those who responded "YES" were made to respond to a list of options that they thought were under the broad area of SRH. 50 respondents recognised "sex education" as being part of SRH and more than half of the respondents also chose "STIs prevention" and "pregnancy" as part of broad areas of SRH. More than one-third of the respondents also recognised "human right" and "abortion" as being part of the broad scope of SRH. However, only 18 of the respondents considered "contraceptives" to be inclusive of the broad areas of SRH.

Meanwhile when engaged in focus group discussions to ascertain what the term SRH meant to others. It was found that their understanding on what SRH entailed was so skeptical. Some admitted that they had not heard about it before. Many of them understood it from the biological perspective of health as some of them put it in similar ways as:

"*Sexual and reproductive health in my opinion is about keeping your private parts clean*." "*It is about personal hygiene and keeping the body free from disease*."

"*It is the health about your sexual and reproductive organ*."

Others also understood it as the activities that go on in the relationships between male and female as one male explained;

"*It means male and female having sexual affairs.*"

No one was able to comprehend and conceptualise SRH as a concept so comprehensive in its nature as defined by authorities such as WHO and ICPD.

3.3 Knowledge on Contraceptives and Pregnancy

The study assessed the knowledge on contraceptive and pregnancy, for example, "what contraceptives are"," types of contraceptives they know or have heard", "do contraceptives have side effects", "can one use contraceptives and still get pregnant and STDs" via the questionnaire. A total of 54 out of the 60 (90%) respondents claimed to know what contraceptives were. When made to respond to as many as applicable to them what contraceptives were used for, 36 and 41 out of the 54 respondents who claimed to know what contraceptives were revealled that contraceptives were used to prevent disease and prevent pregnancy respectively. 22 out of the 54 (40.7%) respondents unfortunately thought that contraceptives were also used for abortion. Then again, the 60 respondents were made to respond to which of these thus condom, implant, injectable, spermicide, diaphragm, sterilisation, pill, cervical cap and intrauterine device they had heard of, 100% of the 60 respondents selected condom, the second known contraceptive was pill representing 71% of the total respondents with diaphragm (3.3%) and intrauterine device (1.7%) being the least known contraceptives as shown in Fig. 1. Again almost half of the

respondents did not know that one could use contraceptives and still get STDs or pregnant. Approximately one- third of the respondents also never knew that contraceptives had side effects. Table 4 shows the details of the responses to each item.

Table 1. Demographic Characteristics of Respondents

Category	Frequency	Percent
Age		
10.-15	23	24.21
16-19	72	75.79
Total	**95**	**100**
Gender		
Male	43	45.26
Female	52	54.74
Total	**95**	**100**
Religion		
Christianity	70	73.68
Islamic	25	26.32
Total	**95**	**100**
Education level		
Tertiary	3	3.16
Senior High School	36	37.89
Junior High School	40	42.11
Primary	16	16.84
Total	**95**	**100**
Marital status		
Cohabitating	7	7.37
Not married	25	26.32
In a relationship	50	52.63
Single	13	13.68
Total	**95**	**100**
What they do		
Student	65	68.42
Trading	14	14.74
Others	16	16.84
Total	**95**	**100**
Who they stay with		
Parents	60	63.16
Guardian	26	27.37
Others	9	9.47
Total	**95**	**100**
Number of child or children		
Yes	17	17.89
No	78	82.11
Total	**95**	**100**

Table 2. Respondents' Recognition of Sexual and Reproductive Health (SRH)

Responses	Frequency	Percentage
Yes	52	86.7
No	8	13.3

Source: Field Survey, 2021

Table 3. Responses of Respondents to What SRH Covers

Number of Respondents = 52		
SRH Areas	**Frequency**	**Percentage (area/52 *100)**
Sex education	50	96.15
STI prevention	31	59.62
Contraceptives	18	34.62
Human Right	20	38.46
Pregnancy	30	57.69
Abortion	21	40.38

Source: Field survey, 2021

Table 4. Responses on Knowledge on Contraceptives and Pregnancy

Item	Frequency	Percentage
Do you know what contraceptives are?		
Yes	54	90
No	6	10
What contraceptives are used for?		
Use to prevent diseases	36	66.7
Use to prevent pregnancy	41	75.9
Use to do abortion	22	40.7
Which of these have you heard of?		
Condom	60	100
Spermicide	8	13.3
Pill	43	71.7
Implant	3	5
Diaphragm	2	3.3
Injectable	22	36.7
intrauterine device	1	1.7
Can you use contraceptives and still get STDs?		
Yes	31	51.7
No	29	48.3
If yes what contraceptives is best for preventing STDs?		
Condom	27	87.1
Injectable	4	12.9
Can one use contraceptives and still get pregnant?		
Yes	34	56.7
No	26	43.3
If Yes, what contraceptives is best for preventing pregnancies?		
Condom	17	50
Spermicide	3	8.8
Pill	7	20.6
Implant	1	2.9
Injectable	6	17.6
Do contraceptives have side effects?		
Yes	39	65
No	21	35

When those who responded "YES" as to the fact that contraceptives had side were probed to state the effect of contraceptives, 4 of them stated the general effect of contraceptives as causing deaths, 9 of the respondents stated injectable (family planning) as causing barrenness, overweight and delaying of pregnancy in the future. Similarly, 16 of the respondents also cited white, rashes, bursting and leaking as the side effects of using condom. The remaining of the respondents cited womb destruction, bleeding, infertility, abortion and changes in menstrual cycle as the side effects of pill.

Meanwhile all those involved in FGDs knew condom with others knowing family planning and pills as other alternatives of preventing pregnancy as one of the female respondents put it:

"For this community, before you grow up to let say ten years, you would probably have heard about condom, what it is actually used for may be a problem"

Majority of the FGDs respondents also opined that contraceptives could also be used for abortion especially, in the morning after pills.

3.4 Knowledge on STDS Including HIV

Knowledge on STDs including HIV was being assessed via survey and focus group discussion. The study showed as detailed in Table 5 that 50 out of 60 of the respondents who responded to the questionnaires claimed to know what STDs were. Those who responded "YES" as usual had knowledge on STDs were further being probed to find out whether they knew about its mode of transmission. 48 out of the 50 respondents (96%) knew that it could be transmitted through "sex", 17 of them claimed that it could be transmitted through "witchcraft", 27 of the respondents recognised "sharing of personal items like towel and blade" and 2 others mentioned "blood transfusion" as one of the modes of transmission with only one respondent claiming STDs could be transmitted through "food". A total of 58 out of the 60 respondents recognised "HIV" as being example of STDs. The second most known STD was "gonorrhea" followed by "syphilis" and "genital wart" with the least known STDs in descending order being "hepatitis B" and "chlamydia". Overall, 44 representing 73.3% of the respondents claimed that STDs could be cured whilst the remaining claimed that they could not be cured.

During the focus group discussion, respondents were asked whether they knew how to prevent STDs or pregnancy during their first sex experience. Most of them claimed to be ignorant on how to prevent STDs or pregnancy during their first sex experience. A female respondent stated that:

"*Before I had my first sex experience, I had no prior knowledge about it. It was someone who educated me on that afterwards. She even advised me to go for family planning."*

Even with those who knew before engaging in sex, clarity was being made by one of them on the fact that they refused to be protected. A male respondent in response to the claim asserted that:

"All what they are saying is right, being the first time you are going to experience sex, you will be rushing and so even if you know about condom, you will not think about it. At that time, it will just be a matter of pushing the penis into it. You will never think about wearing a condom and that is when if you are not lucky you will be in trouble."

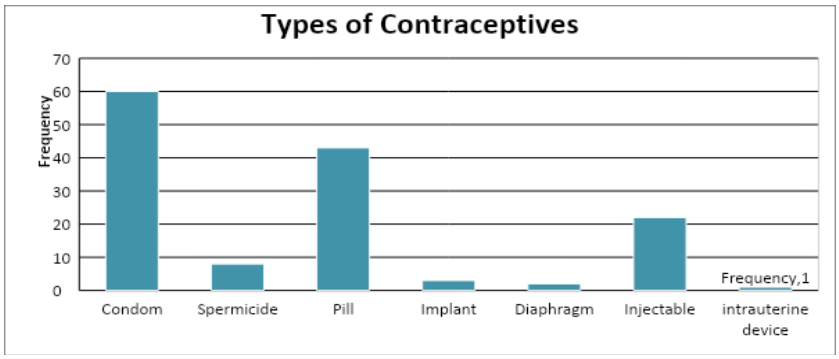

Fig. 1. A Graph Showing Participants' Responses to the Types of Contraceptives They Have Heard Before

Table 5. Respondents' Knowledge on STDs Including HIV

Item	Frequency	Percentage
Do you know what STDs are?		
Yes	50	83.3
No	10	16.7
How can STDs be transmitted?		
Through sex	48	96
Witchcraft	17	34
Through food	1	2
Sharing of personal items like towel, blade etc.	27	54
Others	2	4
Which of these are examples of STDs?		
HIV	58	96.7
Gonorrhoea	47	78.3
Chlamydia	5	8.3
Syphilis	36	60.0
Heptatitis B	7	11.7
Genital Wart	12	20.0
Can STDs be cured?		
Yes	44	73.3
No	16	26.7

Source: Field Survey, 2021.

Assessing their knowledge on the best way to prevent pregnancy and STDs revealled many facts, misconceptions and beliefs. Some cited abstinence and condom usage as the best way of preventing pregnancy and STDs whilst others held and supported some of these assumptions. Two of the respondents continued separately on the fact that:

"I know that there is a medicine for girls to use to prevent pregnancy when having sex, they call it P2 or you the man and the woman can take chill water just before sex, when it happens like that it will reduce the quantity of sperms that will come out of the man and the few that will enter the woman will be flushed out as the woman urinate right after the sex and no pregnancy will occur."

"Either we use condom or bath just after sex so that any disease around us will be washed away and render us clean. If we do that we will not get any disease."

3.5 Methods/Sources of SRH Information

Respondents claimed to have many sources of SRH information as depicted in Table 6 through the survey. However, the most source of SRH information for the study respondents was found to be school (50%) followed by friends (23.3%), media (113.3%) and parents (8. 3%).The least most source of information for the study respondents were found to be youth club (3.3%) and religious gathering (1.6%). 39 representing 65% of the quantitative survey respondents were ignorant about organisations or facilities in the community that offer SRH services.

As to whom they would prefer to share SRH issues with, 34 of the respondents considered their parents or siblings as one of the entities they would want to discuss SRH issues with, 31 of them were also found to prefer to share SRH issues with their peers and health professionals. Only few were willing to share SRH issues with their teachers and religious leaders. Again, 43 of the respondents chose school as one of the places they would prefer most to learn about SRH with their peers followed by health facility and youth club thus 26 and 25 respondents respectively. Only 4 respondents and 1 respondent liked media and religious gathering respectively.

The study revealled during focus group discussions that most of the adolescents' respondents preferred to discuss SRH issues with their parents/guardians as one of the male respondent asserted:

"I will tell my parents, since they are the ones who gave birth to me and they have taken care of me to grow up. I will never be ashamed to report to them."

Table 6. A Table Depicting the Methods/Sources of SRH Information

Item		Frequency	Percentage (%)
Where they have been getting SRH information from?			
	Friends	42	70
	Parents/guardians	16	26.7
	Media	44	73.3
	School	51	85
	Religious ground	4	6.7
	Youth club	25	41.7
Where they most often get SRH information from?			
	Friends	14	23.3
	Parents/guardian	5	8.3
	Media	8	13.3
	School	30	50
	Religious gathering	1	1.6
	Youth club	2	3.3
Do you have any organisation that offers SRH services?			
	Yes	21	35
	No	39	65
Who they will prefer to discuss SRH issue with?			
	Parent/guardian	34	56.7
	Religious leader	3	5
	Health professional	31	51.7
	Teacher	13	21.7
	Peers	31	51.7
Where they will prefer to learn about SRH with peers?			
	School	43	71.7
	Media	4	6.7
	Health facility	26	43.3
	Youth club	25	41.7
	Religious ground	1	1.7
	Home	14	23.3

Source: Field Survey, 2021

Others also argued that they were shy of their parents and so they would either tell their friends or go to the drug store to seek for help. In support of this claim, one of the female respondents alluded that:

"For me, I am shy of my parents so I will tell my friends."

However, as discussions went on, emphasis was placed on the fact that it depended on the type of SRH issue to be discussed. Being supported by the other female respondents, two of the female respondents emphasised separately that:

"*If it happens that I wake up now and experience any changes in my reproductive organ, the first person I will tell is my boyfriend*."

"*Not all things should be told to a friend especially the sensitive ones. They will even ridicule you with it in the future*."

As to where they would prefer most to learn on SRH, most of them cited school as the best place to learn or receive knowledge on SRH. One of them made a remarkable comment that:

"To me, I wish they could remove core mathematics and replace it with it. So that it will become one of the core subjects, because

you are always told to find X but I don't see its relevance in my life, this is what will help my life."

One of the female respondents when discussing said:
"I heard the government wanted to add it to the subjects but the parents refused, but if it is true then they have committed a sin and a crime because they want the children to go wayward and continue getting pregnant anyhow. It should be allowed to be taught in schools because most people don't have any idea about it and our parents themselves don't know much about it."

Others also proposed youth club and where the public used to gather as one of the best places to receive knowledge on SRH aside school. Most of them also agreed that it would be best to discuss SRH issues in group as this would enable them to learn and share experiences with each other. This would not also let others perceive one as a "bad boy" whom they are giving some sort of advice especially when engaged individually. In support of this assertion, two male respondents concurred on the fact that:

"When they engage only me, it will be like they are offering only me advice and I will never agree, when we are in group then I will agree because they are offering all of us advice and I will be Ok."

"Group is nice, everyone will share idea, and so group is better that individual."

Others also recommend that the information be shared through media as they would be able to reach to many more people since the media has become a common place for people including adolescents to share and receive information. Buttressing this opinion, one female respondent opined that:

"They should spread the message in social media, since everyone nowadays goes there."

4. DISCUSSION

4.1 Knowledge on Sexual and Reproductive Health in General

Findings indicated that adolescents had limited comprehensive knowledge on what SRH is all about as defined by authorities. For example, only less than a one-third of those who claimed to know what SRH entailed were able to recognise contraceptives as being part of broad SRH domain. United Nations, 1995 recognised human rights as being one of the major parts of the SRH domain [12] yet only a one-third of the respondents were able to recognise it as such and same is true for abortion. This may be as a result of the fact that the subject matter is not well taught in schools in its systematic and comprehensive nature, thus some sections are being taught whilst others are ignored. The manner in which some aspects of the subject matter are taught in school confirms the reason why a significant of them were able to recognise sex education and STIs as such since most of the respondents are in schools (68.42%) or have been students before. This of course is in line with findings of Ivanova et al. [13] study on adolescents in which adolescents pointed out inadequacies related to the range of SRH topics taught in school, which were usually limited to abstinence with very little information on contraceptives.

4.2 Knowledge on Contraceptive and Pregnancy

Adolescents' knowledge on contraceptives found in the findings of the result of this study was quite comparable to their counterparts in other parts of the world. Eliason et al. [14] found that a little over 90% of young women of reproductive age knew at least one method of modern contraceptives as compared to this study where 90% claimed to understand what contraceptives are used for and where all the respondents understood at least one type of contraceptive (condom). It is also in conformity to the GDHS [15] finding that knowledge of contraceptives among young females and adolescents has been relatively high. The findings on the best contraceptive to prevent pregnancy also match with Ayalew et al. [16] findings that is, 50% versus 47.7% respectively. Even though the study did not use quantitative approach to explore contraceptives usage, the insights revealed in the focus group discussions explained why contraceptive usage is low as reported in the finding of GDHS, [15] and Ivanova et al. [13] as clearly observed in the discussions of the female respondents when being asked whether their guys use condom during sex. In support of the facts that they and their guys are not willing to use contraceptive, two of the female respondents separately alleged that:

"Will you want to eat toffee with the rubber on, I know my boys even if you give them condoms they will never use it, they prefer it raw, we the

ladies sometimes have to protect ourselves by taking pills."

"I have not given birth even if I have; I will never do family planning. I will not do that so that if I don't give birth in the future, no one will say is my grandmother sitting somewhere who is responsible."

Such statements stress on the fact that even though they knew and had options in choosing contraceptives to prevent pregnancies, however, they were not willing due to their own personal reasons and other misconceptions.

4.3 Knowledge on STDS Including HIV

Findings of the result depicted that a very significant number of the study respondents were very conversant with STDs. Most respondents knew what STDs are and how they are transmitted (refer to Table 5). This of course do not deviate from the research conducted on adolescents in secondary school in Nigeria which found out that majority of the adolescents had good knowledge on STIs and their mode of transmission [17]. The study is also in conformity to the findings of GDHS, [15] which reported that nearly all the respondents had heard about HIV thus this study found out that 96.7% of the respondents knew HIV as an STD. The study also goes a long way to reflect the findings of Eaton et al. [18] and Hassan et al. [17], who found out that generally adolescents were well informed or more knowledgeable on HIV/AIDS than any other STDs.

What is alarming and needs to be discussed is the very misconception that STDs can be transmitted through witchcraft which the results of this study indicated (27 representing 34% of the respondents who took part in the survey). In a community where culture and spiritualty are upheld and the fact that all study respondents were affiliated to one religious group or the other, it is also not surprised that some of the adolescents hold such misconception

4.4 Methods/Sources of SRH Information

The findings of the results indicated that adolescents have multiple sources of SRH information however, the most often source of SRH information was found to be school (see Table 6) which however does not match well with Awusabo-Asare et al. [19] study in Ghana which found out that the media was the leading source of SRH information for adolescents followed by friends. Perhaps this may be as a result of time lapse between the current study and the Awusabo-Asare et al. [19] which is more than ten years ago. The other bid may also be on the paradigm shift of media from providing services that are solely beneficial to the entire society to services that only yield returns in monetary terms. Even though the survey revealed parents followed by peers and health professionals to be the most preferred entities adolescent will want to share SRH issues with in general. The focus group discussion revealed that the type of SRH issue or condition will determine the entity to be discussed with at any given time. This partly explains why research conducted in south Ethiopia on student adolescents which shows that 87% of the respondents reported that it was important to discuss SRH issues with parents however, only 32% of the respondents were doing so with their parents due to fear and lack of SRH knowledge by the parents themselves [20]. Mchome et al., [21] found that many SRH services or programmes have been under-utilised and this with respect to this study may be as a result of the rigidity and proximity of the programmes or services. Services or programmes designed must reach the people and not the other way round in order to enhance its utilisation.

It is also alarming to recognise that a significant number of the respondents (65% of those 60 respondents who responded to the questionnaires) were ignorant about organisation/facility that offers SRH services. This means a lot of health promotion and education campaigns are needed. If they do not know where to receive help, then they are bound to rely on other unreliable sources in moment of crises which will consequently land them into trouble.

5. CONCLUSION

This study revealed that even though respondents had knowledge on SRH, most of them held some misconceptions about SRH which is likely to affect their understanding and tolerance of the topic. This can lead to poor SRH outcomes such as high prevalence of HIV/AIDS. There is therefore the need for effective education among adolescents in the study community by the Ghana Health Service and relevant stakeholders. Moreover, the school should be used as an important vessel for educating adolescents on SRH issues.

CONSENT

Consent from respondents, their guardian, teachers or parents were also sought as well as adherence to confidentiality and anonymity of study respondents within and after the study period.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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