

Knowledge about Sexual and Reproductive Health Services and Practice of What Is Known among Ghanaian Youth, a Mixed Method Approach

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Abstract

Most young person will become sexually active before their 20th birthday having to battle with early and unplanned pregnancies, unsafe abortions, maternal deaths and injuries. This study examined young person's sexual knowledge, attitudes and practices and their levels of utilization of sexual reproductive health. Our study progresses beyond current research of reporting only sexual behaviour among youth to have insight into sexual and reproductive health update drivers yielding new empirically robust results for the Ghanaian case for sexual and reproductive health service uptake. The descriptively cross sectional design was employed in sampling 170 youth (150 surveyed and 20 Interviewed) using the stratified sampling technique together with a purposive selection of one key informant. Test of significance and associations were performed with the Chi-square test. In all 45.2% (77/170) of youth (10 - 24) had had sexual experience in life time. In respect of in-school youth, 42% (63/150) had had sexual experience while 70% (14/20) out-of-school youth had had sexual intercourse in life time. A total of 28.8% (49/170) of all the youth had sexual intercourse in the last six months with only 40.1 (20/49) using condom for protection. Parental discussion of contraceptive methods (29.3%) and sexual and romantic relationship (28.0%) was the least sexual and reproductive health area discussed among in-school youth. Youth knowledge of the available sexual reproductive health service was statistically associated with reproductive health service utilization ($X^2 = 0.00$, $P \leq 0.05$). A concerted effort is required from govern-

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ment, NGO, Civil society organizations and religious bodies to help translate youth knowledge about sexual health into responsible sexual life and protective sex.

Keywords

Youth Knowledge, Sexual Attitude and Practices, Sexual Reproductive Health Services, Utilization, Ghana

1. Introduction

Young people can be defined as those aged 10 - 24 years, and this group combines adolescents-aged 10 - 19 years- and youth-aged 15 - 24 years [1]. The Ghana Health Service [2] report reveals that the prevalence rate of HIV/AIDs in Ghana between the age group of 15 to 24 years accounted for 3.4% as in 2002. Through national interventions aided by operations research, this has reduced considerably. With a reported HIV prevalence in general population in Ghana standing at 1.37% in 2012, the Ghana AIDS Commission and others together with the Ghana Health Service submits that prevalence for the age group 15 - 19 years in 2013 stood at 0.7% and that among young people 15 - 24 years, which is used a proxy for new infections, it represented 1.3% while young person's 15 - 24 years of age contributed 28% (2044 of 7323), (2236 of 7991) for 2012 and 2013 respectively of new infections showing no reduction in new infections [2]-[5].

The UNICEF reports that concern about Youth Reproductive Health has grown following reports that sexual related activities, early pregnancies and sexually transmitted diseases rates are continuously increasing among young people in developing countries [6]. In Ghana, many people hold the view that the youth are healthy since they show low levels of illness compared to younger children and adults. However, the Ghana Demographic Health Survey report of 2008 [7] and other studies by Odoi-Agyarko, Awusabo-Asare and colleagues supported by the Ministry of Health [8]-[10] reveal a higher magnitude of sexual and reproductive health problems of the youths, the most crucial being unprotected sex and risky sexual behaviour. According to Homans, the habits and lifestyles that are established during this period have a profound effect on future health and development [11].

Many of the young people across the world have had to navigate their way through sexual maturity without the benefit of any information or services which are known to promote healthy sexual and reproductive life. Adolescence stage of the youth has been noted to represent the period with the highest frequency of negative consequences. These consequences are associated with sexual activities like sexually transmitted diseases and unwanted pregnancies [12]. This implies that the availability of reproductive health service delivery matters a lot with regards youths' growth and development. Youth access to sexual reproductive health is partly determined by the availability of the health services and their procedures for utilization. The sexual behaviour of youth has a relationship with sexual reproductive health service utilization. Stone and Ingham observed that many young people think about, and take steps to obtain adequate protection only after having sexual intercourse [13].

In the study of Hock-long and others [14], three-quarters of female participants in the United Kingdom aged 21 or younger, who had not sought reproductive health care before first sex, did so within six months of sexual initiation. Further observation was made to the effect that adolescents who face greater sexual health risks have greater access challenges to services than their less exposed peers. They noted, for instance, that youths in the United States were at greater risk of pregnancy and STDs than their British and other western Europeans peers. However, the US youths were more likely to encounter access challenges than those in United Kingdom and other western European countries. Cohen indicates that adolescents also seek health care services less frequently than any other age group and are less likely to have health insurance than any other age group [15]. The challenge of accessing reproductive health services are greater for adolescents living in developing countries where adolescent health care services are few or lacking, and there are no mandatory health insurance systems [16].

It has also been observed by Frost and Driscoll [17] that in sub-Saharan African, although adolescents face greater sexual health risks, they also face greater challenges in access to reproductive health services, including

preventive care. They further submit that in Kenya, like in other developing countries, existing societal, cultural and external prohibitions affect provision of adolescent reproductive health services. The youth are often exposed to various forms of sexual and reproductive health risks.

In a study by the Pathfinder [18] in Ghana, while 56% of youth used condoms to prevent HIV/AIDS transmission; according to 44% it was to prevent pregnancy with 33% having no idea about condom use. The study further reports that, 59% of youth clients have had sex. The risk ranges from sexual coercion, female genital cutting, unplanned pregnancies, early marriage or sexual debut, closely spaced pregnancies, abortion, sexually transmitted infections (STIs), to HIV/AIDS [19] [20]. In Rada study in Romania, sexual abstinence before marriage had been a common traditional custom, notably among rural dwellers, however there has been a persistent decline on abstinence resulting from weakening traditional norms, increase in levels of educational, modernization, and population migration [21]. Early sexual initiation of sexual activity has a potential of ending young persons into possible cervical cancer, breast cancer, early aging, infertility and infection with human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). Bogale and Seme in a cross-sectional study among 826 in school youths to assess premarital sexual practices and its predictors in North West Ethiopia report that early sexual debut increases youth risk for infection with HIV and other STIs [22].

In using multiple logistic regression analyses, Bogale & Seme [23] report in their cross sectional study in North West Ethiopia that youth who have early sexual activity were more likely to be exposed to high-risk sex laying credence to earlier works by Mitikie and colleagues [23] and Asrat [24] where premarital sexual practices ranged from 11.8% to 23.2% among in-school youths. In the same study 157 (19%) of the participants reported having had premarital sexual intercourse, of which 91 (22.7%) were males and 66 (15.5%) were females. The mean (SD) age at first sexual intercourse was 16.48 (1.59) for males and 15.89 (1.68) for females. On the part of young girls, a proof of obedience could only be known when they have been able to postpone first sexual intercourse accounting for their low involvement in early sex. The quantitative cross-sectional analysis of Rada [21] found out that 7.2% of youth who engaged in first intercourse were below the age of 15. Younger persons less than 14 years have difficulty of obtaining information about SRH. Averagely first sexual experience was lower for men (18.08 years compared with that for women (18.97 years). Similar findings have been established from Oanes-Faludi and the Health Informatics & Integrated Surveillance Systems Division of Disease Prevention study [25] [26]. The reasons could be as a result of the encouragement received by men from society to demonstrate their manhood. The study further demonstrated that averagely, the youth first received information on SRH at 15.39 years of age. Only 120 (10%) of the youth surveyed listed the school, doctors or medics as a source of SRH with 315 (25.9%) of the youth sourcing sexual education from classes in school. The proportion of youth who ever discussed “a lot” with their parents about sexual abstinence before marriage, sexual problems, sexually transmitted diseases, menstruation/first spontaneous ejaculation, how pregnancy occurs were a marginal minority of 51 (4.2%).

The need for an exploration into reproductive health knowledge levels among Ghanaian youth, their sexual attitude and how it influences their reproductive health service utilization is timely. This paper has as its objective examining youth knowledge, sexual attitude and practice and reproductive health service utilization.

2. Methods

2.1. Research Setting

The study was conducted in the Kwadaso Sub-Metropolitan district of Ghana. The Kwadaso Sub-metro district is located in the western part of Kumasi, the Ashanti regional capital of Ghana and shares boundary with Atwima Nwabiagya (Nkawie) to the north, Bantama to the South Nhyiaeso to the east and the Atwima Kwawoma (Ofoase) to the west. The Sub Metro Council comprises fifteen communities which are sub-divided into nine (9) electoral areas. It has a population of 220,798 [2]. The Sub-Metro district is an urban setting with several educational establishments. One of the nation’s public Universities, that is, the University of Education Winneba-Kumasi campus is located in the Sub-Metro. The study area has 5 hospitals within its boundaries. It has a very youthful population with several artisanal and apprentice’s shops located in the area.

2.2. Study Design and Sampling

The study used both qualitative and quantitative methods. The study design was descriptive cross-sectional survey. The data was collected between January 2014 and May, 2014. The multi-stage sampling technique was

employed in the study. The simple random sampling facilitated the selection of one school from each level of educational ladder (Junior high school, Secondary and Tertiary) within the Kwadaso Sub Metro district and designated as the primary sampling unit. Using a three stage stratified technique, the in-school youth were stratified according to the levels of their education; Junior high school, Secondary and Tertiary as the Secondary sampling Unit (SSU). The in-school secondary sampling units (PSUs) was then selected with probability proportional to size. Fifty (50) students were selected from the three schools with the Forms (Form 1, Form 2 and Form 3) serving as stratum within which students were randomly sampled. The tertiary sampling unit involved conducting face-to-face interviews for out of school youth. Verbal and written informed consent was obtained from all participants. The final response rate was 100% for the interviewees and 94% for the questionnaires.

Interviews informed the collection of qualitative data. The study area was divided into two and 20 youth interviewed with 10 youth coming from Sofo-line area as the unaffiliated youth base known for its marketing and hawking and the Kwadaso-Fie as the affiliated youth with so many apprentices shops. All youth aged 10 - 24 were considered as constituting the population of the study. A total of one hundred and Seventy (170 youth (in-school, affiliated to an apprenticeship and non-affiliated street hawking youth) were sampled using stratified random techniques. The inclusion criteria involved youth who had stayed or schooled in the study area for at least six months and was aged 10 - 24 years. Two methods were adopted in collecting data. This was through the administration of questionnaires and interviews. The questionnaires were pre-tested at Elite College; a mixed sex Secondary School and modifications were made on the questionnaire.

2.3. Measurement

Variables were measured at nominal level with a “Yes” or “No” response. The Independent variable was “Knowledge of available reproductive health services” with the dependent variable being “Reproductive health services utilization”. Participants were asked to indicate whether they knew or were in the known of any available facility based youth friendly reproductive health services offered to them in the study area and whether they had accessed any reproductive health service from any reproductive health services facility in the area in their life time of schooling or staying in the district. Through the application of the triangulation approach, probing and negative case analysis, reliability and validity of data was ensured.

2.4. Data Analytical Techniques

Data collected through the surveys were analyzed using both descriptive and inferential statistics. Results were cross-tabulated to identify patterns. The chi-square test and Pearson moment correlations were performed to find out whether there was any association between young people’s knowledge of available youth friendly reproductive health service and service utilization. The Confidence Interval was taken as ± 1.96 at 95% confidence level. The qualitative data was analyzed by transcribing whiles applying the pattern matching method. The data was later categorized into appropriate themes on the basis of the study objectives. Content and thematic analysis formed the basis for the interpretation.

2.5. Ethical Clearance

The study complied with the ethical requirements necessary to protect human subjects in research. Permission was sought from the headmasters/mistresses of the schools which participated in the survey. Additionally, written and verbal consent was sought from the students and the out-of-school youth before they were administered with the survey tool. Ethical issues which relate to anonymity, privacy and confidentiality were also strictly adhered to.

3. Results

3.1. Socio-Demographic Characteristics of Youth

A total of 170 study participants constituting 150 in-school youth and 20 Out-of school youth (**Table 1**) were recruited for the study. An equal proportion of 50 youth were represented from junior, senior high school and tertiary level education. The highest age cohort with a 35% representation was found among those aged 15 - 17 years. The sex distribution showed more males than females (58% males and 42% females). Majority of the youth professed the Christian faith (94.7%), a pattern that reflects the national religious distribution in the study region [16].

3.2. Youth Sexual Knowledge and Related Sexual Attitudes

The variables considered under this section were aimed at eliciting information on youth sexual relationship history, age at first sexual relationship and length of stay in the relationship. From **Table 2**, 84 (56.0%) of the 150 in-school have ever had a boyfriend. A total of 34 (40.8%) of young persons who had ever had girlfriend (s) were males. Females with sexual relationship history remained higher (50%, 59.2%) than males. Out the 84 in-school youth who responded ever having boyfriend/girlfriend, majority (36.9%) of them were between the ages of 18 - 20. Interestingly a fourth of the population (20.4%) of the youth had first entered into boyfriend/girlfriend relationship when they were between 12 - 14 years. The majority 18 (21.3%) of the youth had stayed with their boyfriend or girlfriend for over a year, with 16% staying in their current relationship between 2 - 3 months.

Table 1. Background characteristics of in-school youth (n = 150).

Characteristic	N	%
Sex		
Male	63	42
Female	87	58
Age (years)		
12 - 14	15	10.4
15 - 17	53	35.3
18 - 20	36	24
21 - 23	40	26.7
24 + yrs	6	4.0
Educational Level		
Junior High School	50	33.3
Secondary	50	33.3
Tertiary	50	33.4
Religion		
Christianity	142	94.7
Moslems	7	4.7
Traditionalist	1	0.6

Table 2. Sexual knowledge and related sexual attitudes.

Variables	N	%
History of boyfriend/girlfriend relationship		
Yes	84	56
No	66	44
Age at first boyfriend/girlfriend		
12 - 14	17	20.4
15 - 17	25	29.7
18 - 20	31	36.9
21 - 23	11	13
Length of stay in current or past relationship		
Less than a month	6	6.7
Two to three months	13	16
3 - 6 months	10	12
6 - 12 months	4	4.7
Over a year	18	21.3
Can't recall	33	39.3

3.3. Relationship between Gender, Sexual and Romantic Experiences

The study showed that 60.71% (51/84) of the participants with history of sexual relationship were currently with their boyfriend or girlfriend. This shows a decrease of 33 youth (51/84) who make up a reduction proportion of 39.39% of the total youth who had ever had boyfriend or girlfriend. Females were much more in relationship than males at the current time of the study (31/51 vs. 20/51). Females in sexual relationship were 1.51 times higher than males. Out of the sample participants, 39.8% (20/51) of males had girlfriends, as compared to 60.2% (31/51) of females who had boyfriends. Male youth who had ever had girlfriend but at the time of the study were without girlfriend was 57.8% compared to 42.2% females of similar characteristics. Generally, the proportion of youth with sexual experience was near half. In all, 45.2% (77/170) out of the sampled study population (In-school and out of school youth) had history of sexual experience. A total of 63 representing 42% of in-school youth had engaged in pre-marital sex in their life time. Out of this, almost two thirds 69.8% (44/63) had had sex in the last six months preceding the conduct of the study. The total number of youth (All categories-both In-school and out-of-school youth) who had had sex in the last six months preceding the conduct of the study were 28.8% (49/170) comprising 44 in-school youth and five out-of-school youth.

Out of the total number of in-school youth who had ever had sexual experience in lifetime, females who had had sexual experience were higher 55.6% (35/63) compared to 44.4% males (28/63). The evidence show that sexually active out-of-school youth were smaller 25% (5/20) in proportional terms than the sexually active in-school youth, 29.3% (44/150) with sexual experience in the last six months. In respect of the twenty (20) youth who were interviewed, the study identified that only six of them had not had sexual experience. The remaining fourteen (14) with ages ranging between 14 to 24 had had sexual exposure with some having it more than once. The results are presented in **Table 3**.

3.4. Community Level Perceptions on Youth Sexual Behaviour and Uptake of Sexual and Reproductive Health Services

An interview with a key informant who had had working relationship with youth and pastors one of the biggest youth congregation in the study area corroborated the evidence:

Investigator: What are your views on the sexual behaviour of your church youth?

Key Informant (KI): *Sexual behaviour is a threat to youth in general of which the church youth are not exempted. This day's youth cannot control their passion for sex. They easily engage in sex. This has eaten into church that Christian brothers and sisters before they marry they have sex.*

First as Paul advised Timothy to free from youthful lust, youth of today rub into it. They take adventure to explore.

He continued when asked the extent to which the youth are engaging in risky sexual behaviour:

“Youth talk on sex on phones, Facebook, Whats App and other social media. They also engage in them through kissing and other sexual words that could lead to sexual abuse. They do not use any of the contraceptives to protect themselves. They do not check their blood groups, sickle cells, HIV Virus and other related diseases”.

A female, 18 year old youth in the unaffiliated category affirmed this by saying:

“I had several sex with my boyfriend, he was my boyfriend so once we were in love we had sex”.

Table 3. Gender and boyfriend/girlfriend and sexual experience of youth.

Gender of Youth	Current Boyfriend/Girlfriend status of youth		Total	Percentage
	Yes	No		
Male	20	14	34	40.5
Female	31	19	50	59.5
Total	51	33	84	100

Gender and youth lifetime ever sexual experience				
Gender of Youth	Whether in-school Youth has had sex in life time		Total	Percentage
	Yes	No		
Male	28	27	56	41.7
Female	35	43	78	58.3
Total	63	70	134	100

An interview with the youth in affiliated category (dressmaker, hairdressers, bakers etc) in the study area brought to the fore that, they have minimally used sexual and reproductive health services. Four hair dressers agreed on the same point by saying:

“As for us we have never been to any hospital for these services you are talking about before”.

A lady who plaits hair when asked her shared experience on service use opined:

“Reproductive health services that we know and have used before are counseling received from our church leaders on abstinence”. One young lady age 21, intimated;

“I have never used any sexual reproductive health service and have never also have sex before and I think I don’t need it. I am ok.—A 23 year lady seamstress from Asuoyeboa, Kwadaso.

When youth in the unaffiliated category were interviewed, similar results were identified. In quoting, one female youth interviewed;

“I have used female condom before and, my guy asked me to use it so I don’t get pregnant. Also I had some menstrual problem so I visited a nearby hospital down there [Name Withheld] and the nurses gave me sexual counseling on menstrual pains and pregnancy”—A 20 year Credit card seller.

Similar opinion was expressed by a male store keeper who shared his experience:

“For sexual reproductive health, the actual hospital one, I have not gone for any services there, but I have received counseling services from my church pastor on abstinence. Apart from that I haven’t gone for any services at any place. In fact, I don’t just know where to go for it. I sometimes hear about information on condom, family planning and some advert on T.V”—A 17 year male store keeper.

In contrast, a nineteen year SHS graduate opined that he had used SRHS before, he had this to say

“I have used condom before, I used it when I was young, I used to watch pornography. I was very young then, it was later on that I used condom. But for now, I don’t use it—A19 Nineteen SHS graduate—St. Peters area—Kwadaso.

3.5. Sexual Behaviour, Experience and Relationship Lifestyle of Youth

The total number of youth who had been sexually active in the past six months was 49 (Table 4). Proportionally, in school youth (44/150) proved sexually active more than out of school youth (5/20) in respective proportions of 29.3% and 25%. Condom use was confirmed among four in every ten youth (40.9%) with sexual encounter in the last six months. Reasons cited among the majority 59.1% participants who did not use condom ranged from being shy and afraid to ask partner to use condom (31%) to the perception that condom could burst during intercourse (6.9%). From a total of 15 in-school females who had been pregnant, 13 (86.7%) aborted the pregnancy. Although 49, of the female participants shared no history of pregnancy, more than a quarter 26.4% (23/87) of the female youth declined responding to the research question to assess their pregnancy history and abortion intentions. They considered it too sensitive to respond.

Nine of the 13 youths had performed abortion only once, three had aborted three (3) pregnancies. One participants however said she had engaged in abortion more than thrice. Majority 46.1% (6/13) of respondents said their abortion was performed by a specialist at a hospital or health care center with four (4) performing their abortion through self-medication.

A key informant interviewed during the study shared his views on abortion and contraceptive usage by the youth. He had this to say:

An abortion of any form by the youth is a sin against God and must be prevented by teachings. The youth need to be taught to abstain from sex. My view is to teach the youth to abstain from sex. Safe sex is only applicable only by obeying the natural laws. I will rate the sexual abstinence to be 70%.

When further asked about his views on abortion and contraceptive use, he shared:

An abortion of any form by the youth is a sin against God and must be prevented by teachings. The youth need to be taught to abstain from sex. My view is to teach the youth to abstain from sex. Safe sex is only applicable only by obeying the natural laws. I will rate the sexual abstinence to be 70%—Key Informant.

3.6. Family Planning Awareness, Practicing Methods and HIV/AIDS and STI Prevention Techniques Used by Youth

Awareness of family planning methods and practice, knowledge of STI and HIV prevention methods and approaches have profound influence on reproductive service utilization. Safe sex practices, how to say no to sex and HIV/AIDS prevention, affirmed by (57.3%) of study participants, were the most frequent sexual and reproductive

Table 4. Sexual behaviour, sexual experience and relationship lifestyle of youth.

Variables	N	%
Sexually active by youth status		
In school youth	44	89.8
Out of school youth	5	10.2
Condom use by youth in past six months sex		
Yes	20	40.9
No	29	59.1
Why youth did not use condom		
Shy and afraid to ask partner	9	31.0
Condom use is not considered needful	6	20.7
Condom use not enjoyable	5	17.3
Irritation when condom is used	4	13.8
Condom can get lost in vagina	3	10.3
Condom can burst during intercourse	2	6.9
Youth ever been pregnant (N = 170)		
Yes	15	8.8
No	155	91.2
Outcome of last pregnancy		
Gave birth	2	13.3
Had abortion	13	86.7
Frequency of abortion by female youth		
Once	9	69.2
Twice	3	23.1
Thrice or more	1	7.7
Place of performing the abortion		
Self-medication/going to drug store to buy drug	4	30.8
A specialist at a hospital/health care center	6	46.2
Use of traditional herbs	2	15.4
Other Method	1	7.6

health domains that youth received much education from their parents and adult family members. Discussion on sexual and romantic relationship was very low at a percentage of 28.0% among youth. Participant's discussion on contraceptive methods with adult family member was very low and reported among only 29.3% of In-school study participants. The majority of the youth got informed about sexual and reproductive health through radio. The school also serves as a channel to inform 44.0% of the youth studied.

Family planning services constitute a component of sexual and reproductive health services. Some of the family planning services and options are facility based, others are non-facility based while some are both. The family planning options ever used by the youth are therefore both facility-based (Contraceptives: Pills, IUD, Injectable, Condoms etc.) and non-facility based sexual reproductive health services (Withdrawal) and both (Abstinence, Natural method). The results as illustrated in **Table 5** show that a larger number of the participants 64.1% (109/170) had never utilized any of the method. Nonetheless, 29 expressive of 17.0% revealed their ever

Table 5. Awareness and practice of family planning methods and HIV/AIDS/STI prevention methods used among youth.

Variables	N	%
Sexual and Reproductive health area discussed with parents		
HIV/AIDS prevention	86	57.3
How to say No to sex	86	57.3
Safe sex practice	86	57.3
Female menstrual cycle	77	51.3
Sexually transmitted infections	72	48.0
How pregnancy occurs	68	45.3
Use of contraceptive methods	44	29.3
Sexual and romantic relationship	42	28.0
Sources of information on SRH, STI and HIV/AIDS (N = 150)		
Radio	78	52.0
Friends	46	30.7
Health Worker	45	30.0
Newspaper	38	25.3
Relatives	20	13.3
Youth group	20	13.3
Posters/books/pamphlet	14	9.3
Mosque	1	0.7
Church	29	19.3
School	66	44.0
Private Clinic	18	12.0
Grocery/Pharmacy	4	2.7
Family Planning method used by all youth (N = 170)		
Pill	8	4.7
IUD	2	1.1
Injections	7	4.1
Condoms	29	17
Natural Method	5	2.9
Withdrawal	2	1.1
Abstinence	8	4.7
None of the FP methods	109	64.1
Experience of STI infection in the past 12 months		
Syphilis	10	6.7
Gonorrhea	19	12.7
Genital warts	4	2.7
Cancroid	3	2.0
Chlamydia	1	0.7
Herpes simplex	1	0.7
None	112	74.7
Disclosure of STI infection to sexual partner, N = 38		
Yes	10	26.4
No	17	44.7
Don't remember	11	28.9

utilizing condoms. The rest gave answers like pill (4.7%), IUD (1.1%), injections (4.1%), natural method (2.9%), withdrawal (1.1%) and lastly abstinence (4.7%).

The study further illustrates the STIs that in-school youth has had in the past 12 months. Majority 12.6% (10/150) had acquired Gonorrhoea. In the past one year, 6.7% of study participants had contracted Syphilis infection, with 2.7% and 2.0% reporting history of Genital warts Cancroid infection. Majority 44.7% (17/38) of the in-school youth who had had an STI in the last one year responded did not make their partners aware when they were diagnosed of STI's. A little over a quarter of the youth (26.3%) informed their partners.

3.7. Hypothesis Testing

H1: *Young people's Knowledge of available youth friendly Reproductive health service in the district significantly influences the utilization of Reproductive Health.*

Independent Variable: Knowledge of available Reproductive Health services.

Dependent: Reproductive Health Services Utilization. This results of the cross tabulation is presented in **Table 6**.

In respect of hypothesis H1, a chi square test of significance was conducted with reproductive health service utilization as the dependent variable and Knowledge of available Reproductive Health services as the independent variable. The results showed that, Pearson coefficient at 95% confidence level had its *P value* for two-tailed test of significance at 0.00. The results presented demonstrate that there is an association between youth awareness or knowledge about the available sexual and reproductive health services provided to them in the area and service utilization. Thus the null hypothesis is rejected and its alternative hypothesis that youth awareness of available sexual reproductive health services in the study area significantly influences their utilization of sexual reproductive health is supported at 5% level of significance.

Table 6. Cross tabulation of facility based reproductive health service awareness in the area and use of youth friendly reproductive health services by participant.

Whether youth has ever used reproductive health Service	Awareness of any youth friendly reproductive health services rendered to them in the area		Total	P value at 0.05 level of significance
	Yes	No		
Yes	18	13	31	0.00
No	9	78	87	
Total	27	91	118	

P value = 0.00.

4. Discussion

The study was towards assessing youth knowledge, attitude and sexual practice and reproductive health service utilization informed by a cross sectional qualitative and quantitative design. Our finding demonstrates a positive relationship between youth awareness about the available sexual and reproductive health services in the area and service utilization. This finding is consistent with the study of Hock-long and others [14] and corroborates the evidence by Frost and Driscroll [17] where non-availability of reproductive health service facilities prevent youth from utilizing sexual and reproductive health service.

The study found out that large number of respondents entered into relationship between the ages of 18 - 20 years. This was followed by 15 - 17 years with majority affirming that they have had sex in their life time. This result corroborates the extant literature by Mitikie and others [23], Asrat [24] and Rada [21] laying credence to Bogale and Seme [22] recent study. Most youth involved in pre-marital sex early in their life time.

Females who have ever had sex in their life time exceed the number of males with females being sexually active in the past six months constituting one and half times higher than their male counterparts. This finding corroborates GDH survey [2] which found out that whiles eight percent of women and 4 percent of men had sexual intercourse by age 15 Forty-four percent of women and 28 percent of men had had sexual intercourse by age 18 respectively. This result has the same platform with studies in Asia [21] and other Western and European [25] [26], showing similar pattern that sexual experience in females is higher than that of males.

However, the results is not consistent with similar African setting [22] like the study among in-school youth in Ethiopia where the proportion of male youth who had engaged in pre-marital sex was higher (22.7%) than their female counterpart (15.5%). In this present study whiles 55.6% of females had had sexual exposures, 44.4% of in-school males had had sexual exposure. More females engage in sexual intercourse younger in their life time than their male counterparts.

The finding of this study further illustrates that pre-marital sexual experience among in-school youth was high in Ghana (42%) than that of Ethiopia [22] where it was report that less than a fifth of the in-school youth (19%) have engaged in pre-marital sex. It could be identified that whiles only 11.4% of their study population were aged 20 - 24, this study had a 51.3% of the in-school youth studied aged less than 18 and a 49.7% above age 18. The difference is accounted for on the basis of the average proportion of “young persons” and adolescents” included in this study with young people likely to have engaged in pre-marital sex than adolescence. Additionally, there could be “under reporting” in the Ethiopia study since Ethiopian youth (Females in particular) may be more conservative about reporting their sexual histories than Ghanaian youth due to the relative higher levels of exposures among Ghanaian youth.

The results show that many young people thought about and take steps to obtain adequate protection only after having their first sexual intercourse [13]. This finding brings to the fore that condom use is chiefly not determined by the desire to prevent STI infection but pregnancy prevention [18]. Those who do not access the facility based reproductive health services out-number the respondents who access facility-based sexual reproductive health services [15] who stipulates that the youth and adolescents do not mostly access reproductive health service especially in developing countries such as Ghana. More to the present study is the finding that there is limitedness or scantiness of the nature of reproductive health facilities in many countries as the major reason why the youths and adolescents do not have access to reproductive health related services [16] [27] [28].

Some youth held the view that they have been pregnant before and they attempted aborting the pregnancy [19] and that abortion remains a challenge or risk associated with the youth [20]. The study however did not reveal the problems associated with youth pre-marital sex and abortion as indicated by Rada [21] such as the problem of cervical cancer, breast cancer, early aging, infection and others. Further finding is made from this present study in that due to risky sexual behaviour, gonorrhoea infection leads among the STIs contracted by youth in the last anniversary. The findings provided in this study show that despite the appreciable level of youth sexual knowledge on sexual and reproductive health options and the risk associated, risky sexual behaviour among the youth is high.

5. Conclusion

This study represents a contribution to studies on current sexual and reproductive health update among youth from a life course perspective. A major finding of this study is the dissonance between knowledge of what is known about sexual and reproductive health and practice of what is known. Youth attitudes, norms, and perceive changes in sexual behavioral is yet to correlate with sexual decision making. Contraceptive use among sexually active young people was very low especially among those who had had sex in the last six months. Despite youth fair knowledge and in some specific reproductive health cases, excellent knowledge about sexual reproductive health, youth risky sexual behaviour does not seem to be influenced by knowledge about youth friendly sexual reproductive health. On this basis, we recommend that the youth should be given sexual and reproductive health education appropriate to their age. This should include but not limited to the provision of education on puberty before sexual debut as well as issues of menstruation and personal hygiene. Political will and stakeholder involvement in sexual and reproductive health education is required to meet the uptake of sexual and reproductive health services whiles translating knowledge into practice.

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Competing Interests

The authors declare that they have no competing interests.

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Abbreviation

SRHS, Sexual and reproductive health service