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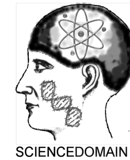

Knowledge and Perception of Adolescents on Sexual and Reproductive Health Rights in Ghana: A Case Study of Yamoransa in the Mfantseman Municipality

Elijah Yendaw[1*], Ebenezer Martin-Yeboah[2] and Daniel Bagah[3]

[1]Department of Community Development, University for Development Studies, Wa Campus, Migration Studies, Adolescent Reproductive Health, Climate Change Adaptation and Issues in Population, Environment and Development, Ghana.
[2]Main Library, University of Cape Coast, Cape Coast, Adolescent Reproductive Health, Ghana.
[3]School of Business and Law, University for Development Studies, Wa Campus, Adolescent Reproductive Health, Medical Sociology, and Issues in National Health Insurance Policy, Ghana.

Authors' contributions

This work was carried out in collaboration between all authors. Authors EY and MEY designed the study and performed the statistical analysis. Authors EY and DB wrote the protocol, and wrote the first draft of the manuscript. Authors EY and MEY managed the analyses of the study and managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

According to the 2010 Population and Housing Census report of Ghana, Yamoransa has one of the highest number of young adolescents in the Mfantseman Municipality. However, it appears there is no evidence of empirical study conducted on adolescents' knowledge and perception of sexual and reproductive health rights. Meanwhile, sexual and reproductive health rights (SRHR) are the foundation of sexual and reproductive health outcomes of young people. To fill this literature gap,

**Corresponding author: E-mail: eyendaw@uds.edu.gh;*

this study assessed adolescents' knowledge and perception of SRHR using 209 adolescent residents in the study area. Data for the study were collected through the survey approach. The study has shown that over 80% of the respondents have heard and known some aspects of SRHR. However, a higher proportion of female adolescents (56%) as compared to male adolescents (46.2%) lacked knowledge on how ignorance of one's SRHR could lead to sexual rights violations. The view that men should be the sole decision makers on sexual issues was held by some adolescents. The study, therefore, recommends that government and other relevant stakeholders such as UNICEF should educate and empower young people to exercise their SRHR during adolescence and in adulthood.

Keywords: Adolescents; Ghana; Knowledge; perception; reproductive health rights.

1. INTRODUCTION

Adolescents and young people comprise almost half the world's population [1]. They have sexual and reproductive rights, just as adults do, but their low social status, poverty, lack of autonomy, and physical vulnerability make it more difficult for them to exercise such rights [2,3]. For instance, a study by Ogunjuyigbe and Adeyemi [4] found that older women in conjugal unions only had control over their sexuality during certain occasions such as menstruation, breastfeeding, pregnancy, and when they are sick. Perhaps, this could have been different if they had, in their adolescent years, known and developed their capacity to exercise their sexual and reproductive health rights as individuals.

Knowledge of sexual and reproductive health rights are a major concern of the adolescent period, in part because earlier sexual maturation and later marriage have increased the period of risk for early or non-marital pregnancy and exposure to STIs. Sexual relations typically occur before adolescents gain experience and skills in rights protection, self-protection, adequate information about STIs, and before they can get access to health services and supplies such as condoms. By age 18, more than two-fifths of young women (44%) and 26% of young men had had sexual intercourse [5].

Studies on adolescent sexuality suggest that a number of adolescents are deterred from access to high quality health services by cost and the often judgmental attitudes of health care providers, particularly when seeking care and advice on sexuality-related matters [6-8]. In general, Ghana remains a relatively conservative country where discussions of sexual issues, abortion and adolescents' usage of contraceptives are still widely a taboo [5,8]. The government of Ghana has in place a comprehensive adolescent reproductive health policy, but in practice many organizations emphasize abstinence until marriage. This is despite demand from an estimated 22% to 27% of young people who want to use family planning but are unable because they cannot easily obtain contraceptive services [9]. Adolescents often do not know where to go for impartial advice and contraceptives and the number of teen-friendly clinics providing these services are limited in Ghana, especially outside the main cities. Meanwhile, adolescents need to be empowered in diverse ways to assert their rights and personally protect their own reproductive health from risk.

Although vast empirical literature exists on adolescent sexual and reproductive health issues globally, there is a scarcity of evidence on the scope of adolescents' knowledge and perception of sexual and reproductive health rights in Ghana. While a claim could be made about similar studies conducted in Ghana [8,10], regrettably, these studies failed to interrogate in-depth adolescents' level of knowledge and perception of sexual and reproductive health rights, in particular, a peri-urban settlement like Yamoransa which has one of the highest number of out of school adolescents in the Mfantseman Municipality [9]. Besides, both studies largely involved an analysis of secondary information and thus not based on primary data. In that regard, this study assesses the scope of adolescents' of knowledge and perception of sexual and reproductive health rights matters in Ghana using a peri-urban community (Yamoransa) as a case. The study examines their views on some rights-related scenarios and power relations in marital unions, their knowledge of acts that constituted human rights violations, and adolescents' reaction upon denial of sexual and reproductive health services.

The rationale for this study are two folds: first, it is anticipated that the study will contribute to the growing body of literature on adolescent sexual and reproductive health issues in Ghana and the rest of the world, by providing a more in-depth understanding of the phenomena from the perspective of respondents. Previous studies [11,12] on the subject have dealt with these issues in non-Ghana context. Consequently, there is paucity of empirical studies on adolescents' SRH rights in Ghana. Second, it is expected that the study will provide some policy directions for government and other relevant stakeholders on how laws, customs, practices, and reproductive services could be tailored to guarantee adolescents' access to impartial SRH services and rights. Among other things, the study was guided by the hypotheses that adolescents' age, sex, educational level and religion have no significant association with their perception of sexual and reproductive health rights in Ghana.

2. STUDY METHODS

The study was conducted at Yamoransa in the Mfantseman Municipality, Ghana (Fig. 1). This municipality is located along the Atlantic coastline of the Central Region of Ghana, and extends from latitudes 5°7' to 5°20' North of the Equator and longitudes 0°44' to 1°11' West of the Greenwich Meridian, stretching for about 21 kilometres along the coastline and for about 13 kilometers inland constituting an area of 612 square kilometers [9;13]. Mfantseman Municipality is bounded to the West and Northwest by Abura-Asebu- Kwamankese District, to the North by Ajumako Enyan Essiam District and Assin-South District, to the East by Gomoa-West District and to the south by the Atlantic Ocean. Due to its proximity to the Atlantic Ocean, Yamoransa has mild temperatures, which range between 24°C and 28°C. It has a relative humidity of about 70 per cent and as well experiences double maxima rainfall with peaks in May-June and October [9,13].

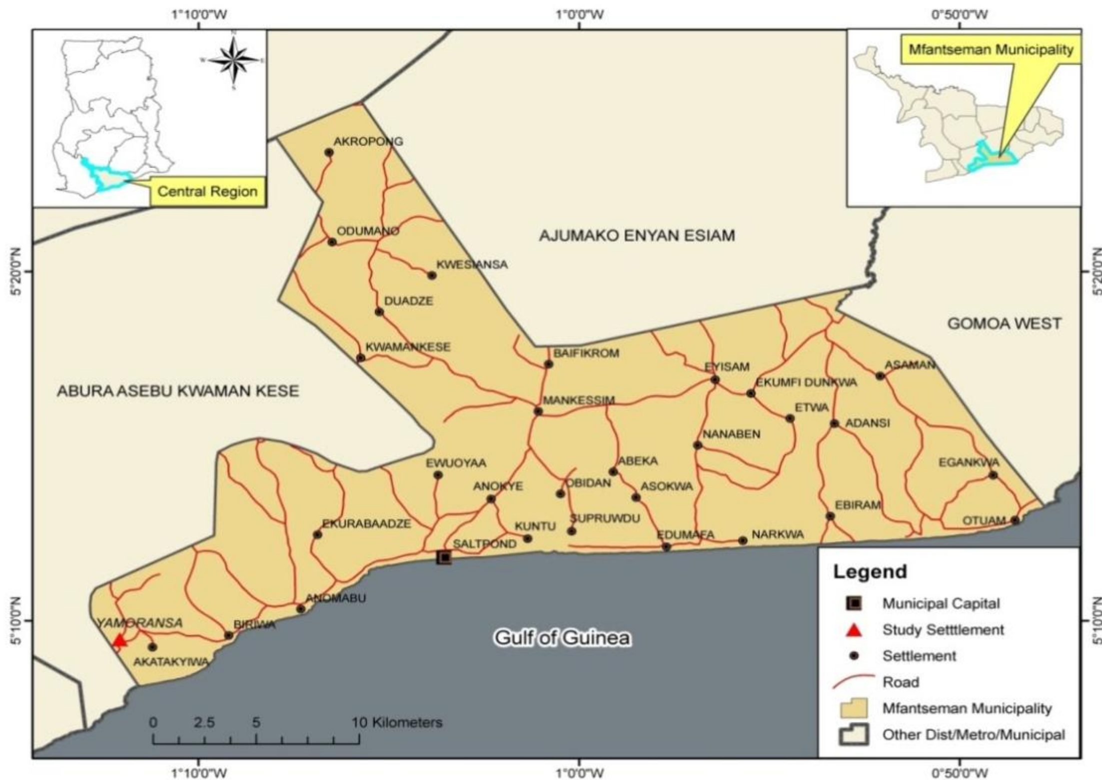

Fig. 1. Map of Mfantseman Municipality showing the study area

Source: Remote sensing and Cartographic Unit; Department of Geography and Regional Planning; UCC (2011)

Yamoransa was selected for the study because it is one of the poorest communities in the region and has one of the largest proportions of out of school adolescents [9,13]. More so, Yamoransa is a nodal settlement and located along the Trans-West African Highway which serves as a link to the Northern corridors of the country (Ashanti, Brong Ahafo and Northern Ghana) and thus attracts a large number of commercial traders from within and outside Ghana, therefore, putting the lives of young adolescents at risks of sexual rights abuses [9,13].

The study relied on a more current data of the study area which were collected in 2010 by the Department of Population and Health, University of Cape Coast (UCC), Ghana. According to the Department of Population and Health [14], Yamoransa has a total population of 5,283 comprising 2,416 males and 2,867 females. Adolescents of ages 15 to 19 years, who constituted the target population, were 608. Of this, 296 representing 48.7% were males as against 312 (51.3%) who were females (Department of Population and Health, 14). This data was used for the study because it was the most current data at the time of the study because results from the 2010 Population and Housing Census were not readily available.

This study was situated within the quantitative methodology of the positivist science tradition. It employed a descriptive cross-sectional research design where a subset of the target population (adolescents of ages 15-19 years) was studied simultaneously within a short period of time. The use of cross-sectional study design was aimed at eliciting information on adolescents' level of knowledge and perception about sexual and reproductive health rights. Using the Fisher et al. [15] formula for determining sample size, an estimated sample size (n) of 216 respondents was obtained. This formula was used because the target population had similar features in terms of residence and age group. More females than males were chosen for the study to reflect the existing sex ratio in the community (48.7% males and 51.3% females).

A proportionate stratified sampling technique was used to select the respondents. According to Sarantakos [16], stratified random sampling is a probability sampling procedure in which the target population is divided into a number of strata, and a sample drawn from each stratum. For this particular study, sex was the criterion for the division of the target population into strata and from each stratum, the respondents were then randomly selected using the lottery method of the simple random sampling technique. This was done using a sex disaggregated data of all adolescents aged 15-19 years (sample frame) which was generated from the data base of the Department of Population and Health, UCC. In all, 111 female adolescents were selected from 312 females (representing 51.3%) and 105 male adolescents from 296 males (representing 48.7%), making up the total sample size of 216 respondents. The unit of analysis for this study was the individual adolescent and not a household head.

The main instrument used to collect data for the study was an interview schedule. The interview schedule was made of both close and open-ended questions. The instrument was structured in two parts namely A and B. The items in Section 'A' elicited information on the background profile of the respondents while section 'B' was composed of items bringing forth respondents' experiences, knowledge, views and perception on sexual and reproductive health rights issues. A pretest of the instrument was carried out at Akotokyire, a village on the fringes of UCC on April 5, 2010 to check the validity and reliability of the instrument. The actual data collection commenced on April 15 to 19, 2011. One major challenge encountered with the data collection was that out of the 216 respondents earmarked for the study, only 209 adolescents responded representing a 96.8% response rate. The 3.2% non-response rate was mainly due to the fact that some of the adolescents selected for the study migrated out of the study area and some of the information obtained in some of the instruments were found to be unsuitable for any serious analysis and were therefore discarded. Two field research assistants were carefully selected and trained to assist with the data collection exercise which lasted for two weeks.

All the 209 instruments were edited for inconsistencies, and serially coded. Afterwards, the statistical product and service solutions (SPSS) (version 16) software was used for the data entry and analysis. The main descriptive tools used for the data analysis and presentation included tables, frequencies, percentages and figures. The Chi-Square Test of Independence was used to analyze the data. Chi-Square is a test statistic which is used to test the association between categorical variables [17]. Though Chi-Square is somewhat regarded as a less robust technique, the choice of this non-parametric tool

was informed by the fact that the data used for this study did not meet the stringent requirements of parametric techniques such as logistic regression. The independent variables used for the chi-square test were the demographic characteristics of the respondents such as sex, age, religion and education while the dependent variables were obtained from the respondents' level of knowledge and perception of sexual and reproductive health rights. The rationale was to bring out the various factors in the independent variable and measure their association on the dependent variable.

Ethical issues are important component of any empirical research, especially in the social sciences domain. In that regard, this study strictly adhered to all standardized ethical concerns governing the conduct of social science research. In particular, ethical clearance was first sought from the Ethical Review Board of University of Cape Coast, Ghana, before the actual data collection commenced. More so, issues such as informed consent, anonymity, privacy and confidentiality of respondents were given prominent attention throughout the study. It is, however, imperative to caution at this point that the data of this study were limited to one peri-urban settlement in the Mfantseman Municipality of Ghana, hence extrapolations and/or generalizations from this study should be done with some level of care.

3. RESULTS AND DISCUSSION

3.1 Profile of the Respondents

There were more female respondents (51.7%) than male respondents (48.3%). Respondents aged 19 years constituted the highest (32.6%) proportion of all the respondents followed by those who were aged 17 years with the least being those who were 16 years. Table 1 further revealed that the respondents were mostly Christians which comprised 85.2% females and 74.3% males. In terms of ethnicity, the majority of the respondents (69.3% males and 69.4% females respectively) were Fantes. More than 46% males were at the Senior High School (SHS) level whereas a greater proportion of females (47.2%) were at the Junior High School level. Over one tenth of males (12.6%) and about 7% of females were at the tertiary level which goes to confirm findings from Ghana Statistical Service [9] reports where more males than females have higher level of education in Ghana. It also emerged that 48.5% males were living with both parents. For females, the usual living arrangement was with their mothers (41.7%). Table 1 further showed that almost all the respondents interviewed had never married (98.0% males and 90.7% females), but among those who were married, a large proportion (9.3%) were female adolescents as against 2.0% of their male counterparts. This implies that young female adolescents are more likely to enter into early marriages than their male counterparts hence have a higher propensity of becoming vulnerable to sexual and reproductive rights violations.

3.2 Knowledge and Perception of Sexual and Reproductive Health Rights

In order to have adequate understanding of the level of adolescent's knowledge and perception about sexual and reproductive rights in the study area, their views were sought on some rights-related scenarios, and power relations in marital unions. To begin with, the adolescents were first asked about what they knew about human rights (Fig. 2). It emerged from the results (Fig. 2) that over 80% of the respondents (87.1% males and 80.6% females) have heard and known some aspects of human rights. However, when asked as to whether a lack of knowledge of one's SRH rights could make him or her vulnerable to sexual rights infringements, a little over half of males (53.8%) and less than half of females (44.3%) agreed to this assertion. The above revelations find credence in what Wouhabe [18] had observed in his study on the Sexual behaviour, knowledge and awareness of related reproductive health issues among single youth in Ethiopia where individual level factors of adolescents such as sex influenced their knowledge level and perception about sexual and reproductive health rights issues.

Although from the study (Fig. 2), it appears most of the respondents were aware about human rights, the fact that about one fifth (20%) of female adolescents have never heard anything about human rights and also that about two thirds (60%) of them lacked knowledge about their implications on reproductive health calls for worry and thus require some lessons on human rights in order to avoid future sexual abuses and exploitations. Correa and Petchesky [19] for instance, have underscored the significance of SRH rights education for young people by indicating that knowledge of SRH rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing,

health, security, education and political participation.

The adolescents were further asked questions on their perception on sexual and reproductive health rights violations. Specifically, they were asked about their perception on which acts constituted sexual and reproductive health rights infringements. From the results (Table 2), it was found that the respondents were almost unanimous in pointing out denial of SRH services, forced marriages, forced sex, abusive sexual language, non-consensual touching, punishment for discussing sexual issues, suppression of sexual expression, as well as discrimination based on one's sexual orientation.

But, it was discovered that more males as compared to females (Table 2) were more enlightened on issues that constituted sexual and reproductive health rights infractions. For instance, with the exception of forced marriages and forced sex, male adolescents were among the majority who cited the remaining sexual violations. But among all the sexual right violations mentioned, discrimination based on one's STI status was not so much considered as an infringement on one's sexual rights. The fact that males outnumbered their female counterparts in terms of their knowledge level about SRH rights infringements could be attributed to the low level of female education (Table 1) and other socio-cultural stereotypes which often limit women's knowledge on SRH matters [17,20].

With respect to the respondents' level of knowledge about what constituted SRH rights and their educational background (Table 3), it was discovered that respondents who had tertiary level of education identified more acts as constituting infringements on SRH rights as compared to those whose education were below tertiary level. That is to say, the respondents' perception of an act as reproductive rights violations increases directly with the educational continuum.

For instance, while 84.2% of adolescents at the tertiary level saw suppression of sexual expression as an act that constituted sexual rights infringement, none of the respondents with no formal education considered it as such. The above revelations as presented in Table 3 are said to be in congruent with what Heise and Elias [20] had observed among their study samples in a national survey in Australia where adolescents' knowledge of SRH rights was positively correlated with their educational level particularly behaviours that constituted abuses.

As part of efforts to ascertain the various capacities in which adolescents have asserted or could assert their rights in various aspects of sexual and reproductive health, they were asked various questions ranging from their likely reaction when denied the opportunity to buy a condom due to age to reaction when a sexual partner imposes a SRH decision on an adolescent. The essence of this objective was to test the resilience and self-confidence level of the adolescents.

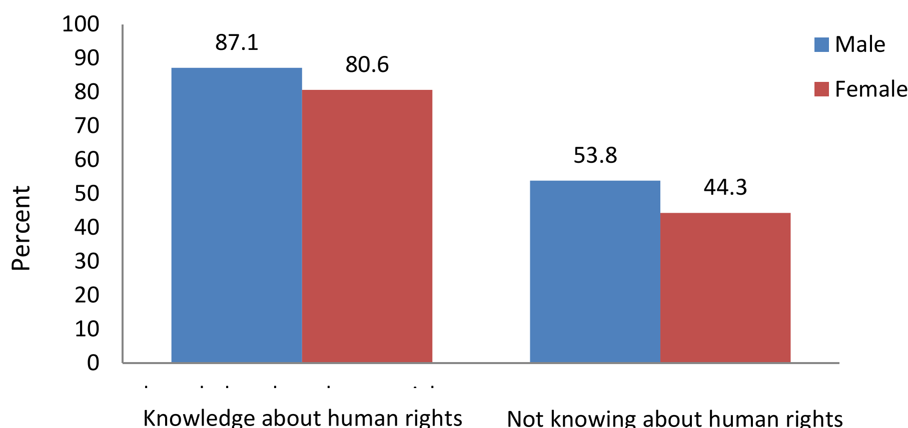

Fig. 2. Awareness of human rights
Source: Fieldwork; 2011

Table 1. Profile of the respondents

	Males						Females					
	All	**15yrs**	**16yrs**	**17yrs**	**18yrs**	**19yrs**	**All**	**15yrs**	**16yrs**	**17yrs**	**18yrs**	**19yrs**
N	101	19	12	22	19	29	**108**	15	21	17	16	39
%	48.3	9.1	5.7	10.5	9.1	13.9	**51.7**	7.2	10.0	8.1	7.7	18.7
Religion												
Christianity	74.3	78.9	58.3	59.1	78.9	86.2	**85.2**	53.3	90.5	94.1	100.0	84.6
Islam	18.8	15.8	41.7	18.2	15.8	13.8	**12.0**	46.7	4.8	0.0	0.0	12.8
ATR*	6.9	5.3	8.3	13.6	5.3	3.4	**2.8**	0.0	4.8	5.9	0.0	2.6
Ethnicity												
Fante	69.3	68.4	66.7	45.5	78.9	82.2	**69.4**	66.7	71.4	88.2	75.0	59.0
Dagomba	3.0	10.5	0.0	0.0	0	3.4	**3.7**	20.0	0.0	0.0	0.0	2.6
Ashanti	10.9	0.0	25.0	22.7	5.3	6.9	**6.5**	0.0	14.3	11.8	6.3	2.6
Ewe	6.9	0.0	0.0	22.7	0.0	6.9	**2.8**	0.0	0.0	0.0	0.0	7.7
Ga-Adangme	1.0	0.0	0.0	0.0	5.3	0.0	**4.6**	13.3	4.8	0.0	6.3	2.6
Others	9.9	21.1	16.7	9.1	10.5	0.0	**12.0**	6.7	9.5	0.0	6.3	23.1
Marital status												
Never married	98.0	100.0	100.0	100.0	89.5	100.0	**90.7**	100.0	95.2	100.0	100.0	76.9
Married	0.0	0.0	0.0	0.0	0.0	0.0	**8.3**	0.0	4.8	0.0	0.0	20.5
Separated	2.0	0.0	0.0	0.0	10.5	0.0	**0.9**	0.0	0.0	0.0	0.0	2.6
Living arrangement												
Both parents	48.5	47.4	41.7	40.9	47.4	58.6	**30.6**	46.7	28.6	23.5	43.8	23.1
Mother only	14.9	10.5	8.3	27.3	15.8	10.3	**41.7**	26.7	47.6	47.1	37.5	43.6
Father only	12.9	26.3	33.3	9.1	5.3	3.4	**8.3**	13.3	9.5	17.6	6.3	2.6
Partner	0.0	0.0	0.0	0.0	0.0	0.0	**6.5**	0.0	4.8	0.0	0.0	15.4
Self	8.9	0.0	0.0	0.0	21.1	17.2	**1.9**	0.0	0.0	0.0	0.0	5.1
Other relation	14.9	15.8	16.7	22.7	10.5	10.3	**11.1**	13.3	9.5	11.8	12.5	10.3
Education												
No formal	3.0	5.3	0.0	0.0	10.5	0.0	**0.9**	0.0	0.0	5.9	0.0	0.0
Primary	7.9	21.1	16.7	9.1	0.0	0.0	**7.4**	26.7	9.5	11.8	0.0	0.0
JHS	30.7	31.6	58.3	31.8	36.8	13.8	**47.2**	66.7	71.4	58.8	37.5	25.6
SHS	46.5	42.1	25.0	40.9	52.6	58.6	**34.3**	13.3	14.3	29.4	43.8	51.3
Tertiary	12.6	0.0	0.0	18.2	5.3	27.6	**6.5**	0.0	4.8	0.0	0.0	15.4

*Source: Fieldwork, 2011; * = African Traditional Religion*

Table 2. Knowledge of sexual and reproductive rights abuses by sex

Knowledge of sexual rights violation	Males (N=101) (%)	Females (N=108) (%)
Denial of SRH Services	66.7	65.3
Forced Marriage	94.1	86.1
Forced sex	85.1	86.1
Abusive sexual Language	65.7	52.5
Non-consensual Touch	76.9	54.5
Punishment for discussing sex	58.3	56.4
Suppression of expression	62.0	60.4
Discrimination due to sexual orientation	53.7	51.5
STI-based Discrimination	52.5	40.7

Source: Fieldwork; 2011

Table 3. Knowledge of sexual and reproductive rights abuses by educational level

	No formal (%)	Primary (%)	JHS (%)	SHS (%)	Tertiary (%)
Denial of SRH Services	50	38.1	57.3	83.1	73.7
Forced Marriage	75.0	85.7	89.0	91.6	94.7
Forced sex	50.0	85.7	82.9	86.7	100.0
Abusive sexual Language	50.0	57.1	59.8	63.9	47.4
Non-consensual Touch	0.0	57.1	68.3	66.3	73.7
Punishment for discussing sex	0.0	33.3	51.2	66.3	73.7
Suppression of expression	25.0	38.1	52.4	72.3	84.2
Discrimination on sex orientation	25.0	57.1	42.7	61.4	57.9
STI-based Discrimination	0.0	57.1	42.7	50.6	31.6

Source: Fieldwork; 2011

With this background, the respondents were questioned as to how they would assert their right to this service despite their age and low status in the society. Results from Fig. 3 showed that a little over half of the respondents (51%) said if an attendant refuses to sell condom to them for reasons of they being too young or spoilt, they would stop the purchase and that they would not try any other place at any other time to buy it. The above findings buttressed what Warenius [6] and Awusabo-Asare et al. [8] had observed that provider attitudes about adolescents having sex can pose a significant barrier to reproductive service utilization. The results (Fig. 3) further showed that a quarter (25%) of the respondents said they would go elsewhere to get it whereas one-fifth (10%) said they would insist that they be served. It was only a few (3%) of the adolescents who were courageous enough to say that they would report such misconduct to the regulatory body under whose auspices such a pharmacy shop operates. Results from a Chi-Square test statistic also revealed association between the age of an adolescent and his or her tendency to stop the contraceptive purchase (X^2=16.974: df=4, p=0.002) as well as the tendency to insist on been served (X^2=16.932: df=4, p=0.002).

The current findings observed above have some serious policy implications for the state and other stakeholders whose responsibility it is to address the spread of STIs and unwanted pregnancies among Ghanaian adolescents. This is because if health care providers are not well informed about the dangers associated with denying young people reproductive services, it would compound the already swelling incidences of STIs, unintended pregnancies and unsafe abortions in the country [9].

As observed by Mbiti [21], unequal power balances in gender relations that favour men usually translate into an unequal power balance in heterosexual interactions. To Heise and Elias [20], male pleasure supersedes female pleasure, and men have greater control than women over “when, how, and with whom sex takes place”. To unravel some of these claims, the respondents were questioned in a hypothetical scenario, of their reaction if it happened that there were differences in opinion on some issues concerning reproductive self-determination (Table 4). That is, whether they would at all times defend and assert their rights on when to have sex, when to give birth, the number of children to give birth to and adoption of family planning, or would rather comply with their partner’s stance. This in a way sought to ascertain their readiness to succumb in terms of power relations in marital or consensual unions.

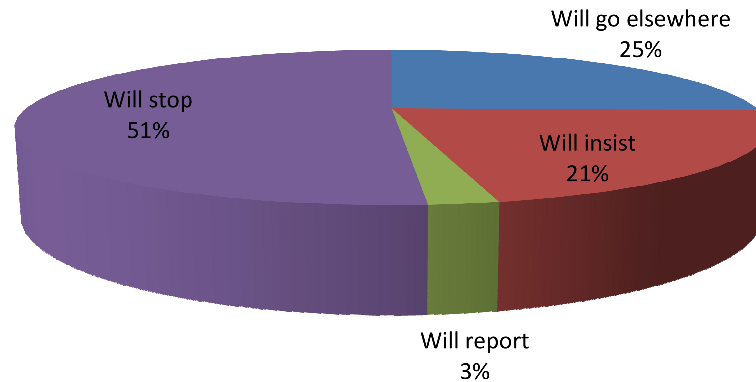

Fig. 3. Reaction upon denial of condom purchase
Source: Fieldwork; 2011

Table 4. Readiness to succumb to SRH decisions by socio-demographic characteristics

	Non- consensual Sex (%)	Number of children (%)	Adoption of family Planning (%)	Pregnancy (%)
All	41.6	35.4	54.1	34.4
		Sex		
Male	38.6	25.7	51.5	30.7
Female	44.4	44.4	56.5	38.0
		Age		
15	50.0	50.0	52.9	47.1
16	42.4	51.5	51.5	30.3
17	28.2	12.8	51.3	30.8
18	40	34.3	51.4	37.1
19	45.6	33.8	58.8	30.9
		Religion		
Christians	40.7	35.9	52.7	34.7
Moslems	46.9	40.6	65.5	37.5
ATR	50.0	10.0	50.0	30.0
		Education		
No formal	50.0	50.0	75.0	75.0
Primary	47.6	76.2	57.1	71.4
JHS	36.6	36.6	57.3	28.0
SHS	42.2	25.3	49.4	33.7
Tertiary	42.1	21.1	63.2	26.3

Source: Fieldwork; 2011

From the results (Table 4), it was noticed that only in adoption of family planning that more than half (54.1%) of the respondents answered in the affirmative that they would succumb to what their partners preferred. It came out that less than half of the respondents said they would yield to imposition of sexual decisions on them. A similar observation could be made within all the socio-demographics, except in few cases. That is, while about half (50%) of the proportion of African traditional religion were willing to comply with their partner on when to have sex, more than 70% of the respondents with no formal education, as well as those at primary school level were willing to give in to the decision of their partners on when to become pregnant.

Again, the results (Table 4) portray that apart from the decision as to when to have sex; more Moslems were willing to obey any imposition of

sexual and reproductive health decisions from their partners compared to the other religions. The present evidence discussed above support what Mbiti [21] has observed that religion remains a very significant feature in determining SRH decisions and that culture informs the values, norms, mores, beliefs and practices of a given people. Furthermore, it could be realized that a greater proportion of female respondents, compared to males, said they would give in on any key reproductive health decision imposed on them by their sexual partners. For example, whereas 44.4% of females said that in a marital union, they would comply with the number of children their partner would want to have, only 25.7% of males said so.

Results from a chi square test statistic revealed a significant relationship between the respondents' sex and their willingness to cooperate with a partner's sole decision on the number of children to bear in a marital union (X^2=7.982: df=1, p=0.005) as well as age and one's preparedness to agree to a partner's decision on the number of children to produce (X^2=15.703: df=4, p=0.003). There was also a significant relationship between respondents' educational level and their readiness to support the sole decision of a partner on when to become pregnant (X^2=15.508: df=4, p=0.004), and the number of children to bear (X^2=20.804: df=4, p=0.000). These results as shown above further go to validate what Wouhabe [18] had observed among his study samples where individual level factors such as age and sex as well as factors within adolescents' volitional control such as religious affiliation, educational attainment, and marital status wielded a high degree of influence on adolescents' level of knowledge and perception about sexual and reproductive health rights issues in Ethiopia.

4. CONCLUSION

Although most of the respondents have heard and known of sexual and reproductive health rights, it was discovered that less than half of female adolescents were aware that lack of knowledge of SRH rights could lead them to poor sexual and reproductive health outcomes. The respondents demonstrated their knowledge of acts that constituted infringement on one's sexual and reproductive health rights. They overwhelmingly cited instances such as forced marriages and forced sex as serious sexual rights violations which might have been due to the numerous sexual and reproductive health programmes roll out in the country through the various media platforms.

Furthermore, age and education demonstrated a significant relationship with adolescents' knowledge of sexual and reproductive health rights as opposed to sex and religion. The study also showed that a higher percentage of females compared to males conceded that they would comply with any reproductive health decisions imposed on them by their partners. Respondents' age, sex and education in particular, were significantly associated with their readiness to act in accordance with their partners' reproductive health decisions (Table 4).

5. POLICY RECOMMENDATIONS AND FUTURE RESEARCH

Based on the findings and conclusions drawn from the study, the following recommendations are made for improving adolescents' knowledge on sexual and reproductive health rights in Ghana. To begin with, government together with other relevant organizations (such as UNICEF, PPAG and Plan Ghana) should intensify education regarding how ignorance of one's sexual and reproductive health rights leads to vulnerabilities and sexual exploitations. Moreover, behaviour change communication strategies by government should be geared towards correcting perceived gender stereotypes which normally transcend into unfair sexual relations.

Also, government should eliminate all legal, institutional and cultural barriers such as requirements for parental consent, or age limits for providing contraception which mostly limit adolescents' access to sexual and reproductive health services. Meanwhile, government must remain duty-bound to ensure that agencies where a redress is sought for infringements on one's sexual rights (such as the Police Service and Domestic Violence and Victims Support Unit) are not only made available, but well resourced to discharge their mandate creditably.

Through the Public Private Partnership framework of state, government should actively collaborate with institutions that promote the reproductive well-being of Ghanaian adolescents, especially NGOs and Faith-based Organizations to establish stand-alone outlets solely for adolescents' sexual and reproductive health concerns in rural and peri-urban

communities such as Yamoransa. Finally, much academic inquiry should be carried out on the effects of adolescents' knowledge of sexual and reproductive health rights on fertility decisions, domestic violence in marital unions and contraceptive negotiations.

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COMPETING INTERESTS

Authors have declared that there are no competing interests in this study.

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