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

Abstract

Introduction: Sexual and Reproductive Health is very critical in all aspects of all *Homo sapiens* including their physical, mental, social, economic and emotional well-being. Of much concern is that of the adolescents who are globally said to be the most vulnerable group to 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 respondent had 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 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. School was found to be the most source of SRH information for the respondents and place they will prefer to learn on 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.

Recommendation: The study recommends effective health promotion and advocacy programmes in addressing some of the adolescents SRH misconceptions and knowledge gab by government and other stakeholders. It is also recommended that SRH programmes must also reach and engaged adolescents in their comfort zones rather than stationing it in one particular geographical location.

Conclusion: Even though possession of SRH knowledge does not always translate to one's direct application of that SRH knowledge in daily SRH decisions, however it is imperative to mention that for a successful implementation of adolescents' sexual and reproductive health policies to yield fruition, it is fundamental for various efforts to be first put in place to improve their knowledge on SRH before others are considered.

Key words: *homo sapiens,* well-being, globally, socio-economic, vulnerable, sexual and reproductive health knowledge.

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 (WHO and UNICEF, 2019).

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 (Aaro et al., 2014). 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" (Aaro et al., 2014). 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 (WHO, 2013). 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 12 to 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 (Statista, 2015). Of the estimated 22 million unsafe abortions that occur every year, 15% occur among young women aged 15 to19 years. An estimated one million young people aged 15 to 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, death and illness can be avoided. Gender-based violence is also too common a reality for many adolescents, especially girls (WHO, 2013). 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 (UNICEF, 2011).

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. 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 15-19 year 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 15-19 remains high. Central region consistently ranked as the second region with highest prevalence rate in teenage pregnancy in Ghana for example, recorded more than 13,000 teenage pregnancies in 2016 (GHS, 2016). 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 accounts for

2,865 in pregnancies recorded in 2020 whilst another 107,023 girls between the ages of 15 to 19 were impregnated within same year. 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 pregnancy in Ghana. KEEA municipality for which Komenda is one of the circuits is one of the hot spot areas in the region where most adolescent faces these challenges (District Health Information management report, 2020).

All these phenomena show that there is a gap that needs to be filled upon all governmental and Non-Governmental Organisations' (NGOs) efforts to significantly reduce such unhealthy sexual and reproductive incidents in the region and the country at large.

It is against this background that this study seeks 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 adolescents possess on sexual and reproductive health in Komenda community in the Central Region.

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

(iii) Proposing methods of enhancing the knowledge in sexual and reproductive health of the youth of Komenda community in the Central Region of Ghana

LITERATURE REVIEW

Scope and Concept of Adolescent Sexual and Reproductive Health (SRH)

The Bureau of Sexual and Reproductive Health in the Middle East and North Africa, 2008 defined SRH as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual health, although an indispensable component of reproductive health, goes beyond reproductive health. It encompasses problems of STIs including HIV/AIDS, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. A report presented by Sex Information and Education Council of Canada SIECCAN (2004), explains that: A broad conceptualisation of adolescent sexual and reproductive health implies attention to a wide range of issues including sexual attitudes, sexual behaviors, and the personal and social factors that influence them. Reproductive health is also said to be concerned with certain human rights (United Nations, 1995).

Knowledge on Sexual and Reproductive Health

Knowledge on sexual intercourse, contraceptive use and abortion

Eliason et al. (2014) found that a little over 90% of women of reproductive age knew at least one method of modern contraceptives. Most people knew injectable as one of the modern method of family planning but diaphragm was seen as the least known method whereas male sterilisation was the least known amongst birth controls. Sexual activity is found to be high among Ghanaian adolescents and youth. Exposure to sexual activities begins at early ages and this trend has increased in proportion on over the past decades. According to the 2014 Ghana Demographic and Health Survey (GDHS), the proportion of adolescent girls 15-19 years having first sexual activity by 15 has increased by 61.6% in 15 year-period; from 7.3 percent in 1998 to 11.8 per cent in 2014. Among youth aged 15-24, a substantially higher proportion of men (53 percent) than women (35 percent) have never had intercourse (GDHS, 2014). Percentage of adolescent girls (15-19) never having sex has decreased from 62.2 per cent in 1998 to 57.3 per cent in 2014; percentage of adolescent boys (15-19) never having sex has moved from 80.7 percent in

1998 to 73.4 percent in 2014. Knowledge of contraceptives among young females and adolescents has however, been relatively high. Among married 15-19 year olds, knowledge of any form of contraceptive has improved from 85.6 percent in 1993 to 96.5 percent in 2014 (GDHS, 2014).
Another study showed that (82.8%) of students knew about at least one contraceptive method that is used to prevent unwanted pregnancy. The main known case of contraceptive methods by the students for the prevention of pregnancy was condom (47.7%) followed by abstinence (37.1%) (Ayalew et al., 2014). Abortion in Ghana is under reported due to the social stigma attached to it and the restriction imposed on it by the law, estimate shows that proportions of adolescents 15-19 years having abortion has decreased slightly from 21.4 per cent in 2012 to 19.8 per cent in 2015 (GHS, 2016).

Knowledge on HIV/AIDS and STIs

Sexually transmitted diseases continue to be the major and growing public health problem in many parts of the world especially in developing countries. STIs are among the top five disease categories and about one third of STIs globally occur among people younger than 25 years of age. In United States, nearly half of the 20 million new cases of curable STDs each year are accounted among adolescents aged between 15 to 24 years (CDC, 2017). Four in ten sexually active teen girls have had an STD that cause infertility and even death (Forhan et al., 2009). STIs, such as gonorrhea, syphilis, herpes, genital warts and chlamydia are important health concerns in Ghana. According to National AIDS Control Programme (NACP) 2014 annual report, Syphilis prevalence among 15-19 was 1.1 per cent and 0.9 per cent for 20-24 (NACP, 2014). Furthermore, eight percent of females and nine percent of males reported contracting a sexually transmitted infection in the 12 months prior to the GDHS survey in 2014 (GDHS 2014). Research conducted on adolescents in secondary school in Nigerian found out that majority of the adolescents had good knowledge on STIs, their mode of transmission and prevention yet only few were practising safe sex (Hassan et al., 2015). A national research conducted on adolescents in Ghana revealed that over 90% of the respondents knew that HIV can be transmitted through sexual intercourse with an infected person. 80% were aware of mother-to-child delivery however, most respondents had a misconception that the disease can be spread by sharing of food with an infected person or via mosquito bite.10% also believed that a man infected with the virus can be cured if he had sex with a virgin (Awusabo-Asare et al., 2006). Study by Sathe et al., 2016 on assessment of knowledge of reproductive health of adolescent school girls from 13-16 years with special reference to HIV-AIDS found that 55.7% of study respondents recocognised HIV to be transmitted through needles followed by infected blood (51.1%) and sexual contact (49.4%).Generally research conducted on adolescent knowledge on STIs and HIV/AIDS proves that adolescents are well informed or more knowledgeable on HIV/AIDS than STIs (Eaton et al., 2010 and Hassan et al., 2015).

Mechanisms or Sources from Which Adolescents Seek Information on Sexual and Reproductive Health

Research conducted to assess the health services on SRH in two regions in Tanzania came out with clear findings that negative health worker attitudes, coupled with infrastructure constraints and weaknesses, remain significant barriers to young people's access of sexual and reproductive health services across Mwanza and Iringa" health facilities (Mchome et al., 2015). Another research conducted in south Ethiopia on student adolescents shows that 87% of the respondent reported that it was important to discuss SRH issues with parents, however only 32% of the respondents were doing so with their parent due to lack of SRH knowledge by the parent themselves (Kinfe et al., 2018). In Ghana, the most source of SRH information for adolescent is Frequency Modulation (FM) followed by Television, internet and friends (Awusabo-Asare et al., 2006). Although most of the researches conducted on adolescents indicate the mass media being popular source of SRH information for adolescents however adolescent decisions or acts on SRH issues are mostly influenced by their peers (Ivano et al., 2018).

MATERIAL AND METHOD

The study used the following materials: the encyclopedia, quetext, and grammarly. The encyclopedia was used to check the meanings of new vocabulary items which were strange to the researchers. The quetext was used to identify plagiarized contents whilst the grammarly was useful in checking spelling mistakes and grammatical errors.
The study employed the mixed method with a case study design. A case study is a research approach that is used to generate an in-depth, multi-faceted understanding of a complex issue in its real-life context. It is used to explain, describe *or* explore events or phenomena in the everyday contexts in which they occur (Crowe et al., 2011 and Yin, 2009). Specifically, the study employed the observational case study where data were collected by respondent observation which was then enhanced by a focus group discussion.
The study population for this research constitutes adolescents in Komenda community in the Central Region of Ghana. The study took into consideration both inclusion and exclusion criteria in the selection of the study population.

The sample size used for this study was drawn from a pool of adolescents in the Komenda community. As a part a qualitative study, the sample size was determined using the principle of saturations. Guest et al. (2006) 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 does not add up to what had been collected (Mason, 2010). A total of 95 respondents were therefore deployed for the study. This sample size to the greater extent was large enough to mimic the true characteristics of the population being studied.

The study used both simple random sampling and purposeful sampling techniques to equitably select adolescents with varied age range, academic and socioeconomic background from all seventeen electoral areas in the Komenda community to make a total number of ninety-five (95) adolescents. The simple random sampling was used to handle the quantitative aspect of the research whilst the purposeful sampling technique was also used to deal with the qualitative aspect. This collectively enabled the recruitment of respondents who provided in-depth and detailed information about the study under investigation taking research objectives into consideration.
Therefore, taking into account of the very space of this study, questionnaire and focus group discussion guide (in-depth interview guide) were used as instrument to assess knowledge and the experiences of adolescents on sexual and reproduction health.

Data were collected using an in-depth interview guide for focused group discussion, questionnaires, field notes and tape recorder. 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 was also held in different electoral areas in Komenda community with the help of focus group guide. In all 35 adolescents comprising of 20 females and 15 males were deployed for 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-thirty minutes. Discussions were held in both "Fante" (local language of the people) and English. A semi-circular sitting arrangement was planned to ensure there was a good communication between the study respondents and the researchers.

Very conscious of the ethical issues and guidelines for research on reproductive health involving minors (WHO, 2003), permission was sought from University of Education, Winneba where the researchers are affiliated to, leaders of Komenda community where the research was conducted and the KEEA municipal assembly. Consent from respondents, their guardian, teachers or parents were also considered as well as adherence to confidentiality and anonymity of study respondents within and after the said study period. In summary all ethical issues were strictly adhered to.

Data collected from the questionnaires were analysed using SPSS software; version 19 and Microsoft excel 2019. 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 conceptualisation and categorisation of key themes emanating from the data.

FINDINGS AND DISCUSSIONS

Presentation of Findings

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.**

Table 1: Demographic characteristics of both questionnaires and focus group

Category	Frequency	Percent
Age		
10.-15	23	24.21
16-19	72	75.79
	95	**100.00**
Gender		
Male	43	45.26
Female	52	54.74
	95	**100.00**
Religion		
Christianity	70	73.68
Islamic	25	26.32
	95	**100.0**
Education level		
Tertiary	3	3.16
Senior High School	36	37.89
Junior High School	40	42.11
Primary	16	16.84
	95	**100.00**
Marital status		
Co-habiting	7	7.37
Not married	25	26.32
In a relationship	50	52.63
Single	13	13.68
	95	**100.00**
What they do		
Student	65	68.42
Trading	14	14.74

Others	16	16.84
	95	**100.00**
Who they stay with		
Parents	60	63.16
Guardian	26	27.37
Others	9	9.47
	95	**100.00**
Number of child or children		
Yes	17	17.89
No	78	82.11
	95	**100.00**

Source: Field Survey, 2021.

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 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.

Table 2: Respondents recognition of Sexual and Reproductive health (SRH)

Responses	**Frequency**	**Percent**
Yes	52	86.7
No	8	13.3

Source: Field Survey, 2021.

Table 3: Responses of respondents to what SRH covers

	NumberofRespondents=52	
SRHAreas	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.

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 have 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 it nature as defined by authorities such as WHO and ICPD.

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 effect", "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 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 Figure 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 4: Responses on Knowledge on contraceptives and pregnancy

Item	Frequency	Percentage (%)
Do you know contraceptives 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 effect?		
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 death, 9 of the respondents stated injectable (family planning) as causing bareness, 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 involve 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 use for may be a problem"

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

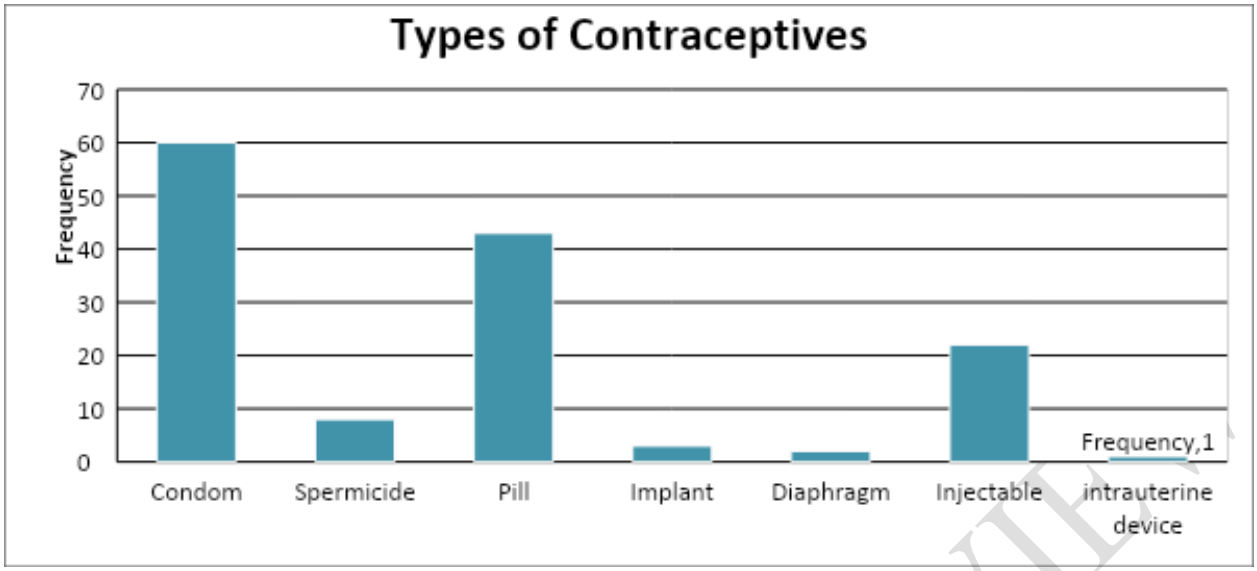

Figure 1: A graph showing participants' responses to the types of contraceptives they have heard before.
Source: Field Survey, 2021.

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 60 of the respondents who responded to the questionnaire claimed to know what STDs were. Those who responded "YES" as usual knowledge on STDs were being probed further to know whether they knew its mode of transmission of STDs. 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 can 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 it could not be cured.

Table 5: Respondents knowledge on STDs including HIV

Item	Frequency	Percentage
Do you know what STDs?		
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.

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 after. She even advises 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."

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."

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 offers SRH services.
As to whom they would prefer to share SRH issue with, 34 of the respondents considered their parents or siblings as one of the entities they would want to discuss SRH issue 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 issue with their Teachers and religious leaders. Again, 43 of the respondent 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.

Table 6: A Table depicting the method/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 any organisation that offer 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**

Source: Field Survey, 2021.

The study revealled during focus group discussions that most of the adolescents' respondents preferred to discuss SRH issue 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."

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 help. In support of this claim, one of the female respondents alluded that:
"For me I am shy of my parent so I will tell my friends."

However, as discussions went on, emphasis was laid on the fact that it depends 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 woke 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 will remove core mathematics and replace it with it. So that it will become one of the core subject, because you are always told to find X but I don't see it's relevant 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 subject but the parents refuse, 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 school 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 issue in group as this will enable them to learn and share experiences with each other. This will 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 was made by two male respondents 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 will be able to reach 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."

DISCUSSION OF THE RESULTS

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 third of those who claimed to know what SRH entails 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 yet only a 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. (2019) 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.

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. (2014) 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 2014 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. (2014) 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, (2014) and Ivanova et al. (2019) 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.

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 Nigerian which found out that majority of the adolescents had good knowledge on STIs and their mode of transmission. The study is also in conformity to the findings of GDHS, (2014) 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. 2010 and Hassan et al. 2015, 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 is upheld and the fact that all study respondents were affiliated to one religious group or the other, it is also not surprise that some of the adolescents hold such misconception

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., 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 Awusab-Asare et al., own 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 (Kinfe et al., 2018). Mchome et al., 2015 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

In general, one cannot from the results of the study comprehensively conclude that the knowledge of the respondents is adequate taking into considerations even their very limited knowledge on the scope of SRH and the very misconceptions that significant number of them possesses. Perhaps “poor or fairly” will qualify them much better in that general sense.

However, it is worth noting that this study revealed that most respondent had 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 HIV and their mode of transmission even though a significant number of the respondents were also found to hold misconception that STDs can be transmitted through witchcraft and other means. School was found to be the most source of SRH information for the respondents and where 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 respondents generally would prefer to share SRH issues with.

Notwithstanding, the researchers recommends with regards to the study results effective health promotion and advocacy programmes in addressing some of these adolescents SRH misconceptions and knowledge gab by government and other stakeholders. SRH programmes must also reach adolescents in their comfort zones rather than stationing it in one particular geographical location. Finally, future research must look at the contributing factors that could possibly affect adolescents' knowledge on SRH in terms of socio-demographic characteristics.

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