

UNIVERSITY OF CAPE COAST

ADOLESCENTS' KNOWLEDGE AND PERCEPTION OF SEXUAL AND  
REPRODUCTIVE HEALTH RIGHTS IN YAMORANSA, GHANA

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BY

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## DECLARATION

Candidate's Declaration

*I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.*

Candidate's Signature: ..... Date: .....

Name: Ebenezer Martin-Yeboah

Supervisors' Declaration

*We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.*

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## **ABSTRACT**

Sexual and reproductive health rights are the bedrock of sexual and reproductive health. Sexually Transmitted Infections (STIs), fertility control, sexual violence and abuses are reflections of the level of control individuals have over their reproductive autonomy.

This study sought to assess the level of adolescents' knowledge and perception of Sexual and Reproductive Health Rights (SRHR), and was situated in the theory of sexual interaction. The study adopted a cross sectional study design. Data was obtained from 209 adolescent residents of Yamoransa in April, 2010. The Statistical Package for Service Solutions programme was employed to analyze the quantitative data.

The study found out that majority of adolescents had comprehensive knowledge of SRH Rights, knew the appropriate avenues to seek redress in the event of rights abuses. It was however revealed that only a few had actually asserted, or admitted could assert their sexual rights. Over half of the respondents conceded they would succumb to any imposition of a sexual and reproductive health decisions by their sexual partner. The view that men should be the decision makers on sexual issues in marital unions was held by most adolescents.

Based on the findings, it was concluded that though adolescents are aware of their sexual and reproductive rights, they may not have the capacity to assert those rights, and would succumb to instances where certain SRH decisions are imposed on them. Government and other stakeholders should, through education, empower adolescents to exercise their sexual and reproductive health rights during adolescence, and in adulthood.

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## **DEDICATION**

To Madam Elizabeth A. Tandoh, Mr. Ebenezer Martin-Yeboah and  
Sister Emily Martin-Yeboah.

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## LIST OF ACRONYMS

|        |   |
|--------|---|
| ATR    | African Traditional Religion                                  |
| BECE   | Basic Education Certificate Examination                       |
| CEDAW  | Convention on the Elimination of Discrimination against Women |
| CHPS   | Community-based Health Planning Services                      |
| CRC    | Convention on the Right of the Child                          |
| DOVVSU | Domestic Violence Victims Support Unit                        |
| GDHS   | Ghana Demographic and Health Survey                           |
| GHS    | Ghana Health Service  |
| HIV    | Human Immunodeficiency Virus                                  |
| ICF    | Intermediate Care Facility                                    |
| ICPD   | International Conference for Population and Development       |
| IPPF   | International Planned Parenthood Federation                   |
| JHS    | Junior High School  |
| MDG    | Millennium Development Goals                                  |
| NACP   | National AIDS Control Programme                               |
| NHIS   | National Health Insurance                                     |
| NPC    | National Population Council                                   |
| OHCHR  | Office of the High Commissioner for Refugees                  |
| PRB    | Population Reference Bureau                                   |
| RTI    | Reproductive Tract Infections                                 |
| SHS    | Senior High School  |
| SPSS   | Statistical Product for Service Solutions                     |
| SRH    | Sexual and Reproductive Health                                |

|        |   |
|--------|---|
| SRHR   | Sexual and Reproductive Health Rights             |
| STD    | Sexually Transmitted Diseases                     |
| STI    | Sexually Transmissible Infections                 |
| TPB    | Theory of Planned Behaviour                       |
| TRA    | Theory of Reasoned Action                         |
| UN     | United Nations                                    |
| UNAIDS | Joint United Nations programmes on AIDS           |
| UNFPA  | United Nations Population Fund                    |
| UNICEF | United Nations International Child Emergency Fund |
| USAID  | United State Agency for International Development |
| WAJU   | Women and Juvenile Unit                           |
| WHO    | World Health Organisation                         |

## **CHAPTER ONE**

### **INTRODUCTION**

#### **Background to the study**

The 2007 World Development Report posits that quality transitions adolescents undergo in learning, work, health, family formation, and citizenship provide opportunities to safeguard and develop human capital (World Bank, 2007). These are critical for poverty reduction and growth because they relate to building, maintaining, using, and reproducing human capital. Success in the transition to adulthood, in the views of Cohen (1996) requires the development of human capital, the capability to make competent choices, and the development of a sense of well-being.

During the rapidly changing period of adolescence, adolescents strive to establish independence from parents, create and maintain relationships with peers, (complete their formal schooling), and take their place in social systems and the workforce. These developmental stages do not only take place in the context of changing political, cultural and socioeconomic environments, but also are modified by factors related to gender, class, and family.

The situation of young people today presents the world with an unprecedented opportunity to accelerate growth and reduce poverty. Due to the development achievements of past decades, more young people are surviving

childhood diseases. Helping adolescents make a healthy transition to adulthood while increasing their opportunities for education and livelihoods is perhaps the most important investment a society can make in its future development and the most important long term strategy to reduce poverty. Adult behaviour patterns are formed during this crucial stage in life. Gains made in child health and survival programmes are lost if adolescents are not helped enough in making a healthy transition to adulthood.

Consideration of mortality rates alone has resulted in young people being seen as healthy, and this has led to their being accorded a low priority for health related interventions, neglecting and denying them the basic human right to reproductive health (World Bank, 2007). Oware-Gyekye (2005) also noted that adolescents may be physically capable of procreation, but suffer from the inconsistencies that exist between nature and the realities of the social world. While adolescents are, in general, a healthy population group, they are prone to risky behaviour, sexual violence and sexual exploitation. At the Joint United Nations Programme on HIV/AIDS in 2006, it was established that adolescent girls in particular are vulnerable to unwanted pregnancies, sexually transmitted diseases, including HIV/AIDS (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2006). In many regions of the world, new HIV infections are heavily concentrated among young people of 15–24 years. Adolescents' right to health is therefore dependent on health care that respects confidentiality and privacy and includes appropriate mental, sexual and reproductive health services and information (Ford, Millstein & Halpern-Feisher, 1996; Ogunlayi, 2005).



Risky or unwanted sex and other unhealthy behaviours are tied to individual, family, and community factors that influence youth behaviour and that are closely related to economic and educational prospects. At both the International Conference on Population and Development in Cairo in 1994 and International Conference on Women and Development in Beijing in 1995, adolescents' health was identified as a major public health concern especially among developing nations of the world (United Nations, 1995). This is as a result of the developing nature of adolescents' physical and biological systems with respect to the social context of their growth. Adolescent sexual and reproductive health and rights issues have been particularly of interest in the last decade because of their significance in the HIV/AIDS burden.

During the 1994 International Conference on Population and Development (ICPD), reproductive health was defined as “a state of complete physical, social and emotional wellbeing and not merely the absence of diseases in all matters relating to the reproductive system and its functions and processes (United Nations, 1994). Sexual and reproductive rights, on the other hand, rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It as well involves the right to attain the highest standard of sexual and reproductive health, and also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence (United Nations, 1994).

Reproductive health entails a general body of well-being with emphasis on the reproductive system's functions and processes, and this is achieved within the framework of reproductive rights. That is, any direct or indirect physical actions, social norms and practices – sexual intercourse, pregnancy and birth, abortion, contraception, puberty/initiation rites, virginity test – that impact on the reproductive system should be within the individual's utmost unconditional control in order to bring about wellbeing. This implies a full knowledge of the reproductive processes as well as the existence of social and legal institutions that afford the adolescent to have autonomy over his sexual and reproductive system. As could be seen from the definition, social wellbeing of the individual focuses on the ability of the individual to be assertive in order to claim and protect his or her rights, and the opportunities available to attain such assertiveness. This implies that countries make available the necessary physical infrastructure, legal systems and human resources for ensuring the right to sexual and reproductive self-determination.

According to Bartholomew, Parcel, Kok and Gottlieb (2006), a rights-based approach serves the needs of young people by involving them, thereby making policies and programmes more effective and sustainable. This kind of approach provides the framework for meeting the actual sexual and reproductive health needs of young people, and not just as perceived by adults.

Sexual and reproductive health rights, in particular, were first officially recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994. Prior to this, reproductive health programming had

focused on family planning, fertility control and safe motherhood, having emerged from concerns about population control. Family planning programmes were based on ideas about state control for the future social good with its focus skewed towards adults, particularly married couples. However, the focus of sexual and reproductive health agreed upon in Cairo moved beyond this, and was notable for being broad and comprehensive, and for placing reproductive health in the context of human rights and the right to health. This included rights to sexual health, and focusing not only on problems and diseases, but on what should be positive experiences around pregnancy, parenthood, sexuality and relationships (United Nations, 1994).

Glazier (2006) reiterates that beyond the provision of infrastructure and services, adolescents have yet another need, in this case, the right to knowledge, access to services and above all, autonomy over their body and behavioural choices. In many societies, according to Carovano (1992), there is a culture of silence that surrounds sex and dictates that “good” girls are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for girls to be informed about risk reduction, or even when informed, makes it difficult for them to be proactive in negotiating safer sex. Also, in cultures where virginity is highly valued, research has shown that some adolescent girls practice alternative sexual behaviours, such as anal sex, in order to preserve their virginity, although these behaviours may place them at high risk of HIV (Weiss, Whelan & Rao Gupta 2000; Awusabo-Asare, Abane & Kumi-Kyereme, 2004). Again, because of the strong norms of virginity and the culture of silence that surrounds

sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescents (UNAIDS 1999; Weiss et al, 2000).

Schools are institutions where adolescents should be able to learn, grow, and develop their autonomy. Instead, school corridors and classrooms often become traps of violence and abuse. Latin American girls have attested that sexual violence is present in schools. A study conducted by the Office for the United Nations Human Rights Commission (2001) showed that educational environments are the principal settings for sexual violence. In Ecuador, 22% of female students reporting sexual abuse name their male teachers as the aggressors.

According to Khattab (1996), perception is the process of acquiring information about the environment through the senses, and interpreting the sensory input in a meaningful way. Adolescents, unlike most adults, are not fully capable of understanding complex concepts, or the relationship between behaviour and consequences, or the degree of control they have or can have over sexual decision making (Fischhoff, Crowell & Kipke, 1999). This inability may make them particularly vulnerable to sexual exploitation and high-risk behaviours. It therefore becomes necessary for an empirical study to be carried out to identify their (adolescents') level of perception and knowledge on sexual and reproductive health rights so as to inform policies and add to literature.

### **Statement of the problem**

Adolescents and young people comprise almost half the world's population (Population Reference Bureau [PRB], 2009). They have sexual and reproductive rights, just as adults do, but their low social status, lack of autonomy,

and physical vulnerability make it more difficult for them to exercise such rights. When adolescence intersects with other factors, such as poverty, race, and gender, it compounds the challenges young people face in exercising their basic human rights (United Nations, 2003).

Friedman (1999) admits that a further challenge lies in confronting and refuting the assertion of culture as a justification and a defense for adolescents' rights violations. Despite the critical health issues at stake, discussing the sexuality of young people typically sparks controversy. Ogunjuyigbe and Adeyemi (2005) found out 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 SRH 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 women (44 percent) and 26 percent of men had had sexual intercourse (Nabila & Fayorsey, 1996; Ghana Statistical Service [GSS], Ghana Health Service [GHS] & ICF Macro, 2008).

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 (Hedberg, Bracken, & Stashwick 1999; Awusabo-Asare et al, 2004). They face legal barriers such as requirements for parental consent, or age limits for providing contraception; refusal of health workers to provide services to adolescents. All these prevent adolescents from seeking services in the first place (Warenius, 2006).

According to Durojaye and Amollo (2010), due to controversies related to adolescent sexuality, and the usually few reproductive health-related institutions in existence, there is generally limited knowledge about adolescents' sexual and reproductive rights. In general, Ghana remains a relatively conservative country where discussion of sexual issues, abortion and adolescents' usage of contraceptives are still widely a taboo. An Adolescent Reproductive Health Policy is in place, but in practice many organisations emphasize abstinence until marriage. This is despite demand from an estimated 22 to 27 percent of young people who want to use family planning but are unable because they cannot easily obtain contraceptive services (GSS et al, 2008). Adolescents often do not know where to go for impartial advice and contraceptives, and the number of teen-friendly clinics providing these services is limited, especially outside the main cities.

Laws, customs, and practices may affect adolescents differently than adults. They often restrict access of adolescents to reproductive health

information and services especially when they are unmarried. Some laws even penalize those who responsibly seek such services. In addition, even when services do exist, provider attitudes about adolescents having sex often pose a significant barrier to use of those services (Finkelhor, 1995). Such acts are perpetuated in condition of ignorance of one's rights.

Meanwhile, adolescents need to be empowered in diverse ways to assert their rights and personally protect their own reproductive health from risk. The right to own one's body or give consent for any relationship or sexual intercourse, become pregnant or to impregnate, give birth, secure reproductive health services, among others, is an art or a skill that adolescents must consciously learn to ensure its full existence in their lives. They need enhanced capacity to improve their sexual and reproductive health, information about safe-sex practices, including negotiation skills to protect them from potentially dangerous and abusive relationships. The period of adolescence is undoubtedly the ideal time to learn and form positive habits about sexuality. Habits and behaviours formed in adolescence do remain even in adulthood. Therefore, when adolescents are aware of, and assert their sexual and reproductive rights, it goes a long way to influence safe practices.

Despite the potency sexual and reproductive health rights have in bringing about sexual and reproductive well-being, there exist inconsistencies in adolescents' knowledge of some specifics in sexual reproductive health rights (Awusabo-Asare et al, 2004; Ogunlayi, 2005; Peltzer & Pengpid, 2008). The numerous studies about adolescents' sexual and reproductive health seldom cover

their knowledge and perception of sexual and reproductive rights. Thus, the study sought to ascertain the scope of adolescents' knowledge and perception of Sexual and reproductive health rights in the Yamoransa Community.

### **Research objectives**

The general objective of the study was to assess the knowledge and perceptions of adolescents on sexual and reproductive health rights in their transition into adulthood. The specific objectives were to:

- examine how adolescents value sexual and reproductive health rights.
- explore how current transitional processes of adolescence contribute to their knowledge of sexual and reproductive health rights; and
- ascertain the socio-demographic factors that affect adolescents' perceptions of sexual and reproductive health rights.
- investigate some sexual and reproductive health rights experiences of adolescents;

### **Research hypothesis**

The study seeks to, among other things, test the hypothesis that:

H<sub>0</sub>: There is no significant relationship between adolescents' age, sex, educational level and religion, and their perception of sexual and reproductive health rights.



## **Rationale of the study**

Reproductive health is not just the absence of disease or infirmity of the reproductive system, or of its functions and processes. It refers to a spectrum of conditions, events and processes throughout life, ranging from healthy sexual development, comfort and closeness and the joys of childbearing, to abuse, disease and death. Perhaps more than with any other health conditions, the social, psychological and physiological factors are interrelated in reproductive health (Jessor & Jessor, 1977). According to the Population Action International (2005) the MDGs will not be achieved without improving access to SRH rights.

Adolescent sexuality plays an important role in fertility management since the attitudes of young adults to reproduction; family size and development have profound implications for the size and characteristics of the future population of a country. Investing in adolescents' sexual and reproductive health will help create a conducive and healthy environment for young people to learn about their own sexuality and that of the opposite sex. The need to focus on adolescents is grounded in the belief that adolescents are different both from very young children and from adults. Adolescents have distinct needs at different stages of the process of their development and, therefore, different approaches are required for reaching and serving them. Although they are, by no means a homogeneous group, many common characteristics define their lives and affect their ability to access and use reproductive health information and services.

There are potential public health benefits of addressing sexual rights in SRH programmes. This can make people more comfortable with their bodies, and

so more able to communicate wishes to others including safer sex, and to resist coercion (Ingham, 2005). Addressing these issues will affect poverty reduction far into the future. First, the capacity to learn is much greater for the young than for older people, so missed opportunities to acquire skills and good health habits can be extremely costly to remedy. Also, human capital outcomes of young people affect those of their children. Better educated parents have fewer, healthier, and better educated children. These intergenerational effects lift families out of poverty over the long term.

The study would provide first hand insight into some of the problems faced by adolescents in their quest to be assertive of their sexual and reproductive health. The results of this research, hopefully, would justify the need for the implementation of relevant policies which enable adolescents to assert their rights by the government, to help reverse such problems. It is also hoped that this study would be of significance to parents, teachers, health practitioners and all stakeholders in the adolescent sexual and reproductive health community to formulate and implement policies that relate perfectly with the current needs of adolescents in current times. Since research findings are of great importance to individuals, institutions/organisations as well as the nation at large, this study will help give priority attention to ensuring that adolescents are fully knowledgeable and assertive in sexual and reproductive rights issues.

## **Organisation of the study**

The study has been organized into five chapters, with the first being the introduction and background issues to adolescents sexual and reproductive health rights. The objectives of the study, research hypothesis as well as the rationale are also found in this first chapter. The second chapter reviews models, theories, concepts and frameworks in adolescents' sexual and reproductive health rights. Here, theoretical review, empirical review as well as contextualization of some key terminologies are discussed.

Chapter Three outlines the study area, methods of data collection as well as method of analysis whereas Chapter Four discusses the background of respondents, and their knowledge, attitudes towards sexual and reproductive health rights.

The last chapter, Chapter Five, summarizes the major finding of the study and provides recommendations for effective transition of adolescents into adulthood with respect to their Sexual and Reproductive Health Rights.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **Introduction**

This chapter reviews the existing literature on adolescent sexual and reproductive health rights with respect to the concepts, theories, models and frameworks which throw more light on the topic.

#### **Concept of adolescence**

Adolescence represents a transition from childhood to adulthood, with features including secondary sexual growth, changes in hormonal milieu, emotional, cognitive and psychological development (Connel, 1990; Olukoya & Ferguson, 2002). According to the World Bank (2007), adolescence is a period of dynamic change representing the transition from childhood to adulthood that begins at puberty. For girls, puberty is a process generally marked by the production of oestrogen, the growth of breasts, the appearance of pubic hair, the growth of the external genitals, and the start of menstruation (menarche). For boys, it is marked by the production of testosterone, the enlargement of the testes and penis, a deepening of the voice and a growth spurt. The World Health Organisation [WHO], (2001), defines adolescence as the period of progression from the onset of secondary sex characteristics to sexual and reproductive

maturity, the development of adult mental processes and adult identity; and transition from socio-economic dependence to relative independence.

WHO (1999) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19 years. It is further subdivided into the following categories: pre-puberty (before age 10), early adolescence (ages 10–14 years) and late adolescence (ages 15–19 years). Although age is often not an accurate measure (because of variations in cultural norms and expectations) such categorization could be useful as a basis for understanding the process of adolescence. Adolescents form about 20 percent of the world's population with about 85 percent of them in developing countries (PRB, 2009; WHO, 2009). Okonofua (2000) corroborated that Sub-Saharan African countries have larger proportion of adolescents than any region in the world.

The biological determinants of adolescence are fairly universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations. Furthermore, this period has been radically altered over the past century by earlier onset of puberty, later age of marriage, urbanization, global communication, and changing sexual attitudes and behaviours. Adolescence is a period of growth and development during which young people are universally exposed not only to exciting new opportunities but also to risks. These changes can be overwhelming and intensify the need for information, support and experimentation (Thomson, 1986). According to the World Bank (2007), in many ways, adolescence is a joyful and creative time, and

youth can be a boundless national and international resource when it is nurtured and if its energies are thoughtfully channeled in positive directions.

### **Adolescents' reaction to puberty**

Adolescence is the time when adolescents' self awareness reaches a peak with sexual awareness. They try to either hide or advertise changes in their body. There is an inner urge to sexual awakening. The girl in early adolescence may experience pleasant sensations and even tingling in the genital area. Awusabo-Asare et al (2004) point out that adolescents engage in sexual relationships for pleasurable sensations, to satisfy their sexual drive, out of curiosity or a desire for conquest, as an expression of affection, or because of inability to withstand pressures to conform. Adolescents are limited in their knowledge and understanding of sexuality in the opposite sex. Adolescents are at the stage of life when the sexual aspects of interpersonal relationships become particularly important. Society places the responsibility on the girl for inhibiting the boy's sexual advances. Therefore if she accedes (through the need to conform or gain acceptance), she is faced with fear of disease or pregnancy or just being labeled fast or bad, resulting in feelings of guilt or worthlessness. In the view of Berman, Snyder, Kozier and Erb (2008), adolescents need to know more about the mechanism of conception, gestation and birth and sexuality and beyond these, the rights thereof to either allow these mechanisms willingly in one's reproductive system.

Adolescent empowerment is an attitudinal, structural and cultural process whereby adolescents gain the ability, authority and power to make decisions and implement changes in their own and other people's lives, including the youth and adults. These can be achieved through the promotion of the rights of all people, which should be the fundamental basis of all government and community supported policies and programmes in the area of reproductive health, including sexual health and family planning. Educating adolescents on their legal rights and exploring innovative ways of increasing access to safe services for unmarried women will reduce the rate of exposure to vulnerabilities such as death or complications from unsafe abortions as well as STI infections (Awusabo-Asare et al, 1993).

### **Sexual and reproductive health and rights defined**

The International Conference on Population and Development (ICPD) adopted a definition of reproductive health as: "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations, 1994). Reproductive health entails a general body well-being with emphasis on the reproductive system's function and processes. A well functioning reproductive system implies the ability of the individual to assume absolute control of the physical and social conditions that affect it. That is, any direct or indirect physical actions and social norms and practices that impact on the individual's sexual performance should be within his absolute

control in order to bring about wellbeing. This requires the individual's full knowledge of the reproductive processes and the social and structural institutions that afford him or her to have absolute autonomy of his sexual and reproductive system.

As could be seen from the definition, social wellbeing of the individual focuses on the ability of the individual to be assertive of the rights and opportunities available to attain the physical wellbeing. This implies that countries make available the necessary infrastructure, legal systems and human resources for ensuring the right to sexual and reproductive self-determination.

According to the United Nations (1994), sexual and reproductive health rights are the rights of all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote sexual and reproductive health. The International Planned Parenthood Federation, posits that reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so (International Planned Parenthood Federation [IPPF], 1995). They also include the rights of all to make decisions concerning reproduction free of discrimination, coercion and violence. The responsible exercise of human rights requires that all persons respect the rights of others. Reproductive health rights aim to promote 'complete



physical, mental and social wellbeing’, and are based on concepts of individual control for current quality of life (IPPF).

In the words of Correa and Petchesky (1994), sexual and reproductive rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing, health, security, education and political participation. Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and child care, gynecological health and sexual activity, as well as the resources to carry out those decisions safely and effectively.

According to WHO (2002), Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and

- pursue a satisfying, safe and pleasurable sexual life.

In the views of Petchesky, 1994), a rights-based approach emphasizes the fact that all people should be treated equally: both males and females, whatever their sexual orientation, people who have or have had a sexual health problem, and people living with HIV/AIDS. It also encourages the appropriate redress action if rights are violated (for example, in cases of sexual abuse or discrimination). Putting the theory of rights into practice involves many different people working together. In this case, national governments, organisations that serve young people, and, of course, the young people themselves. While making sure that young people are provided with all they are entitled to, other people's rights must be respected too - friends, partners, parents, family or community. A human rights-based approach to programming differs from a basic needs approach in that it recognizes the existence of rights, and gives duty-bearers (usually governments) more opportunities to respect, protect and guarantee these rights (Petchesky, 1994).

Prior to the International Conference on Population and Development (ICPD) in Cairo in 1994, reproductive health programming had focused on family planning, fertility control and safe motherhood, having emerged from concern about population control. According to Cleland (2006), family planning has caused conflict in the past, partly due to cases in some countries (such as China and India) when it involved coercion. However, efforts have been made more recently to bring the two (family planning and reproductive health) together as complementary approaches, fulfilling individual rights to achieve greater social

aims. The current focus on rights-based approaches to SRH represents a shift from policy-making based on population level rationales such as population growth, economic and environmental factors, to recognition of the needs and rights of individuals. There is a requirement for the individual to behave responsibly – but this assumes they have the relevant knowledge, skills and resources to do so, which depends on responsibilities of others: researchers, health professionals, religious leaders, national governments, donor governments (Shaw, 2006).

In recent years, there has been an increased exchange of ideas and strategies between practitioners in the fields of human rights and public health, and specifically between those who promote women's human rights and those seeking to improve women's quality of reproductive and sexual health. Throughout the years, rights were defined with increasing specificity, and the idea of sexual and reproductive rights was addressed explicitly in the Declaration of the World Conference on Human Rights in Tehran, 1968, which proclaimed that parents have the basic right to freely determine the number and spacing of their children, as well as the right to education and information concerning this issue. Later, at the World Conferences on Population held in Bucharest during 1974 and Mexico in 1984, this paragraph was adopted and adjusted so that the term "parents" was replaced by "couples and individuals" (IPPF, 1995).

Other conferences and declarations reinforced the notion that the right to decide about reproduction, as well as the right to access health services was basic human rights. In 1979, the General Assembly of the United Nations approved the

Convention on the Elimination of All Forms of Discrimination against Women, and signing countries committed to take measures to ensure the full development and advancement of women. One of these measures is a commitment to ensure equal access to health services, including those related to family planning, and to promote the same rights for men and women to decide the number and spacing of their children. This measure also highlighted the need to access information, education and the resources necessary to exercise these rights. The 1993 World Conference on Human Rights in Vienna reiterated the importance of eliminating all forms of sexual discrimination, together with the need to work to eradicate gender-based violence.

At the International Conference on Population and Development in Cairo, certain sexual and reproductive rights were explicitly recognized as basic human rights. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (United Nations, 1994).

The United Nations Fourth World Conference on Women in Beijing reaffirmed earlier consensus on the need to eradicate all forms of discrimination and violence against women and to guarantee the right to decide freely and responsibly about matters of sexuality and reproduction. The Beijing Platform for

Action mentions factors that influence women's health, which are often overlooked as circumstantial.

Young people's sexual and reproductive rights have been a much-discussed topic, particularly at international conferences. In 1989, the Convention on the Rights of the Child (CRC) introduced a rights-based approach to the sexual and reproductive health of young people. Exactly 191 governments worldwide have signed and approved the CRC (United Nations Children Emergency Fund [UNICEF], 1989). They have bound themselves to respect and promote young people's sexual and reproductive rights, and to ensure that all children and young people below the age of 18 survive, grow, are protected and participate as active members of society.

United Nations conventions since then have reinforced and further elaborated on the rights of young people. All these conventions were the outcomes of global meetings: the International Conferences on Population and Development (UN, 1994) and the UN's Conferences on Women (UN, 2010). These conferences contributed to the fact that young people are now recognized internationally as sexual beings with a right to self-determination, education and information, youth-friendly services, protection and participation (IPPF, 1995). At the 1994 International Conference on Population and Development in Cairo, for example, women from diverse backgrounds forced policymakers to recognize that population policies should be driven not only by a political agenda such as fertility reduction, but also out of respect for women and the importance of their role in decision-making. At the Fourth World Conference on Women in Beijing

the following year, the discussion focused not just on the deprivations that governments need to alleviate, but also on what governments must do as a result of their human rights obligations to ensure change.

Responding to adolescents' sexual and reproductive health issues requires new information in diverse areas, such as their current levels of knowledge; attitudes and behaviours that put them at risk for HIV transmission or unwanted pregnancy; their differential risks of HIV transmission and unwanted pregnancy; barriers to seeking sexual and reproductive health information and services; and how they, especially very young adolescents, are currently responding to their sexual and reproductive health needs (Dryfoos, 1990; Awusabo-Asare et al, 2004).

### **Legal regimes of sexual and reproductive health rights**

Several laws and conventions both at the local and international levels push for the recognition and protection of people below the adult age bracket. The Children's Rights Convention acknowledges that minors have "evolving capacities" to make decisions affecting their lives and recognizes that some minors are more mature than others depending on individual circumstances (UNICEF, 1990). Furthermore, while the Children's Rights Convention requires states parties to "respect the responsibilities, rights and duties of parents to provide appropriate direction and guidance in children's exercise of their rights, it clearly recognizes that, in all matters, the best interests of the child take precedence, and the child should be enabled to exercise his or her rights.

In Ghana, a formal child protective system has been developing since 1992. A combination of forces, including Ghana's democratic process, the United Nations Convention on the Rights of the Child, the Concluding Observations of the UN Committee on the Rights of the Child in the Ghana Report in 1997, and the signing of the African Charter on the Rights and Welfare of the Child in 1997 prompted the development of this system, which has culminated in the enactment of the Children's Act 1998 (Government of Ghana, 1998). Ghana's child protective system is governed by the 1992 Ghana Constitution, the Criminal Code, and the Children's Act 1998.

The Children's Act is a comprehensive law for children, which consolidated and revised existing laws and filled in gaps. It sets out the rights of the child and parental duties and provides for the care and protection of children. In Ghanaian laws, a child is seen as someone below eighteen years of age. The United Nations classifies an adolescent as someone between the ages of 10 and 20 years (Government of Ghana, 1992). This presupposes that an adolescent has a considerable amount of his or her life guarded or protected by laws that apply to children in Ghana, which is Act 560 - The Children's Act.

Per this act, the best interest of the child shall be paramount in any matter concerning a child. Thus, the best interest of the child shall be the primary consideration by any court, person, institution or other bodies in any matter concerning a child. This right, among others, protect the child from non discrimination on the grounds of gender, race, age, religion, disability, health status, custom, ethnic origin, rural or urban background, birth, socio-economic

status or because the child is a refugee. It assures every child of the right to life, dignity, respect, leisure, liberty, health, education and shelter from his parents (Government of Ghana, 1998).

Section 11 of the Children's Act most clearly reflects the principles expressed in Article 12 of the Convention on the Rights of the Child and Articles 4 and 7 of the African Charter on the rights and welfare of the Child (Government of Ghana, 1998). It directly echoes the language used in the Convention, stating, "No person shall deprive a child (capable of forming views) the right to express an opinion, to be listened to and to participate in decisions which affect his or her well-being. The opinion of the child be given due weight in accordance with the age and maturity of the child".

The children's act enjoins every parent to protect the child from neglect, discrimination, violence, abuse, exposure to physical and moral hazards and oppression. A parent or any other person who is legally liable to maintain a child or contribute towards the maintenance of the child is duty-bound to supply the necessities of health, life, education and reasonable shelter for the child (Government of Ghana, 1998). The above issues raised may be quite general; however, the Act 560 is quite explicit on some specific issues bordering sexual and reproductive health rights. For example, issues of consent to marriage or forced marriage where no person shall force a child to be betrothed; to be the subject of a dowry transaction; or to be married, are addressed.

In addition to the Constitution and statutes, other instruments such as case laws, court rules, and ethical rules do inform the role of counsel in the



representation of the child in the law court and advocacy on behalf of the child. According to the key actions adopted by the 21<sup>st</sup> special session of the General Assembly, 1999 the implementation of population and development policies by governments should continue to incorporate reproductive rights in accordance with paragraphs 1.15, 7.3 and 8.25 of the Programme of Action.

The key actions again encourage governments to strengthen as appropriate, the reproductive and sexual health as well as the reproductive rights development policies and programmes. Also, governments should ensure the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care. Above all, countries should establish mechanisms for consultation with all relevant groups, including women's organisations. In this context, governments are urged to incorporate human rights into both formal and informal education processes.

### **Reproductive health policies and programmes**

Several international, regional and national documents recognize the need to protect children and guarantee their right to life and survival, including their sexual health. For instance, article 10 (3) of the international Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), article 34 of the Convention on the Rights of the Child (CRC), and article 18 (3) of the African Charter on Human and Peoples' Rights all provide solid foundations for the Cairo's Programme and the Beijing's Platform (UN, 2003). In particular, the CRC states inter alia, that "the state shall protect children from sexual exploitation

and abuse, including prostitution and pornography” (Adedoyin & Adegoke, 1995), and against this background, various national policies call for appropriate legislation to discourage and punish people who put adolescents in the family way.

According to Tsui, Wasserheit and Haaga (1997), Policies and programmes to promote healthy sexuality on the dimensions of freedom from violence, the right to refuse unwanted sexual relations and the ability to seek to express and to enjoy one’s sexuality can be divided into three broad types:

- policies and programmes that increase the information and knowledge base needed to promote reproductive health, including the need to collect more information, as well as the need to disseminate such information to those who need and can use it;
- policies and programmes that provide individuals the means to achieve such healthy sexuality; and
- policies and programmes that provide the social, legal, and community support needed to prevent sexual violence as well as to protect and treat the victims of such violence.

Culturally-appropriate interventions are needed at a variety of levels: social and political structures, norms, communities, families, couples, and individuals. The extent to which each of these levels is involved in protecting healthy sexuality is culture and situation specific (Wouhabe, 2007).

In formulating the Adolescent Sexual and Reproductive Health Policy, it was recognized that young people constitute a major potential for socio-economic

development in every country (National Population Council [NPC], 2000). Creating an acceptable atmosphere for adolescents to learn about transition to adulthood is one of the central issues. The policy recognizes that values, attitudes and behaviours for promoting positive living, including those on reproductive health, are first formed at the adolescent stage. Therefore, educating adolescents and young adults on sexual and reproductive health has the benefit of contributing to the well-being of the members of the society as well as helping them to develop their potentials. Thus, the policy responds to the government's responsibilities towards the development of population policies as indicated in Article 37(4) of the 1992 Constitution which states that “the State shall maintain a population policy consistent with the aspirations and development needs and objectives of Ghana (Government of Ghana, 1992).

Furthermore, the medium term objective of the Government of Ghana, as stated in the Vision 2020 document, is to achieve a middle income status by the year 2020. The objectives of such a vision can be achieved by harnessing the human resources of the country, particularly young people”. This is in line with objective 4.3.7 of the 1994 National Population Policy which seeks “to educate the youth on population matters which directly affect them such as sexual relationships, fertility regulation, adolescent health, marriage and childbearing, in order to guide them towards responsible parenthood and small family sizes” (section 4.3.7).

The premise is that the adolescents have the capacity to respond to developmental processes when their needs are met, including reproductive health.

Every individual or couple has the right to information and services on population and health issues, and this includes reproductive health. Adolescents are a heterogeneous group: there are young ones under 15 years; there are those who have had sex before but not married, and those in casual or permanent sexual relationships. The policy therefore, admits the need for services such as information and counseling for those who are not sexually active and family planning services and counseling for those who are in sexual unions. To meet the needs and aspirations of the clientele, the services should be comprehensive, reliable and user-friendly.

The Adolescent Sexual and Reproductive Policy admits that the social and economic consequences of poor adolescent reproductive health manifest themselves at two levels: individual and societal (NPC, 2000). At the individual level, early marriage and early motherhood can severely curtail one's education and employment opportunities and are likely to have long term adverse impacts on their own and their children's quality of life. Adolescents who become pregnant while in school dropout and the education of those who wish to continue is interrupted while some feel too ashamed to go back to school. This adversely affects the social, intellectual and economic development of adolescents, especially girls. At the societal level, poor adolescent reproductive health leads to a less healthy, less educated, and consequently, less productive work force that cannot contribute its full potential to the socio-economic development of the country (NPC, 2000). Therefore, it is important to address the sexual and

reproductive health needs of adolescents and young adults as part of overall socio-economic development.

The policy complements a number of existing national policies and action plans which specifically address the needs of adolescents. Among them are aspects of the 1992 Fourth Republic Constitution of Ghana, the Vision 2020 Document, the National Population Policy, the National Youth Policy, the National HIV/AIDS policy, and the National Health Policy as well as some of the national laws and by-laws passed by District and Metropolitan Assemblies such as those on teenage pregnancies, marriage and child abuse (NPC, 2000).

After 25 years of its implementation, Ghana's National Population Policy was revised in 1994. The revision took into account emerging issues such as HIV/AIDS, population and the environment, concerns about the elderly and children, and the development of new strategies to ensure achievement of the revised policy objectives. The revision of population policy also entailed concerted effort to systematically integrate population variables in all areas of development planning (GSS et al, 2008). The major goals of the revised population policy include:

- Reducing the total fertility rate from 5.5 in 1993 to 5.0 by the year 2000, 4.0 by 2010, and 3.0 by 2020.
- Reducing the population growth rate from about 3 percent per annum to 1.5 percent by the year 2020; and
- Increasing life expectancy from the current level of 58 years, to 65 years by 2010, and to 70 years by 2020 (Government of Ghana, 1994).

The attainment of these population goals is recognized as an integral component of the national strategy to accelerate economic development, eradicate poverty, and enhance the quality of life of all Ghanaians. The National Population Council and its Secretariat were established in 1992 as the highest statutory body to advise the government on population related issues as well as to facilitate, monitor, coordinate, and evaluate the implementation of population programmes.

In collaboration with the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), the World Bank, and other development partners, Ghana has implemented several projects aimed at reducing reproductive health problems in the population. Support from these agencies has targeted policy coordination, implementation, and service delivery.

The priority areas identified include addressing the problems of HIV/AIDS and other sexually transmitted infections (STIs), malaria, tuberculosis, reproductive health, maternal and child health, accidents and emergencies, and specialized services (Ghana Health Service [GHS], 2006). Emphasis is also being placed on preventive as well as community-based health care services. This has necessitated the introduction of the Community-based Health Planning and Services (CHPS) programme in which trained nurses are stationed in selected communities to provide health care services to the people of the community (GHS).

The scare associated with the spread of HIV/AIDS attracted considerable attention from the government and its development partners. The government set up the National AIDS Commission to oversee the implementation of HIV/AIDS programmes using a multi-dimensional approach. This was to ensure that

HIV/AIDS prevention education, treatment, care and support reached every corner of the country. The Ghana Health Service also set up the National AIDS Control Programme (NACP) to offer HIV/AIDS prevention education and services. The combined efforts of all stakeholders ensured the implementation of the Ghana HIV/AIDS Strategic Framework 2001-2005 (World Bank, 2003). This collaborative effort had a positive impact and in 2003 only two percent of Ghanaian adults had contracted HIV (Ghana Statistical Service [GSS], Noguchi Memorial Institute for Medical Research [NMIMR] & ORC Macro, 2004).

### **Some rights-related reproductive health issues**

#### **Forced sex and sexual violence**

Gender-based violence has an obvious impact on people's control over their sexuality and therefore their sexual health. The negative consequences of violence that have a direct bearing on reproductive health include physical injuries, STIs, pelvic inflammatory disease, unwanted pregnancy, and unsafe abortion or miscarriage – as well as the mental or psychological aspects of sexuality, such as depression, anxiety, and sexual dysfunction (Heise, Moore & Toubia, 1995; Heise, 1998).

The fear of domestic violence can make a woman unable to negotiate condom use or practice contraception if, for example, she fears accusations of infidelity (Folch-Lyon, Macorra & Shearer, 1981; Fort, 1989). Rape changes a woman's relationship with her partner and her family, thus a serious consequence for her social or economic status. The social and psychological consequences are particularly negative because most acts of violence against women, including

rape, are committed not by strangers but by persons known to the victim, especially family members (Heise et al, 1995; Heise, 1998). The issue of forced sex or sexual coercion though occurs among adolescents, is seldom reported due to its sensitive nature. In the 2004 National Adolescent Sexual and Reproductive Health Survey, 16% of females and 7% of males aged 15–19 years reported that they had ever been physically forced, hurt or threatened into having sexual intercourse. Perpetrators of sexual coercion often range from acquaintances, friends, strangers and even relatives, school mates and teachers (Awusabo-Asare et al, 2004). In a study of in-school and out-of-school adolescents in Dodowa, evidence from the focus group discussions, further reinforced by quantitative data, suggested that forced sex was a common phenomenon. Thirty-three percent of 86 sexually active females reported ever having been forced to have sex (Afenyadu & Goparaju, 2003).

In a study of eight hundred 16-17 year-olds in South Africa, girls had significantly more than boys experienced various forms of sexual abuse and violence. Seventeen percent of the girls reported having been raped, 13% sexually molested, 7% having had sexual experience with relatives and 21% having experienced physical violence with a partner (Reddy, Panday & Swart, 2003). Sexual violence and coercion are widespread problems and have serious health consequences. High priorities in every society should be identification and removal of barriers to victims' access to the law enforcement system and creation of support services for victims (Office for the High Commissioner for Human Rights, 2001).



Though the concept of rape of a spouse has been defined under legal codes in some areas, husbands have been considered to have unlimited right to sexual relationships with their wives in most cultures. Even separation or divorce may not always limit men's right of sexual access. For example, some Latin American studies suggest that once a woman has been "possessed" by a man at one point, she loses her right to refuse sexual relationships with him (Pick, Givaudan & Aldaz, 1996). However, there is currently some evidence that in many parts of Africa, the fear of infection is slowly becoming a legitimate ground for refusing sexual relations, most likely due to the increasing prevalence and awareness of HIV infection (Awusabo-Asare, Anarfi & Agyeman, 1993; Orubuloye, Caldwell & Caldwell 1993). Healthy sexuality in the more positive sense of access to sexual relations can be thought of under three separate aspects: control over when sexual activity starts, control over the choice of one's sexual partner, and control over the frequency or intensity of sexual activity.

### **Abortion**

Pregnancy entails profound physical, psychological, and long-lasting consequences for a woman. A woman's freedoms are significantly restricted if she is forced to carry a pregnancy to term. Every pregnancy carries some risk, even normal healthy ones. According to McDonagh (2005), full-term pregnancy and childbirth has a complication rate 25 times that of early abortion, and a risk of maternal death that is 10 times higher than early abortion. This notwithstanding, unsafe abortion causes an estimated 13% of all maternal deaths globally, and 20-

30% result in Reproductive Tract Infections (RTIs), many of which result in infertility (WHO 2004), and an estimated 220,000 children lose their mothers each year due to unsafe abortions (Vlassoff, 2004; Vlassoff, Singh, Darroch, Carbone & Bernstein, 2004). Practically all of these deaths are avoidable by providing women with access to legal, unrestricted safe abortion. The public health arguments for promoting safe abortion, as well as provision of post-abortion treatment and care are strong – for example in South Africa, abortion-related deaths dropped by 91% from 1994 to 2001, during which period abortion was legalized and made available on request (Thomson, 1986; Grimes, Benson, Singh, Romero, Ganatra, Okonofua & Shah, 2006).

However, mainly due to the influence of the US Christian right and the Vatican, abortion remains illegal or highly restricted in 72 countries, and is punishable by imprisonment in many. The US government in 2001 reintroduced a policy stating that recipients of US family planning funds may only receive funding if they do not engage in most abortion-related activities, even with their own funds (Grimes et al, 2006). In Kenya this has led to the closure of eight reproductive health clinics, leaving at least 9,000 people with little or no access to services. Even in countries where abortion has been legalized, women may still not use services due to stigma, lack of services, and uncertainty about the law (Hirve, 2004; Ganatra & Hirve, 2006).

## **Rights of different groups**

People with alternative sexual identities, or who in some way do not conform to societal norms, face stigma, discrimination and violence, often backed up by repressive laws. This can limit their access to services, for fear of persecution or abuse, or by pushing groups underground so that it is hard to access them with programmes (Berger, 2004). Many religious or cultural traditions pay at least lip service to the idea of male fidelity or to the idea of carefully restrained male infidelity. These social and cultural traditions have implications for the reproductive health of especially women such as increasing their risk of infections. The practices of polygyny, premarital commercial sex, extramarital sex during postpartum abstinence (and during periods that males travel to cities, usually for work) are all at least partly institutionalized in the belief that males need sexual release (Tsui et al, 1997). In contrast, very few cultures have similar beliefs or condoned practices for women who do not have access to regular sexual relations. Women who are unmarried, widowed, or separated from their husbands because of migration are usually expected to have a celibate life.

Because of social conditioning, as well as women's lack of information about female sexuality, most women may be content with restricted sexual expression. Beliefs about female sexuality are strongly connected to notions of shame and honour, which seek to determine how women may express their sexuality and how their activities need constant monitoring to prevent an undue expression of such sexuality. For many women, sex is a burden to be accepted

quietly, or a functional necessity to have children or a commodity to be sold to ensure survival or protection. And for far too many women, sexuality is associated with lack of control, abuse and resounding silence. Overall, far too many women worldwide are denied their right to basic human dignity and bodily integrity.

The concept of sexual and reproductive health rights emerged from the women's movement, and has focused on women's control of their bodies and women's rights. It has unfortunately tended to place blame on men, and this has thus alienated men rather than engaging them, and resulted in the SRH needs of men often not being addressed. The women's rights movement is still a strong player in SRHR, but there is increasingly a call for men's rights. In the middle is a gender equity approach, which aims to achieve equitable access to sexual and reproductive health instead of focusing on either women's or men's rights alone.

Traditionally, sexual and reproductive health programmes have problematised sex, seeing it as something that needs to be controlled in order to avoid negative consequences such as STIs, HIV and unwanted pregnancy. Positive aspects of sex and sexuality, such as pleasure and fulfillment, have been ignored. This has partly resulted from the public health perspective, as well as discomfort in seeing sex for procreation not reproduction. The concept of sexual right brings together both aspects of sexuality, including protection against negative aspects such as disease and discrimination, and promotion of positive aspects. Promotion of sexual rights faces fierce opposition, in particular from religious fundamentalist groups, many of which consider only certain forms of

sexuality to be acceptable – usually heterosexual and within marriage. On the other hand, there are examples of religion engaging positively, such as the ‘Coalition for Sexual and Bodily Rights in Muslim Societies’, which brings together organisations in the Middle East & South East Asia (Pleasure Project, 2006).

## **Theoretical issues**

### **Biogenetic universalism theory**

The psychologist who is generally credited with establishing adolescence as a period of psychological and social development deserving a separated study is G. Stanley Hall. The Biogenetic Universalism Theory of Hall (1904) typifies adolescence as a recapitulation of the militant stage of a man’s evolution characterized by selfishness, resentment and insubordination. Hall and his adherents considered the biological change of puberty to be responsible for many of the peculiar characteristics of the adolescent, accompanied by heightened emotionality and irritability.

Presenting a biological theory of human development, Hall (1904) described adolescence as a time of great “storm and stress”. He depicted adolescence as a transitional period bridging the “savagery” of childhood with “civilized” adulthood. In his view, personal development retraces the social evolution from a savage to a civilized society. As such, adolescence reflects the tumultuous history of humanity arriving at its current civilized state. Adolescents are, thus in a state of flux, alternating between periods of high enthusiasm and utter despair, between energy and lethargy, between altruism and self-

centeredness. These radical shifts of necessity make adolescence a period of storm and stress. The theory held that, development was controlled from within since the period was seen as being inevitably and necessarily determined. Hall's view exerted marked influence on the study of adolescence as a stage in development for many years. However, not all writers agree to normal adolescence as a period of "storm and stress".

In his research, Bandura (1964) found that most young people with whom he had contact were not anxiety ridden and stressful. Bandura felt that the assumption of a tumultuous adolescence was a gross overstatement of fact. Bandura's principal point was that when society presumes adolescence to be a period of radical tension, it runs the risk of creating a self-fulfilling prophecy. Recent views of the storm-and-stress concept again concluded that normal adolescence is not characterized by turmoil (Oldham, 1978; Adelson, 1979).

Repeatedly, researchers have found that the evidence simply does not justify the stereotype of adolescence as any more tumultuous than any other period in life as projected by Hall. The criticisms were that: Hall's biological genetic explanation of behaviour allows no room for the role of the environment since human development is always an interplay of heredity and environment (Conger & Petersen, 1984). In spite of the criticisms, the theory is still applied in some circles. According to Rice (1996), any over generalization about adolescents and adolescents' development is certain to meet with exceptions and qualifications. For some adolescents, the transition to adulthood will be stressful

and tumultuous. For others, the transition will be smooth and pleasant. Not all adolescents are the same.

Indeed, adolescence is still regarded as erratic, deviant or troublesome thus perpetuating Hall's views (Rice, 1996). The biological theorists as championed by Hall see adolescence as a state of great storm and stress due to the bodily changes that occur in the adolescent and the fact that they would be expected to abandon the childish behaviours and assume adult behaviours. These, therefore, put them in a state of flux. Some will have to be guided and directed. It is in view of this that, the study intends to find out what the perception and knowledge of the adolescents are, regarding sexual and reproductive health rights. As to whether these perceptions of adolescents are informed by societal interpretation of their status or are a true reflection of their understanding of rights. Issues about whether an adolescent is to be considered as disrespectful if he or she insists on the sexual and reproductive health rights could be explained by this biogenetic theory.

### **Psychoanalytic theory**

In the view of psychoanalytic theory, adolescence is dominated by a renewed struggle to control sexual impulses. Sigmund Freud's original formulation emphasized the development of an individual through a series of psychosexual stages starting at birth and continuing through adulthood. In his three essays on theory of sexuality, Freud (1958) described adolescence as a period of sexual excitement, anxiety and sometimes of personality disturbance.

The libido theory points to the fact that the peak of sexual development is reached in adolescence. At puberty, the young person starts to move towards adult genital sexuality where oedipal conflicts are reawakened by the rapid increase in the output of sexual hormones. Increasingly, sexual drives are redirected away from parents toward other members of the opposite sex. Freud (1958) felt that frustration of these heightened sexual drives, leads to delinquency and aggression.

In an attempt to achieve balance between the sexual impulses of the “id” and the over control of the “Superego”, the individual develops an “Ego”, which serves to moderate the opposing forces. The ego is the center of personality. A strong “Ego” keeps the forces of domination of one over the other (Freud, 1958). To maintain control, the adolescent draws upon variety of defense mechanisms that help to deal with or dissipate the anxiety. Applying the theory to this study, it could be realized that an individual fixated at the ‘id’ impulse may tend to be overridden by others and not even assert their rights. This may suggest a limited or no effort to know the sexual and reproductive health rights. In a sharp contrast, an adolescent with lots of super ego would seldom allow others to abuse their rights, and may rather impose their sexual values on others. Such instances have an impact on how an individual appreciates and protects his or her sexual and reproductive health rights.

Like Sigmund Freud, Erikson (1968) felt that, failure to resolve conflicts adequately at one stage of development interferes with adjustment at the next and later stages of life. He labels the adolescence stage as one involving a search for identity or a series of identities. The adolescent must accept himself or herself as a



unique person, with strengths and weaknesses. Adolescents become more aware that they control their own destinies, self control, accepting adult responsibilities, and forming personal set of values and vocational goals to follow. That an adolescent has strengths and weaknesses, determine the extent to which one may succumb to, or defy any imposition of sexual decisions. Issues pertaining to when to have sex, the number and spacing of children, the adoption of contraception and raising up of children are significantly dependent on one's ego and this is at the heart of the psychoanalytic theory. At the same time, psychoanalytic theory has as its central focus, the fact that, from a biological point of view, the adaptive function of childhood and child upbringing is the establishment of a stable sexual relationship that will perpetuate the species and provide long-term child upbringing for the generations. This requires a proper balance of power in consensual unions, and will only be probable when people know, appreciate and respect their sexual and reproductive health rights and those of others. This, may however only be probable when people have knowledge of their rights.

### **Theory of reasoned action**

The Theory of Reasoned Action (TRA) was first developed by Ajzen and Fishbein in 1973. It considers that human beings are usually rational in making their decisions and in engaging in a given behaviour, and will therefore act in accordance with their preferences. Intention is a determinant of behaviour, and actions that are not intentional (not under volitional control) will be outside the scope of TRA. The theory recognizes two determinants of intentions: the personal

attitudes affecting the behaviour, and the influence of social pressure in performing or not performing behaviour. TRA has been used to study the individuals' attitude to safe sex (van Landingham, 1993). The theory of reasoned action applies relevantly to a study of adolescents' knowledge of sexual and reproductive health. Since action is an embodiment of intentions and intentions the series of thoughts that emanates from information at one's disposal, knowledge is directly proportional to one's confidence to take actions. Attitudes would reflect an individual's beliefs about their evaluation of for instance, insistence on his or her rights to indivisible sexual and reproductive health rights and reproductive self autonomy. This is represented by a weighted relationship between:

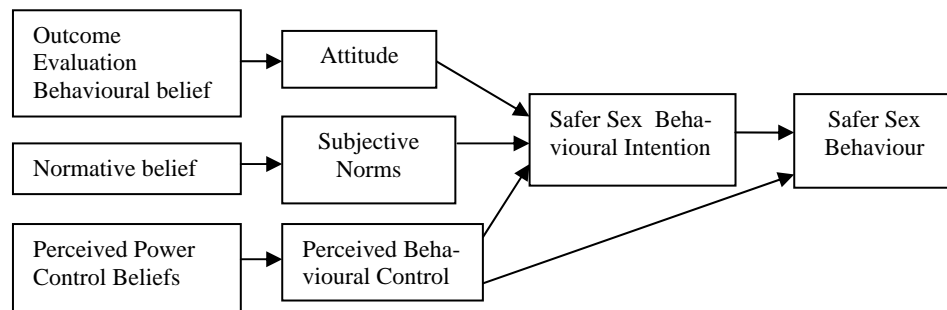
- Behavioural belief that being knowledgeable of, and asserting one's right would result in certain outcome (this would reduce the susceptibility of adolescents to general SRH problems);
- The outcome evaluation of how pleasant or unpleasant the effect of being vulnerable would be as a consequence of non-pursuance of one's rights to reproductive self determination and autonomy;
- The person's normative beliefs, that is the beliefs that specific individuals or groups think he or she should or should not perform the behaviour (whether or not significant others think that being assertive or acting on one's SRH rights is vital for protection against SRH risks); and
- The motivation to comply with the behavioural expectations and

norms of key social figures in their life (the cost of non compliance with, for instance, condom use with their friendship groups).

The authors of the TRA modified it to include Perceived Behavioural Control and named this modified version, the Theory of Planned Behaviour (TPB). Fishbein and Ajzen (1975) based the TPB on the assumptions that:

1. Human beings are rational and make systematic use of information available to them.
2. People consider the implications of their actions before they decide to engage or not engage in certain behaviours.

The relevance of this theory again stems from the fact that the art of knowledge and perception involve a conscious effort at bridging a gap of what one is ignorant about. An individual only seeks knowledge about an issue when such knowledge would eventually help his or her course of action. Here, this theory helps us to identify whether adolescents view sexual and reproductive health rights as being beneficial to bringing about total reproductive well being.



**Figure 1: Theory of planned behaviour**

Source: Fishbein and Ajzen (1975)

## **Theory of sexual interaction**

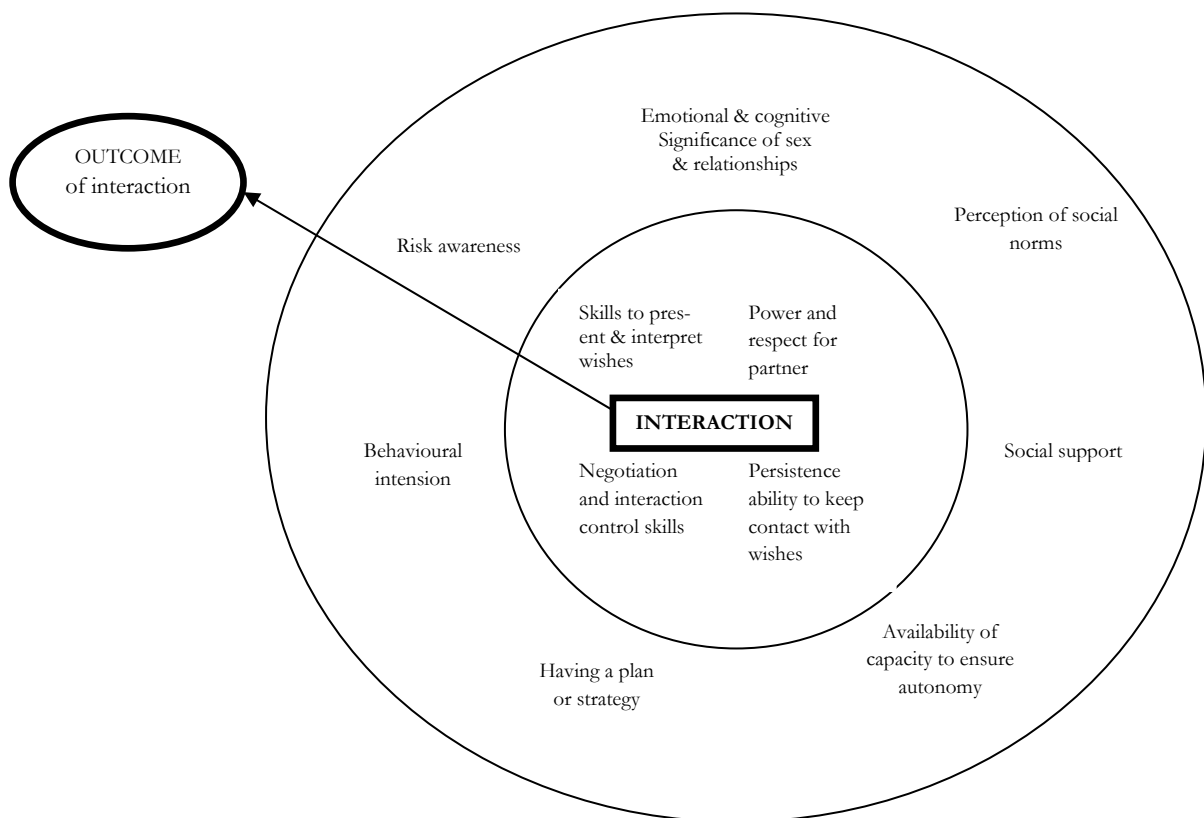
The theory of sexual interaction builds on Planned Behavioural Theory (Fishbein & Ajzen, 1975) which incorporates components of subjective rationales, and John Simons' (1989) loci of causality and control. In it, the Health Belief Model is subsumed by the Planned Behaviour Theory. Provision is made for relationship between the components of the Planned Behavioural Control: loci of control and explanation of outcomes, and for feedback effects from outcome to determinants of intentions. The locus of control refers to the degree of control people perceive to have over events in their lives. While a person with an internal locus of control perceives that events are a consequence of his or her own behaviour, a person with an external locus of control feels that events are beyond his or her own control and are determined by fate, chance or powerful others (Rotter, 1966).

In addition, people's own explanations of the events in their lives have been shown to be valuable for understanding behaviour (Kelley, 1973). In the view of Ingham and van Zessen (1997), to achieve meaningful and lasting change in behavioural support of an enhanced sexual health of populations, there is the need to know how individuals' perceptions, their understanding of social norms and their level of desire to comply with them affect their behaviour. Public health therefore requires individual normative understanding and, crucially, an investment in the reality of individual complexity.

According to the theory of sexual interaction, whatever the individual's intention or behaviour, it is likely to be manifested in beliefs about outcomes and

the expectations of others. For example, the way a person explains or interprets the cause of a particular illness (locus of causality) can influence the way he/she will cope with the disease and the way they will follow proposed treatment or preventive measure. Finally, subjective rationales are powerfully influenced by cultural and material resources. For example, where a community's value orientations emphasize submissiveness, this is likely to be evident in typical power relations in sexual interactions.

In further developing Rademakers and Luijckx's (1992) theory of sexual interaction (as seen in Figure 2), Ingham and Van Zessen (1997) sought to minimize the role of social dimension and to incorporate the interactional process.



**Figure 2: Theory of sexual interaction**

Source: Ingham and Van Zessen (1997)

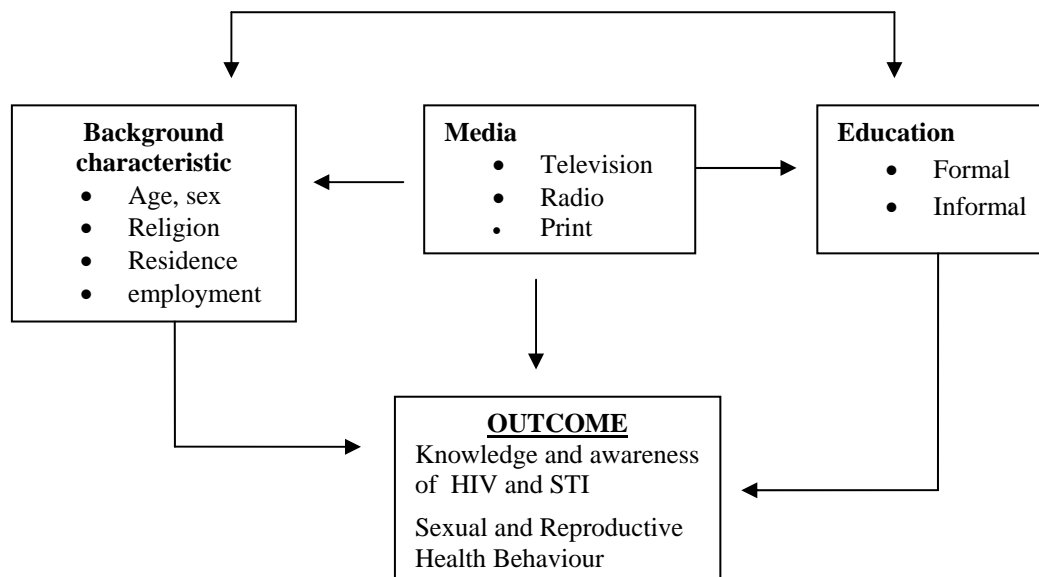
They argue that in the study of sexual behaviour, the object of interest is not the individual decision-making but the interaction itself (see Figure 2). Since individuals enter sexual interactions with all kinds of expectations, plans, desires, capacities and histories, these need to be taken fully into account to the extent that they affect the course of the interaction.

As seen in Figure 2, two layers are distinguished based on the proximity of the factors to the event themselves. As seen graphically, the centre (the arena) is the interaction. The focus of interest is any event described as occurring during the interaction that has any relevance whatsoever to the outcome of interest (safer sex): skill in negotiation, interpretation of wishes, the temporal context and the power and respect for partner. The outer layer contains relevant factors such as risk awareness, behavioural intentions, availability of capacity to ensure autonomy, social support, perception of social norms and economic and cognitive significance of sex and relationships. This theory recognizes the fact that several factors interact to determine adolescents' knowledge, attitude and behaviour towards sexual and reproductive health rights. The individual factors explain the extent to which one has power to determine his or her reproductive autonomy or self-determination. The social or community factors also bring to fore the issues beyond the level of the individual that also determine degree of effectiveness of individual factors. Rademakers and Luijkx (1992) posit that the interactional perspective can be seen as non-hierarchical, as a system of reciprocal determination among macro processes and institutions, social network and dyads, down to the level of the individual.

In a study which seeks to assess the knowledge and perception of adolescents in sexual and reproductive health rights, there is the need to employ an all-encompassing theory which incorporates the various dimensions of how knowledge and perception about rights influences respondents' level of risk aversion ability. It is for the reason of its strengths that the theory of sexual interaction is chosen above all others.

### Conceptual framework

The study is modeled on a conceptual framework designed by Wouhabe (2007) in a study conducted to determine the extent of sexual activity, knowledge and awareness of HIV/AIDS and other STIs, and to examine the influences of socio-demographic factors on sexual behaviour of single youth in Ethiopia (see Figure 3). This model is preferable because of the non-hierarchical nature of the

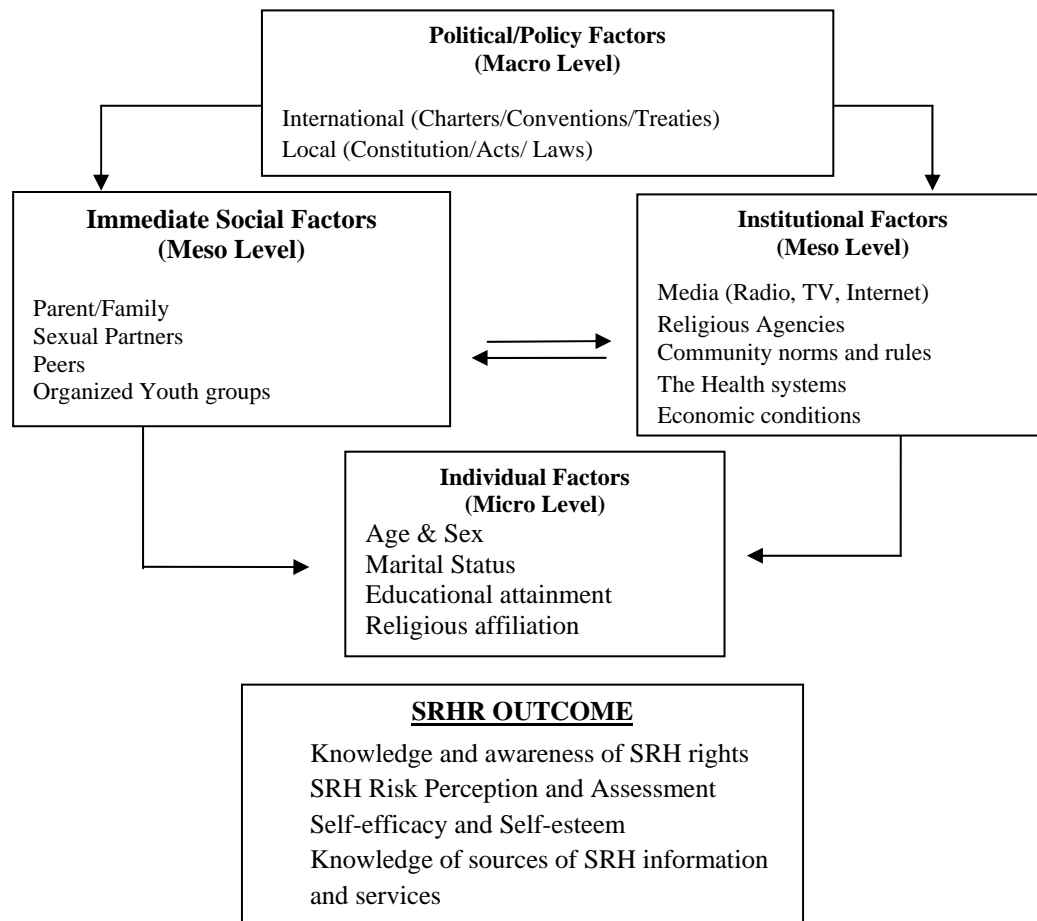


**Figure 3: STI/HIV/AIDS knowledge and awareness framework**

Source: Wouhabe (2007)

process and institutions down to the individual level, making it possible to be situated within the theory of sexual interaction. The framework shows the interplay between explanatory variables (biographic characteristics, media and education) and outcome variables studied (knowledge and awareness of HIV and STI and SRH Behaviour).

The conceptual model is modified for the purpose of this study which seeks to explore the knowledge and perception of adolescents on sexual and reproductive health rights issues. It portrays the interplay of individual, societal,



**Figure 4: Conceptual framework for knowledge and perception of sexual and reproductive health rights.**

Adapted from Wouhabe (2007)



institutional and political factors which clearly bring about sexual and reproductive health right outcomes as shown in figure 4. That is, the model is adapted to accommodate issues that relate perfectly with the Yamoransa community where the study was carried out. As shown in Figure 4, the explanatory or independent variables are the individual, societal, institutional and political factors. The individual factors consist of age and sex (which are beyond his or her control), as well as others within his volitional control such as religious affiliation, educational attainment, marital status, occupation or employment and residence. These factors influence one's level of knowledge and perception of sexual and reproductive health rights issues either in the negative or positive sense.

Operating at the meso level are the social and institutional factors. Among the social factors are the individual's family background (parents or legal guardian) including their educational attainment and occupational status. Here, the adolescent's sexual partners as well as peers become influential in their knowledge and perception of sexual and reproductive health rights. The existence or otherwise of youth groups and associations in the community of the adolescent also determines the awareness level of the adolescents. The framework again captures the media (radio, television, newspapers, and internet), religious agencies, community norms and values, the health systems and economic conditions among others, as institutional factors operating at the meso level, to determine the individual's level of knowledge of sexual and reproductive. Much as institutional factors are most often outside the manipulation or control of the

individual, they directly or indirectly provide information on sexual and reproductive health rights.

Completing this interactive framework are the political factors at the macro level. These include local and international policies such as the constitution of a country and the various charters and agreements that a state signs up to and enforces. Such policies, though appear binding on a nation, are seldom implemented to the letter due to inadequate funds and lack of political will. As discussed earlier, Ghana apart from its National Constitution has a number of policies, Acts and charters which hover on the Sexual and Reproductive well-being of the adolescent. Such policies often affect the regime of adolescents' sexual and reproductive health at the individual level. For example the right to seek, receive and impart information relating to sexuality enjoins all countries to make available the necessary information that citizens need to make the best of reproductive health decisions (WHO, 2002). When this is strictly adhered to, it affords the adolescent wide options to make the best choice. The individual's knowledge and perception of sexual and reproductive health rights issues are dependent on these explanatory factors. Thus they contribute to, or determine the individual's level of Knowledge and awareness of SRHR, his or her SRH risk perception, assessment and aversion, self-efficacy, self-esteem and knowledge and evaluation of the sources of SRH information and services.

## **CHAPTER THREE**

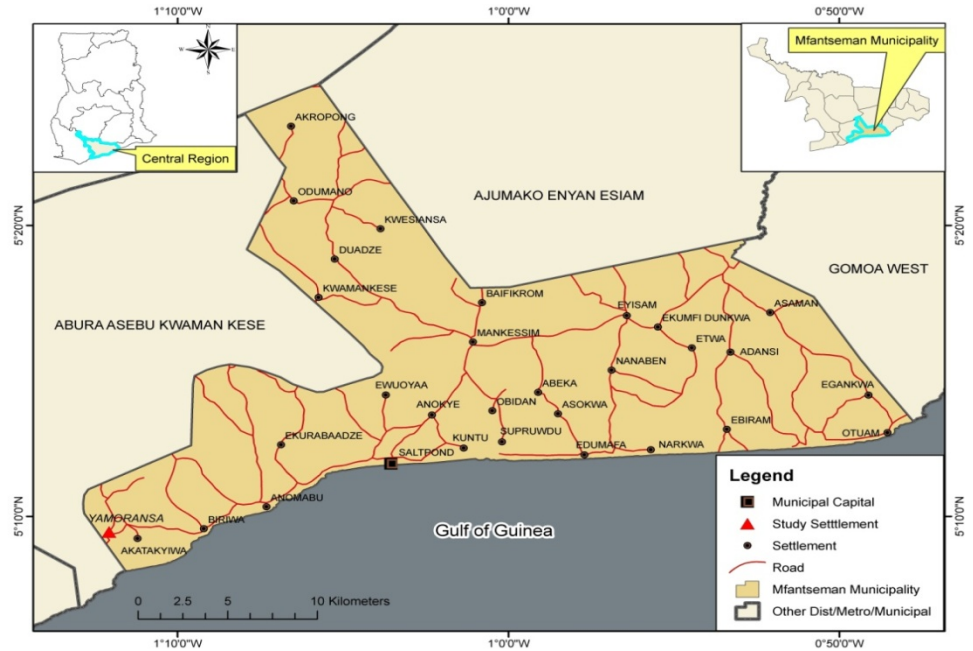
### **METHODOLOGY**

#### **Introduction**

This chapter outlines the study area and considers issues such as the physical description, the population and socio-economic activities. Other issues considered in this chapter include the sources of data, target population, sample size, instruments, sampling techniques, methods of data collection, data processing and analysis, and issues from the field.

#### **Study area**

The study was conducted in Yamoransa in the Mfantseman Municipality. 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. The municipal capital is Saltpond. Mfantseman 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 (Figure 5) (Mfantseman Municipal Assembly, 2008).



**Figure 5: Map of Mfantseman Municipality showing the study area**

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

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. Annual totals of rainfall range between 90cm and 110cm in the Coastal Savanna areas and between 110 cm and 160cm in the interior close to the margin of the forest zone. The periods December – February and July – early September are much drier than the rest of the year (Mfantseman Municipal Assembly, 2008).

Largely, the Mfantseman community is drained by a number of rivers and streams including the Narkwa, Amisa (Ochi) and Bruka; and this directly or

indirectly affects the drainage characteristics of Yamoransa (since other smaller streams in here serve as tributaries of these bigger streams and rivers). The rivers Narkwa and Amisa drain into the sea via the Narkwa and Amisa lagoons at Narkwa and Amisano respectively. The other rivers in the area are the Nkaasu, which empties into the Atufa lagoon in Saltpond, and Aworaba which drains into Entsi lagoon in Kormantse. Other lagoons in the area are the Eko near Anomabu, the Egya at Egyaa and Kwazinze at Kormantse into which flow small streams and rivulets (Mfantseman Municipal Assembly, 2008).

Yamoransa is made up of dense scrub tangle and grass, which grow to an average height of 4.5m. It is believed that the Municipality was once forested, but has been systematically destroyed through centuries of bad environmental practices such as bush fires and deforestation among others. However, pockets of relatively dense forest can be found around fetish groves and isolated areas. The physical characteristics in the municipality as well as its location along the Trans-West African Highway have combined effectively to offer opportunities in agriculture (farming and fishing), light industry and trading to residents of Yamoransa. Farming, fishing, Trading, bakery, Driving, Mining and quarrying constitute the main economic activities of the Community, employing about three-quarters of the total workforce (Ghana Statistical Service [GSS], 2002).

According to Mfantseman Municipal Assembly (2008), farming is done in almost all in and around the fringes of Yamoransa, and crops cultivated include cocoa, oil palm, pineapple, oranges, plantain, maize and cassava. Fishing is done mainly along the coast in settlements such as Biriwa, Anomabo, Otuam, Abandze,

and Kormantse, away from Yamoransa though, but is still an important economic activity to the survival of residents. Residents of Yamoransa who engage in the fishing activities commute among these towns to ply their trade. Women typically engage in the processing and marketing of fish.

Also, mining and other extractive activities such as quarrying, sand winning in the municipality provide a source of employment for residents of Yamoransa. Significant among them are the exploitation of kaolin for building, ceramic materials, talc, granite and silica. Trading, as an important economic activity is carried out with Mankessim as a major focal point, and involves produce from farming, fishing, and bakery. There is also the processing of foods such as sugarcane into local gin, cassava into Gari and Oil Palm into cooking oil. The strategic location of Yamoransa along the Trans-West African Highway and as a link to the Northern corridors of the country (Ashanti, Brong Ahafo and Northern Ghana) lends it the experiencing of brisk business.

### **Study design**

This study was situated within the Quantitative methodology. It employed a cross-sectional design. A subset of the target population (adolescents of ages 15-19 years) was studied simultaneously within a short period of time. Here, an unbiased sample of the target population was selected and asked to complete questionnaires.

This allowed for the various features – age, sex, religion, education – to be compared, with respect to independent variables. The use of cross-sectional study

design was aimed at eliciting information as to which specific factors under the broad factors of social, economic, cultural and institutional factors contribute most to adolescents' knowledge and perception in sexual and reproductive health rights. With this design, the instrument of data collection was easily applied to elicit the underlying factors within respondents' immediate environment as well as external factors as discussed in the HIV/AIDS knowledge and awareness framework (Wouhabe, 2007).

Babbie (1990) recommends the suitability of this design for purposes of making generalizations from a sample to a population. This is to facilitate inferences to be made about some characteristics, attributes or behaviours of the population. The choice of this study design is due to the fact that it enables the researcher make generalizations about the entire population. According to Gay (1992), cross-sectional design involves collecting data in order to test hypotheses or answer questions concerning the current status of the participants of the study. It determines and reports the way things are. In the views of Fraenkel and Wallen (2000), obtaining answers from a large group of people to a set of carefully designed and administered questions, lies at the heart of cross sectional design. It is used with greater confidence with regard to particular questions of special interests or values to a researcher.

### **Data and sources**

The study relied on two major sources of data – primary and secondary sources of data. With respect to the primary source of data, the study adopted a more current data of the study area that was collected by the Department of

Population and Health, University of Cape Coast. The Department undertook a census of the entire Yamoransa community from 23<sup>rd</sup> to 30<sup>th</sup> May, 2010 (Department of Population and Health, 2010). This data was used since it reveals figures that are more up to date than those from the 2000 Population and Housing Census conducted by the Ghana Statistical Service so long as Yamoransa town is concerned. Also, it was the most current because results from the 2010 Population and Housing Census were not readily available during the period of the study. According to the data, Yamoransa has a total population of 5,283 comprising 2,416 males and 2,867 females. Adolescents of ages 15 to 19 years, who constitu-

**Table 1: Age structure of Yamoransa’s population**

| Age group    | All         | Males       | Female      |
|--------------|-------------|-------------|-------------|
| 0-4          | 729         | 343         | 386         |
| 5-9          | 683         | 338         | 345         |
| 10-14        | 749         | 377         | 372         |
| 15-19        | 608         | 297         | 311         |
| 20-24        | 458         | 211         | 247         |
| 25-29        | 416         | 169         | 247         |
| 30-34        | 325         | 130         | 195         |
| 35-39        | 296         | 118         | 188         |
| 40-44        | 222         | 102         | 120         |
| 45-49        | 216         | 78          | 138         |
| 50-54        | 148         | 56          | 92          |
| 55-59        | 135         | 58          | 77          |
| 60-64        | 79          | 38          | 39          |
| 65+          | 232         | 82          | 150         |
| <b>Total</b> | <b>5283</b> | <b>2416</b> | <b>2867</b> |

Source: Department of Population and Health (2010)



ted the target population, were 608. Of this, 296 representing 48.7% were males whereas 312 (51.3%) were females (Department of Population and Health, 2010). From the settlement pattern, Yamoransa could be said to be a peri-urban locality with a dense settlement pattern. These figures, as shown in Table 1, are what informed the choice of the sample size and sampling procedure.

In a study to assess the knowledge and perception of adolescents of sexual and reproductive rights, 15- 19 year olds were chosen due to their peculiar characteristics. Physically, this period of late adolescence is where most youth have entered or completed puberty. Here, many youth would have achieved their full adult height and other adult physical development milestones. This is a period of major broadening of thinking abilities where many can think abstractly and hypothetically, can discern the underlying principles of various phenomena and also applies them to new situations (Freud, 1958). They can as well think about the future, considering many options and logical outcomes of possible events. There is also a greater perspective-taking ability which can result in increased empathy and concern for others, and new interest in societal issues for many. It is also worth noting that the process of identity formation is intense in this period. Experimentation with different roles: looks, sexuality, values, friendships, and especially occupations. Peers help youth explore and develop own identity and cross-gender friendships become more common (Awusabo-Asare et al, 2004).

Secondary sources for the study were obtained from the 2000 Population and Housing Census (GSS, 2002), and the Department of Population and Health Baseline Enumeration of Yamoransa which contains a list of all residents in the

community as well as their demographic characteristics up to 2010. Other relevant books, journals and internet resources on issues of adolescents' sexual and reproductive health rights were also accessed for the study.

### **Target population and sample size**

The study population consists of adolescents aged 15 to 19 years. Sample size refers to basic questions such as: how large or small the sample must be for it to be representative (Sarantakos, 1998). Choosing the right sample size is a major issue that often confronts social investigators. This study adopted the Fisher, Laing, Stoeckel and Townsend (1998) formula for determining sample size. This formula was used because the target population had similar features in terms of residence and age group. As earlier described, respondents reside in Yamoransa and belong to the 15-19 years old group. The formula is given as;

$$n = \frac{z^2 pq}{d^2}$$

Where:

n= the desired sample size

z= the standard normal deviation, usually set at 1.96 which corresponds to 95 percent confidence level;

p= the proportion in the target population estimated to have particular characteristics (in this case adolescents of ages 15-19 years);

q= 1 – p; and

d= degree of accuracy desired, usually set at 0.05

Assuming the study targets 85% of adolescents 15 – 19 years with a similar characteristics who are able to participate in the study which is equivalent to 0.85, with the z statistic being 1.96 and the degree of accuracy set at 0.05%, then the sample size (n) is found to be as follows:

$$n = \frac{(1.96)^2 (0.85) (0.15)}{0.05^2}$$
$$n = 195.9216$$

Hence an estimated sample size (n) of 196 respondents is arrived at. However, as a safety net against non-response, ten percent of the sample size which translates into about twenty (20) respondents was added, bringing the number of respondents to 216. This selection forms a 32.9% of late adolescents (the target population). 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).

### **Research instrument**

The study adapted the procedures used by Awusabo-Asare, Kumi-Kyereme and Abane (2004) in the Ghana Adolescents' Sexual and Reproductive Health Survey (from the Guttmacher Institute) to develop the questionnaire. The items were thoroughly vetted and edited to ensure content validity and reliability. The appropriate suggestions and comments on the meaningfulness and representativeness of the items by the supervisor as well as several lecturers of the department ensured that the content validity of the questionnaire was established and upheld.

The questionnaire had two sections consisting of 46 major items (with some sub-items). The items in Section 'A' elicited information on the background characteristics of the respondents. Factors emphasized in this section include demographic, educational and socio-economic background.

Section 'B' was composed of items bringing forth respondents' experiences, knowledge, views and perception on sexual and reproductive health rights issues. The section was made up of subsections such as respondents' knowledge and perceptions about sexual and reproductive health, issues about rights and some of their experiences about sexual and reproductive health rights infringements.

The questionnaire comprised both close and open-ended questions. The close-ended questions were used to ensure uniformity and more effective comparison between responses given by the various participants. These check-mark answers could easily be coded and tabulated. The open-ended questions, because of their unrestricted and free flow nature gave greater depth of response from the respondents' own words. Open-ended questions allowed free-vent for adolescent's views as far as sexual and reproductive health rights are concerned. They also helped to eliminate the frustration that close-ended questions tend to foster among respondents.

According to Kerlinger (1986), if questionnaire are properly developed to answer research questions, it is very effective for securing factual information about practices and conditions of which the respondents are presumed to have knowledge. Again, if properly understood and implemented, this tool simplifies

the stage of the data analysis. This is because the information obtained is already well organized. Furthermore, the questionnaire has a higher degree of transparency or accountability. The methods and procedures in a questionnaire design can be made available to other parties for assessment.

### **Sampling procedure**

The study used the proportional stratified sampling method to select prospective respondents. According to Sarantakos (2005), 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. The sum of the respective strata makes up the final sample of the study. The strength of this procedure is that it allows all population groups to be represented in the final sample. The division of the population into strata is based on one or more significant criteria, such as sex, age, ethnic background, race or economic status.

For this particular study, sex was the criterion for the division of the population into strata. For each stratum, simple random sampling was used to arrive at the proportionate sample size. Thus the percentage allotted to each stratum took into consideration the size of the strata. In order to reflect the sex composition of the target population, this sample size was disaggregated into the respective male and female population. Thus, 111 females were selected from 312 females (representing 51.3%) and 105 males from 296 males (representing 48.7%), making up a total sample size of 216 respondents. Respondents were then selected from each stratum through a simple random sampling until the required

sample size was reached. This was done through the lottery method where the list of all prospective eligible respondents were written on pieces of paper, folded and shuffled in a container and later picked blindly at random. This technique was adopted to give every eligible adolescent an equal opportunity of being selected. It was upon a successful completion of this process that, field assistants were trained to undertake the pretesting of the instruments.

### **Pre-test**

A pretest was carried out in Akotokyire, a village on the fringes of University of Cape Coast on April 5, 2010. This community was chosen because it had similar demographic and physical features as the study area. The essence of this exercise was to pretest the efficiency and practicability of the research instruments and as well, test the content validity. After this exercise, the questionnaire was reviewed to accommodate issues that emerged.

### **Data collection**

The main method of data collection was questionnaire. This is a data collection method where a predefined set of questions are administered on respondents to elicit specific responses from them and also, for enquiring into opinions and attitudes of the respondents.

The questionnaires were administered from April 15 to 19, 2011. Out of the 216 respondents earmarked for the study, 209 responded representing a 96.8% response rate. Where an eligible adolescent was not present in a house the next

household was turned to but a reminder card was placed in order for the researcher to return later. In accordance with human research ethics, and also, to re-assure respondents of anonymity, as well as to win their confidence, no names were requested (Kahn, Mastroianni & Sugarman, 1998).

### **Community entry**

The Yamoransa Community was visited to inform the appropriate authorities (Assembly woman, some sub chiefs and religious leaders) and formally ask for their permission and support. There was an initial visit to the various sub-localities in the Yamoransa Township to acquaint with how the field process would be efficiently carried out.

### **Challenges encountered in field work**

An interesting issue that emerged from the administration of the questionnaire was when field assistants were mistaken for peddlers of leaked examination questions. The questionnaires administration coincided with the Basic Education Certificate Examination (BECE) period, hence the grounds for this suspicion. This was however dispelled due to the kind co-operation of elders of the town, especially the Assembly woman.

Again, due to a lack of proper lay-out of the town, identifying respondents' places of residence was very difficult. Issues to do with unwillingness to participate, non-response and demand for reward before

participation were however foreseen and thus, managed appropriately by convincing them thoroughly about our identity and what our purpose was.

### **Ethical issues**

The consent of respondents was thoroughly sought before their involvement in the study. With respect to the adolescents under the ages of 18, the consent of their parents was sought.

Confidentiality was adhered to throughout the data collection period and analysis to the end of the study. In accordance with the assurances given by the researcher, all personal details of the respondents were kept between the two parties.

### **Data processing and analysis**

All the 209 questionnaires were edited for any inconsistencies, and serially coded, after which the Statistical Product and Service Solutions (SPSS) software Version 16 was used for data entry and analysis. The main tools used for the analysis were tables, measures of central tendency and charts or figures.

The chi square ( $\chi^2$ ) statistic was used to test the hypothesis stated. This test statistic was deemed appropriate since the data the variables were categorical as well as the values being absolute. The rationale was to bring out the various factors in the independent variable and measure their effect on the dependent variable. The dependent variable is 'knowledge of sexual and reproductive health rights' and the independent variables are socio-economic background



characteristics. This tool was able to bring out the effects that socio-economic factors (independent variables) such as age, sex, education and religion have on the level of adolescents' knowledge and perception (the dependent variable) on some dimensions of sexual and reproductive health rights.

## **CHAPTER FOUR**

### **RESULTS AND DISCUSSION**

#### **Introduction**

This chapter deals with the various issues that emerged from the field concerning adolescents' knowledge and perception on sexual and reproductive health rights (SRHR). Issues covered include the background of the respondents, transitional arrangements for adolescents into adulthood, adolescents' knowledge of sexual and reproductive health, as well as knowledge and perception on issues about SRH rights.

#### **Socio-demographic background characteristics of respondents**

The socio-demographic variables covered in the study include age, sex, marital status, religion, ethnicity, educational level and living arrangements. The study, as shown in Table 2, covered 101 males and 108 females representing 48.3% and 51.7% respectively. Respondents aged 17-18 years constitute more than 35%, with those aged 19 years and 15-16 years constituting 32.5% and 32.1% respectively. Respondents aged 19 years constitute the highest (32.5%) proportion of all the respondents whereas half this number (15.8%) was aged 16 years, constituting the least.

Table 2 again depicts that the majority of the respondents were Christians (85% females and 74% males) with about 19% males and 12% females belonging

to Islam. A few respondents (7% of males and 3% of females) practiced African Traditional Religion. According to Mbiti (1975), religion remains a very significant feature since it informs the values, norms, mores, beliefs and practices of a given people. As such, in investigating the knowledge and perception of adolescents, the religious dimensions was covered in order to assess the overall role it plays.

Ethnic groupings are a collection of individuals and families who share a common cultural practices and ancestral roots (Smith, 1987). The population of Ghana includes dozens of ethnic groups that speak approximately 44 languages. From the study, the majority of respondents (69.3% males and 69.4% females respectively) were Fantes. Ewes (2.8%) were the ethnic groups with the least proportion of respondent for males and females respectively as shown by the Table 2.

More than 46% of males were at the Senior High School (SHS) level whereas a greater proportion of females (47%) were at the Junior High School (JHS) level. Over a tenth of males and 7% of females were at the tertiary level.

It also emerged that 48.5% males were living with both parents. This living arrangement was very dominant among males where nearly three out of five 19 year old male respondents lived with both parents. For females, the usual living arrangement was with their mothers. About two out of five females lived with their mothers only. No male respondent was living with the sexual partner in contrast to 6.5% of female respondents. It is also worthy of note that nearly a fifth of male respondents aged 19 years were living alone.

It could also be seen from Table 2 that almost all the respondents interviewed had never married (98.0% males and 90.7% females). Only about 8% females were married.

Young people are important demographic group; and according to WHO (2009), there are approximately 1.2 billion young people in the world with 85% of them living in developing countries. The demographic importance of the 15 to 19 year olds is expected to increase in the 21st century as its numbers continue to grow. In reference to the framework for knowledge and awareness of STI/HIVAIDS adapted for this study (Wouhabe, 2007); the individual factors represented here are age, sex, marital status, educational attainment, religious affiliation and ethnicity. Of these, age, sex and ethnicity are beyond the volitional control of the individual. Age, for example, is an important variable in any meaningful research, especially in the field of Sexual and reproductive health.

Though individual needs differ at each stage of life, there is a cumulative effect across the life course of events at each phase having important implications for future well-being (World Bank, 2007). Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems.

**Table 2: Socio-demographic characteristics of respondents**

| Characteristics       | 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    |
| <b>Religion</b>       |       |       |       |       |       |       |         |       |       |       |       |       |
| 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   |
| <b>Ethnicity</b>      |       |       |       |       |       |       |         |       |       |       |       |       |
| 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  |
| <b>Marital Status</b> |       |       |       |       |       |       |         |       |       |       |       |       |
| 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   |

**Table 2 continued**

## Living arrangement

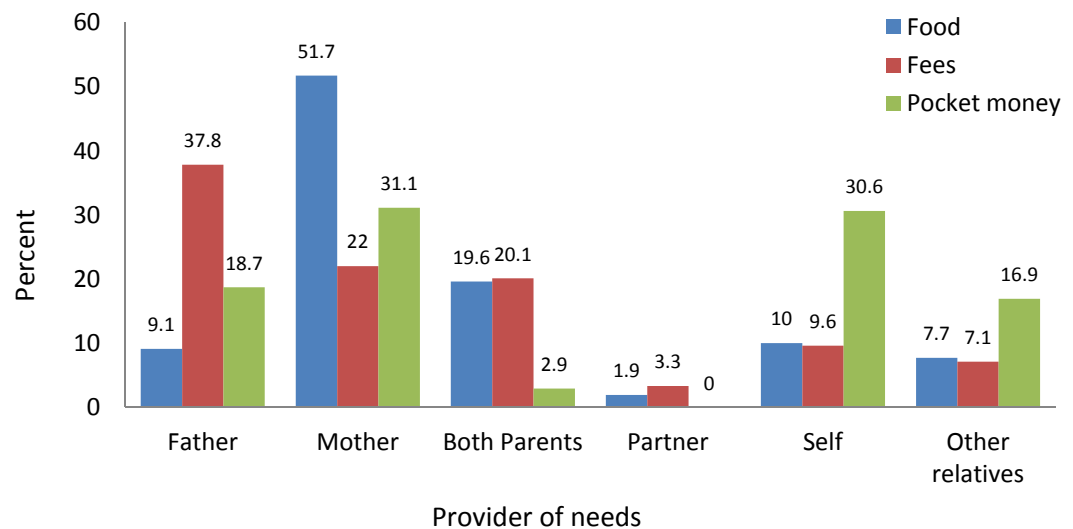
|                |      |      |      |      |      |      |      |      |      |      |      |      |
|----------------|------|------|------|------|------|------|------|------|------|------|------|------|
| Both parents   | 48.5 | 47.4 | 41.7 | 40.9 | 47.4 | 58.6 | 30.6 | 46.7 | 28.6 | 23.5 | 43.8 | 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

### Provider of basic needs

Basic necessities such as food, school or apprentice fees and pocket money, according to the study, may be provided by fathers only, mothers only, both parents, sexual partners, one's self or other relatives. As shown in Figure 6, more than half (51.7%) of respondents depended solely on their mothers for food. About 38% however, acknowledged that their school fees were paid by their father. With respect to pocket money, whereas 31.1% said they received it from their mothers, a similar proportion (30.6%) said they provided it for themselves. In all, about 85% were satisfied with the basic needs they received whereas 15% remained unsatisfied. The level of satisfaction of adolescents in the provisions of their basic needs indicates how strong the existing immediate social factors (parent/family, sexual partners, peers, organized youth groups) are. These affect the individual factors and directly affect sexual and reproductive health rights outcomes (Wouhabe, 2007).



**Figure 6: Provider of adolescents' basic needs**

Source: Fieldwork, 2011

### **Transitional issues**

The period of adolescence marks a new era in the life of the individual. This is the stage that follows from the childhood days and at the same time, a precursor to adulthood (Pratt & Norris, 1994; Erikson & Erikson, 1997; Steinberg, 2008). In recognition of this, the study sought to identify the remarkable issues which characterize the period of adolescence in the study area concerning the individual, family and the entire community.

### **Perceptions of current stage of life**

A key determinant of whether individuals would ever assert their rights is how young or old they perceive of themselves (Marsh, 1989; Harter, 1999; Nurmi, 2004). When someone views himself or herself as an adult, he or she would seldom allow himself to be overridden by others. People who see themselves as kids or children often simply succumb to some situations unchallenged (Harter, 1999; Albert & Steinberg, 2011). Table 3 shows the various reasons respondents assigned to how they perceive their current status.

From Table 3, over two-thirds of all respondents saw themselves as children. About 66% of male respondents as well as 73% of female respondents saw themselves as children. Of the males who saw themselves as children, about 82% said it was because they were cared for by their parents or guardians, whereas 17.9% said so because of other reasons (not at voting age, still in school, not married). Close to 76% of females also said they were still children because they were catered for by others.



Less than a third of all adolescents perceived themselves as adults. Table 3 depicts that of those who considered themselves as adults, 76.5% of males and 55.6% of females said so because they had attained the national voting age. The other reasons such as physical maturity, knowing what is good and bad and catering for one's self also gained prominence, especially female respondents (where not less than 40% of respondents said so). In connection with the theory of sexual interaction, this indicates the locus of control adolescents seem to have over events over their life. People who believe they are still children tend to have an external locus of control, associated with the belief that events are beyond his or her own control and are determined by fate, chance or powerful others, and vice versa (Rotter, 1966).

**Table 3: Respondents' perceptions about current status**

|                    | Males | Females |
|--------------------|-------|---------|
| As a child (N=146) |       |         |
| Cared for          | 82.1  | 75.9    |
| Other reasons      | 17.9  | 24.1    |
| Total              | 100   | 100     |
| As an adult (N=63) |       |         |
| Voting age         | 76.5  | 55.6    |
| Other reasons      | 23.5  | 45.4    |
| Total              | 100   | 100     |

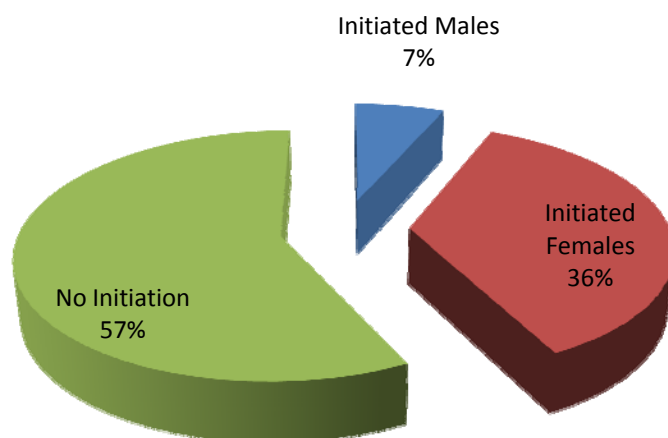
Source: Fieldwork, 2011

## **Initiation rites**

Results of the proportion of adolescents who have experienced initiation rites (as displayed in Figure 7) indicate that in general, males hardly experience initiation rites. Only 7% of the respondents who indicated that they had ever experienced a form of initiation into adulthood were males. This compares with 36% of female respondents who have ever experienced initiation rites. Altogether, 57% of respondents had not undergone any initiation ceremony.

As it used to be the practice in most Ghanaian settings, the onset of puberty (menarche) is marked with communal or family ceremonies to formally usher the young adolescents into adulthood (Rebecca & Fayorsey, 2002). In some communities, mothers or other female caretakers prepare mashed yams and boiled egg for girls to eat as soon as they told the older women of their menses. Boys on the other hand may also be given a gun, amulets or a large piece of land to cultivate. Guardians or parents also used this occasion to discuss sexual issues, with girls endeared to be submissive to their husbands, exacting the suggestion to unconditionally succumb to one's husband (Ogunjuyigbe & Adeyemi, 2005).

However, activities in Yamoransa to usher adolescents into puberty were rather moderate. For girls, they were basically made aware of the implication of the menarche when they report of the first menses. They were cautioned on their relationship with the opposite sex. Boys were however given specific tasks, more responsibilities in the homes and small parcel of land to farm. They were also expected to be more accountable.



**Figure 7: Initiation experience of respondents**

Source: Fieldwork, 2011

#### **Ever undergone initiation rites by ethnicity and sex**

As stated earlier, male respondents hardly experienced initiation. Of the females who had ever undergone initiation rites, 25% of them were Fantes with Ashantis constituting 22.2%. Another 22% of them belonged to other ethnic groups.

Initiation rites form part of institutional factor of community norms and rules that are promoted by traditional agencies. According to the framework for knowledge and perception of sexual and reproductive health (Adapted from Wouhabe, 2007), community norms and rules together with the media, religious agencies, the health systems and economic conditions make up the institutional factors that directly affect SRH outcomes. These factors affect the individual's personality and sexuality.

Results from Table 4 and Figure 7 confirm the fact that formal puberty rites are losing credence in the Ghanaian society. Overtime, the family structure has been affected by social changes such as education, economic crisis, urbanization, environmental crises and AIDS. This has led to the changing phase of initiation rites and thus responsible for the low figures in this contemporary times (McAuliffe & Ntata 1994).

**Table 4: Ethnicity and initiation experience**

| Ethnicity  | Male | Female |
|------------|------|--------|
| Fante      | 0.0  | 25.5   |
| Ashanti    | 0.0  | 22.2   |
| Ga-Adangme | 0.0  | 16.7   |
| Others     | 4.3  | 21.7   |

Source: Fieldwork, 2011

### **Sources of sexual and reproductive health information**

Information relating to Sexual and Reproductive Health, as confirmed by the study, could be derived from one's parents, peers, the media, teachers, religious leaders and health officials. From Table 5, it could be seen that radio is the major source of SRH information for male (78.2%) and female (68.5%) respondents. Also, nearly a seventh of males and six out of every ten females mentioned teachers as a source of SRH information. It is also worthy of note that close to 63.4% of male respondents said they sourced SRH information from their peers. However, the study revealed that health officials were not a major source of sexual and reproductive health information to respondents with only about six and

eight per cent of males and females respectively. This is especially with respondents aged 15-16 years where none admitted that health officials were their source of sexual and reproductive health information.

Aspects of this result confirms a similar study by GSS et al, (2004) which revealed that over the period between 2003 and 2008, exposure to mass media per se had increased with level of education. In the 2008 Ghana Demographic and Health Survey (GDHS), media exposure was higher among younger women (15-19) than older women (45-49). In the view of Chimbiri (2002), urban migration has led to disintegration in the traditional system and has affected communication with young people as more young people grow out of the traditional system. Consequently, the majority of youths rely on friends as primary sources of sexual and reproductive health information while this communication remains minimal in the family. Young people therefore view SRH matters as taboo issues and are embarrassed to communicate them with parents, hence their preference to fellow peers. Child to child approach to securing SRH information has therefore been more recommendable than adult to child approach in a few studies (McAuliffe & Ntata 1994).

That less than a third of male respondents and a fifth of female respondents had parents as their source of sexual and reproductive health information lends credence to the assertion that parents are not a major source of SRH information. This observation calls for concern since Caldwell (1998), observes that changes in adolescent behaviour are not merely as a result of

reactions of adolescents but also of older people, and these changes arise from the pre-existing society or external influences.

**Table 5: Sources of sexual and reproductive health information**

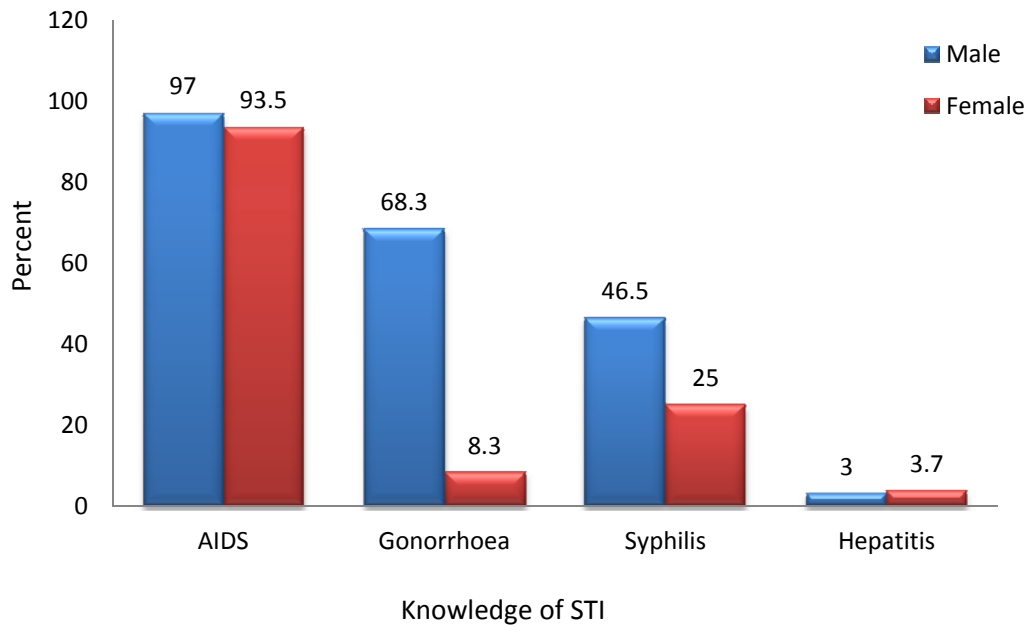
| Variables        | Males (N=101) | Females (N=108) |
|------------------|---------------|-----------------|
| Radio            | 78.2          | 68.5            |
| Television       | 57.4          | 54.6            |
| Newspapers       | 26.7          | 17.6            |
| Peers            | 63.4          | 46.3            |
| Teachers         | 72.3          | 60.2            |
| Parents          | 30.7          | 18.5            |
| Health Officials | 5.9           | 8.3             |
| Religious Leader | 40.6          | 17.6            |

Source: Fieldwork, 2011

### **Knowledge of sexually transmitted infections**

Adolescents' view was sought on some diseases which could be transmitted through sexual intercourse. As shown in Figure 8, about 98% of adolescents knew of HIV/AIDS. More than 72% mentioned Gonorrhoea as a Sexually Transmissible Infection (STI) whereas 35.4% and 3.3% mentioned Syphilis and Hepatitis respectively. Since one benefit of being able to assert one's sexual and reproductive health rights is the possibility to prevent some STI which emanate from vulnerabilities. In the view of the theory of sexual interaction, the focus of interest is the event occurring during the interaction that has any relevance such as safer sex (Ingham & van Zessen, 1997). As such, an

individual's knowledge of STIs leads to risk awareness, the availability of capacity to ensure autonomy and behavioural intentions. It was therefore very paramount to explore what adolescents know about diseases which could be transmitted through sexual intercourse.



**Figure 8: Knowledge of sexually transmitted infections**

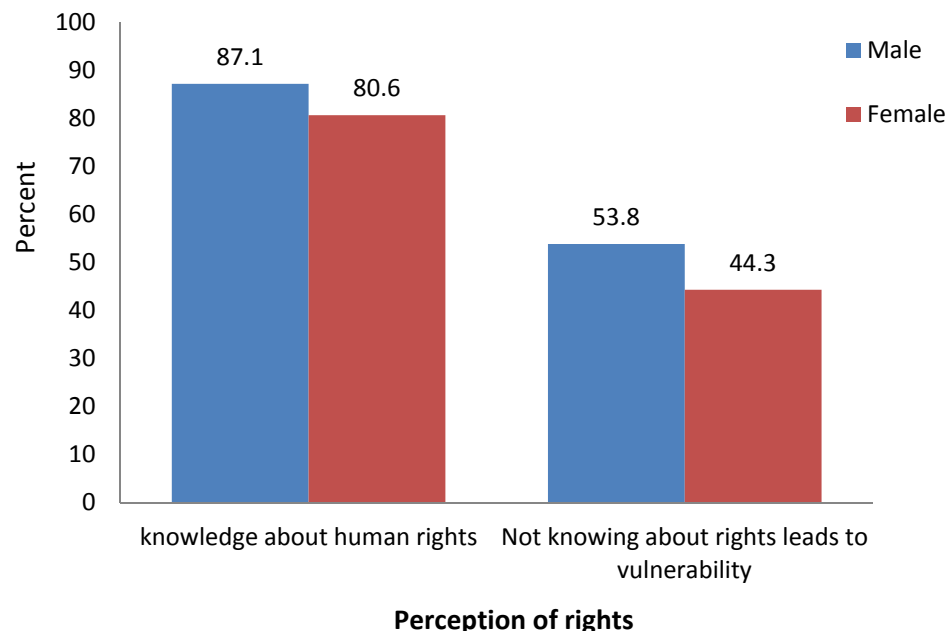
Source: Fieldwork, 2011

### **Awareness of sexual and reproductive health rights**

In order to know the level of adolescent's knowledge and perception about reproductive rights; their views were sought on some rights-related scenarios, power relations in marital unions and possible reasons to deny one's sexual partner intercourse.

## Knowledge about human rights

Adolescents were first asked about what they knew about human rights. It emerged, according to figure 9, that 85.6% had heard and knew some aspects of human rights. Again, when adolescents were asked whether a lack of knowledge on SRH rights issues led to vulnerability, more than 83% answered in the affirmative. For about 17% of respondents, lack of knowledge of it does not lead to vulnerability to sexual abuses and exploitations and STIs.



**Figure 9: Knowledge about human rights**

Source: Fieldwork, 2011

## Adolescents' views on some sexual and reproductive health rights-related issues

Respondents were asked about their view on some statements concerning right to sexual expression. These issues, as shown in Table 6, centered on freedom



to enter into relationships, whether pregnant adolescents and their partners should be expelled from school, whether it is appropriate for adolescents to discuss sexual matters and whether sexual offences should be treated as home or family matter. It emerged from the study that about 60% of males agreed that people should be free to enter into relationship if only they wanted to. This proportion comprises 45.9% who strongly agree and 13.4% who agree. A similar trend could also be seen of female respondents where nearly 43% strongly agree and 17.6% agree that people should have such freedom. About 2% of both male and female respondents had no opinion.

Whereas about 53% of male respondents (made up of 40.6% who strongly agree and 12.9% who agree) believe that girls who become pregnant whilst schooling should be expelled from school, almost 40% disagree to this. However, more female respondents (17.6% disagreeing and 31.5% strongly disagreeing) oppose such expulsion as compared to those who support it. Also, concerning whether school boys who impregnate their colleague girls should be expelled from school, close to one-third of respondents, both males and females either strongly agreed or strongly disagreed.

As to whether individuals should be free to discuss sexual issues, six out of every ten disagreed. This compares to about 31% of both males and females

**Table 6: Right to sexual expression**

| Issue   | Males |      |     |      |      | Females |      |      |      |      |
|---|-------|------|-----|------|------|---------|------|------|------|------|
|   | SA    | A    | NO  | D    | SD   | SA      | A    | NO   | D    | SD   |
| People should be free to enter into relationship      | 45.9  | 13.4 | 2.0 | 16.8 | 22.8 | 42.6    | 17.6 | 1.9  | 15.7 | 22.2 |
| Pregnant school girls should be expelled              | 40.6  | 12.9 | 5.9 | 9.0  | 30.7 | 34.2    | 8.3  | 8.3  | 17.6 | 31.5 |
| Boys who impregnate school girls should be expelled   | 33.7  | 8.9  | 6.9 | 12.9 | 37.6 | 33.3    | 9.3  | 11.1 | 12.0 | 34.3 |
| People should be free to discuss sexual matters       | 23.8  | 8.9  | 4.0 | 26.7 | 36.6 | 19.4    | 11.1 | 6.5  | 24.1 | 38.9 |
| Non-compliance of sexual coercion is akin to rudeness | 9.9   | 0.0  | 6.9 | 17.8 | 65.3 | 10.1    | 1.9  | 8.3  | 11.1 | 68.5 |
| Sexual offences should be treated as family matter    | 20.8  | 8.9  | 5.9 | 10.9 | 53.5 | 19.4    | 13.9 | 7.4  | 13.0 | 46.3 |

SA=Strongly Agree, A=Agree, NO=No Opinion, D=Disagree, SD=Strongly Disagree.

Source: Fieldwork, 2011

who agreed. Table 6 also shows that majority of respondents (about 80%) disagreed that if one does not comply with an adult's sexual advances, then it implies he or she is disrespectful. Only about a tenth of both males and females held an opposing view. That is, one out of ten adolescents believe that an adolescent is a deviant should he or she refuse sexual advances. They believe this is not grounds enough to conclude that one is disrespectful. This runs contrary to Hall's (1904) biogenetic theory which classifies adolescence as erratic, deviant or troublesome, and that, this fear of being tagged as disrespectful makes them often fall prey to perpetrators of sexual crimes from adult figures.

More than 60% males and 50% females respectively disagreed that sexual offences should be treated as "home matter" instead of seeking redress at the appropriately mandated institutions to hear such cases. This confirms the view that the locus of control that individuals have in sexuality matters is a greater determinant of their behaviour (Kelley, 1973; Ingham & van Zessen, 1997). That is, an individual's ability to identify how vulnerable a given situation is making him or her and to appropriately forestall such situation determines his autonomy and well-being. As put out by the theory of sexual interaction, individual's perception, understanding and interpretation of issues (locus of causality) do influence the way he will follow proposed means of averting them.

### **Reproductive decision making**

Views of adolescents who should be taking critical sexuality decisions – of when to have sex, when to give birth, number and spacing of children and

adoption of family planning – were sought. According to Table 7, whereas 63% of females said the decision as to when to have sex should come from the couple, about 47% of males said same. It could also be observed that less than one per cent of females said such a decision should be taken by the woman whereas about 47% of males said the man should decide.

Concerning whose decision it should be on when to give birth, a greater proportion of respondents (54.6% females and 44.6% males) believe it should come from both couple. Again, less than one-fifth believe the woman should decide when to give birth whereas one-third said the man should decide. That is, the proportion of respondents who believe males should decide when to give birth are more than those who think females should take such decision.

Table 7 again shows that more than half of males (50.5%) and females (55.1%) believe that in every marital union, the number and spacing of children should be decided by both the man and the woman. A greater proportion however, also believes that the man alone should take such a decision as compared to those who think the woman should.

The trend is however different when it comes to the adoption of birth control. A greater majority of males (46.5%) said it is the woman who should decide, whilst close to 38% said both should decide. Also, even though half of female respondents believe the decision should come from both couples, a third of them (33.3%) suggest it is the woman to decide. This is the largest female proportion which believes the woman should be the sole decider of a reproductive health decision.

**Table 7: Reproductive decision making**

| Activity                       |                      | Males | Females |
|--------------------------------|----------------------|-------|---------|
|                                | Should be decided by |       |         |
| When to have Sex               | The man              | 46.5  | 36.1    |
|                                | The woman            | 7.0   | 0.9     |
|                                | Both                 | 46.5  | 63.0    |
| When to give birth             | The Man              | 37.6  | 32.4    |
|                                | The Woman            | 15.8  | 13.0    |
|                                | Both                 | 44.6  | 54.6    |
| Number and Spacing of children | The Man              | 43.6  | 27.8    |
|                                | The Woman            | 5.9   | 17.1    |
|                                | Both                 | 50.5  | 55.1    |
| Adoption of birth control      | The man              | 15.8  | 16.7    |
|                                | The woman            | 46.5  | 33.3    |
|                                | Both                 | 37.6  | 50.0    |

---

Source: Fieldwork, 2011

Gupta (2000) has extensively explored the determining role of power in gender and sexuality. Sexuality is influenced by rules, both explicit and implicit, imposed by the social definition of gender, age, economic status or ethnicity (Dixon-Mueller, 1993; Zeidenstein & Moore, 1996).

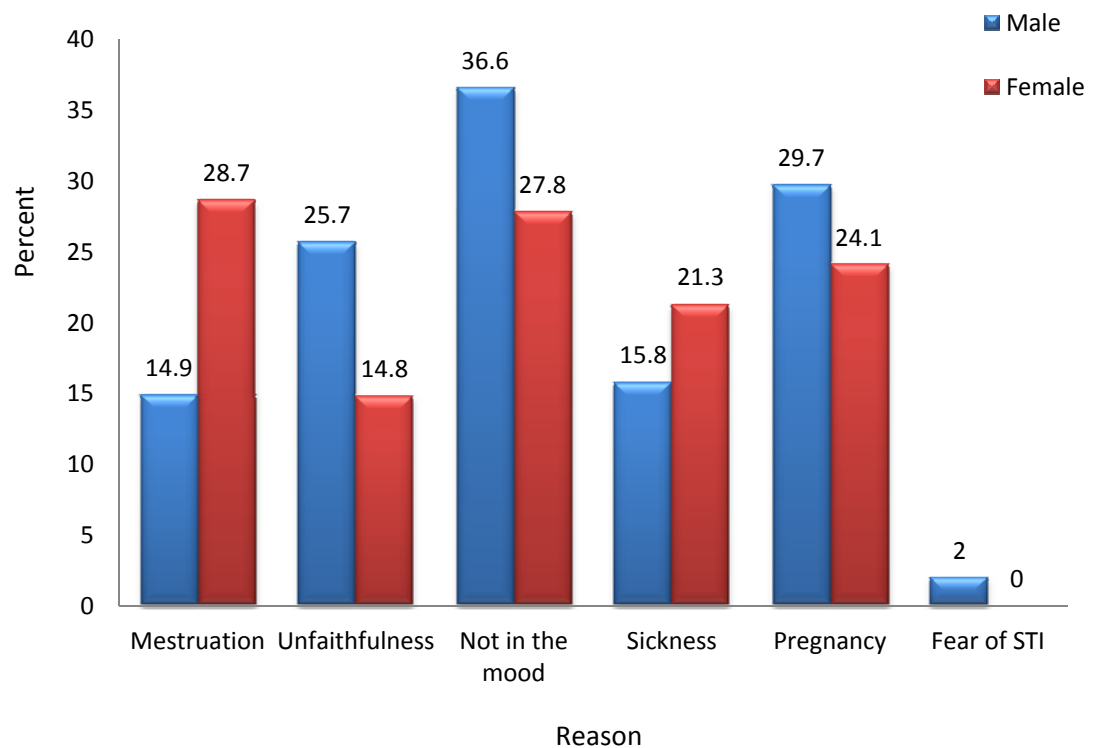
The unequal power balance in gender relations that favors men translates into an unequal power balance in heterosexual interactions. Male pleasure supersedes female pleasure, and men have greater control than women over “when, how, and with whom sex takes place”. Therefore, gender and sexuality must be understood as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power (Heise & Elias, 1995; Weiss et al, 2000). The translation of these reproductive health intentions affects the interpretation of the various wishes and the negotiation abilities of the various partners. As portrayed by the theory of sexual interaction, one’s perception of who in a marital union determines when to have sex, give birth, number and spacing of children among others, would eventually affect the power and control each individual has in the union, and the mutual respect for each other (Rademakers & Luijkx, 1992).

### **Circumstances to refuse sexual intercourse**

Adolescents’ views concerning conditions under which a sexual partner could be refused sexual demands are explored in Figure 10. More than a quarter of male respondents said one could deny the sexual partner sex for reasons of ‘not being in the mood’ (36.6%), fear of pregnancy (29.7%) and unfaithfulness (25.7%). Also, according to nearly 28.7% of female respondents, when a woman is in her menstrual period it is a good reason enough to refuse her partner sexual intercourse. ‘Not being in the mood’ is also a fertile ground for someone to refuse the partner sexual intercourse. This is according to 27.80% of female respondents.

Figure 10 also depicts that two percent of male respondents and no female respondent said a person could refuse the partner sexual due to the fears of contracting sexually transmitted infections.

Some portion of this study runs contrary to some findings on STI and sexual relations. For instance, when a similar question was posed to respondents of the 2008 GDHS, 86% were of the view that when one suspects the partner to be having STIs, it was a reason good enough to refuse sexual intercourse. Similarly, in a study conducted by Wouhabe (2007), majority of respondents (86 percent of women and 91 percent of men) agreed that a woman is justified in



**Figure 10: Possible reasons to deny a partner sexual intercourse**

Source: Fieldwork, 2011

refusing to have sexual intercourse with her husband if she knows he has an STI. Again from GDHS 2008, seventy-five percent think that a woman is justified in refusing sexual intercourse if she knows that her husband has intercourse with other women. More so, around 20% of respondents of this study believe unfaithfulness is a basis to deny the lover sex. In many parts of Africa, there is some evidence that the fear of infection is slowly becoming a legitimate ground for refusing sexual relations, most likely due to the increasing prevalence and awareness of HIV infection (Awusabo-Asare et al, 1993; Orubuloye et al, 1993).

### **Perception and experiences about sexual and reproductive health rights abuses**

Adolescents were asked questions on their perception and experience on sexual and reproductive health rights abuses. Specifically, they were asked about their perception on what acts constitute sexual and reproductive health rights abuses, infringements on rights they have ever experienced and the appropriate institutions to report cases of sexual abuse.

### **Sexual and reproductive health rights abuses**

When asked about their views on what constitutes a violation of one's Sexual and Reproductive Health rights, the respondents were almost unanimous in pointing out denial of SRH Information, 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 (as shown in Table 8).



More than 94% of the males mentioned forced marriage as an act which infringes on sexual and reproductive health rights. About 85% also said that forced sex infringes on an individual’s sexual and reproductive health rights. The trend is not different for the respective age categories. A similar situation is reported of female respondents where 86.1% of respondents considered forced sex and forced marriage as such.

A little above half of all male respondents recognized the other offences (abusive sexual language, non-consensual touching of sensitive parts, punishment for discussing sexual issues, suppression of one’s sexual expression and discrimi-

**Table 8: Knowledge of SRH rights abuses by sex**

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

Source: Fieldwork, 2011

nation based on one's sexual orientation) as sexual and reproductive health rights violations. The table also shows that apart from forced marriage, and discrimination based on one's STI status, the other acts were viewed by proportionately more females than males as constituting sexual and reproductive health abuses. Discrimination based on one's STI status was not so much considered as an infringement on one's sexual rights, especially female respondents (40.7%).

#### **Knowledge of sexual and reproductive rights abuses by educational level**

As shown in Table 9, respondents in the tertiary level of education identified more acts as constituting infringement on sexual and reproductive health rights. To a majority of them, as compared to their other compatriots, when an individual experiences forced marriage, forced sex and suppression of sexual expression, then his or her rights have been violated it could be seen from the table that respondents' perception of an act as reproductive rights violations increases directly with the educational continuum. For instance, while 73.7% of adolescents in the tertiary level saw suppression of sexual expression as an act that constitutes a violation of one's SRH rights, none of the respondents with no formal education considered it as such.

**Table 9: Knowledge of SRH rights abuses by current 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

### **Abuses ever experienced by sex**

Table 10 shows the actual abuses that respondents admitted having ever experienced. The use of abusive language is recorded as the most widely experienced SRH abuse suffered by respondents. A third of both males and female respondents confirmed having experienced such abuse. In some Ghanaian settings, abusive sexual language may include a derogatory use of one's sexual organ or that of the parent (especially the mother) to insult the victim. Such form of insult often demoralizes the victim and often extends to a 'war of words between families'. The Ghanaian culture forbids the open discussion of sexual issues (or mentioning genitals openly), so it is not surprising to note that 34.5% males had been punished for this "offence".

The least experienced abuses were forced marriage (1.0% males, 4.1% females), discrimination based on one’s sexual orientation (3.0% of males and 0.0% of females), STI-based discrimination (2.0% of males and 1.9% of females) and forced marriage (1.5% males and 4.1% females). These figures may seem minimal. However, the fact that there has been an instance or instances of, for example, forced marriage and discrimination means a lot still need to be done.

**Table 10: SRH rights abuses ever experienced by sex**

|  | Males (N=101) | Females (N=108) |
|--|---------------|-----------------|
| Denial of SRH Services                   | 24.8          | 22.2            |
| Forced Marriage                          | 1.0           | 4.1             |
| Forced sex                               | 11.9          | 21.3            |
| Abusive sexual Language                  | 30.7          | 32.4            |
| Non-consensual Touch                     | 20.8          | 28.7            |
| Punishment for discussing sex issues     | 23.8          | 16.7            |
| Suppression of expression                | 21.8          | 16.7            |
| Discrimination due to sexual orientation | 3.0           | 0.0             |
| STI-based Discrimination                 | 2.0           | 1.9             |

Source: Fieldwork, 2011

**Abuses ever experienced by current educational level**

As shown by Table 11, in general, less than half of respondents in any level of education ever experienced any abuse (with the exception of 68.4% in the Tertiary level who experienced suppression of sexual expression). However, the use of insulting sexual language, non consensual touch and punishment for

discussing sexual issues also emerged as having been experienced by over a fifth of adolescents in the primary, JHS and SHS levels.

**Table 11: SRH rights abuses ever experienced by current educational level**

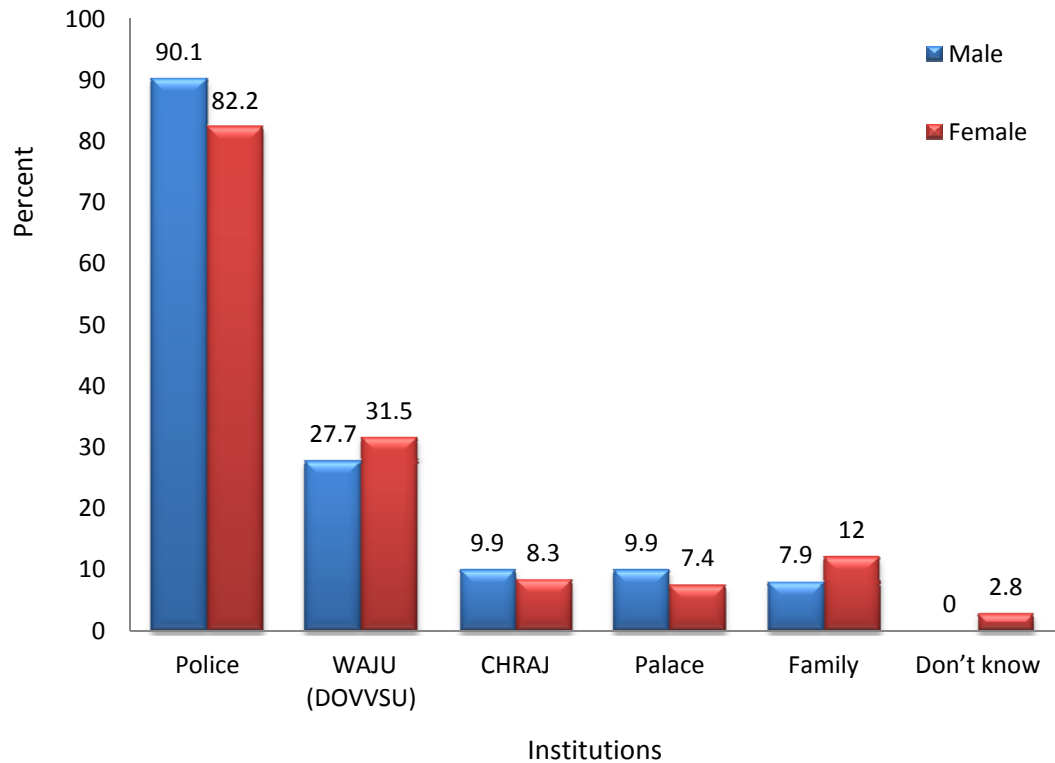
|                                   | No formal | Primary | JHS  | SHS  | Tertiary |
|-----------------------------------|-----------|---------|------|------|----------|
| Denial of SRH Services            | 0.0       | 33.3    | 11.0 | 26.5 | 47.4     |
| Forced Marriage                   | 0.0       | 4.8     | 3.1  | 1.8  | 5.2      |
| Forced sex                        | 0.0       | 14.3    | 19.5 | 18.1 | 5.3      |
| Abusive sexual Language           | 25.0      | 47.6    | 28.0 | 32.5 | 5.3      |
| Non-consensual Touch              | 0.0       | 19.0    | 23.2 | 26.5 | 26.3     |
| Punishment for discussing sex     | 0.0       | 23.8    | 22.0 | 20.5 | 10.5     |
| Suppression of expression         | 0.0       | 0.0     | 8.5  | 24.1 | 68.4     |
| Discrimination on sex orientation | 0.0       | 0.0     | 0.0  | 2.4  | 5.3      |
| STI-based Discrimination          | 0.0       | 0.0     | 3.7  | 1.2  | 0.0      |

Source: Fieldwork, 2011

### **Institutions addressing sexual abuses**

As shown in Figure 11, several institutions were mentioned of as appropriate for one to report infringements on sexual rights. Closely nine out of every ten respondents (90.1% males and 82.2% females) mentioned the police as an agency to report such incidents. The Domestic Violence Victim Support Unit (DOVVVSU) formerly Women and Juvenile Unit (WAJU), according to nearly a third of respondents, is a credible agency to report instances of sexual abuse to. The family, chief's palace and Commission on Human Rights and Administrative Justice also came up for mentioning by around 10% of respondents as agencies

that address abuses of sexual rights. Three females indicated they knew of no institution. This represents of 2.8% of the female respondents.



**Figure 11: Knowledge of institutions that address sexual abuse**

Source: Fieldwork, 2011

It could be realized from Figure 11 that most of these institutions to report sexual and reproductive health rights abuses to form part of factors at the meso level which affects adolescents' knowledge of SRHR, according to the conceptual framework adopted for the study. The family is a part of the immediate social factors whereas the chief's palace, police, DOVVSU and CHRAJ belong to institutional factors which affect one's knowledge of SRHR issues (Wouhabe, 2007).

## **Practices of sexual and reproductive health rights**

As part of efforts to identify 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. These questions ranged from their ability to buy a contraceptive when a parent or guardian is within the premises (right to SRH services), likely reaction when denied the opportunity to buy a condom due to age (discrimination) and reaction when a sexual partner imposes a SRH decision on an adolescent.

### **Ability to buy condom when a parent is within premises**

In order to test adolescents' resilience and self-confidence, adolescents were asked if they would be able to buy a contraceptive when they knew that their parent was within the premises. Here, diverse views emerged as displayed by Table 12. Less than a fifth of both males and females admitted that they were able to buy condom if their parent was within the premises. Age-wise, a little below a third of males (27.6%) and females (28.2%) who are of age 19 years said they were able to do such. But for respondents of no formal educational background, no other categories of respondents had up to 50% admitting that they could do that. With the exception of age ( $X^2=19.114$ :  $df=4$ ,  $p=0.001$ ), there was no significant relationship between respondents' ability to buy contraceptive when a parent is within premises and other socio-demographic variables.

**Table 12: Adolescents' ability to buy condom when parent is within premises**

|              | Male | Female |
|--------------|------|--------|
| Age          |      |        |
| 15           | 5.1  | 4.0    |
| 16           | 7.4  | 6.1    |
| 17           | 8.1  | 7.7    |
| 18           | 28.8 | 26.0   |
| 19           | 27.9 | 28.2   |
| Religion     |      |        |
| Christianity | 21.3 | 13.2   |
| Islam        | 15.0 | 15.4   |
| ATR          | 16.7 | 33.3   |
| Education    |      |        |
| No formal    | 66.7 | 0.0    |
| Primary      | 0.0  | 30.8   |
| JHS          | 19.4 | 10.0   |
| SHS          | 21.7 | 13.9   |
| Tertiary     | 15.4 | 14.3   |

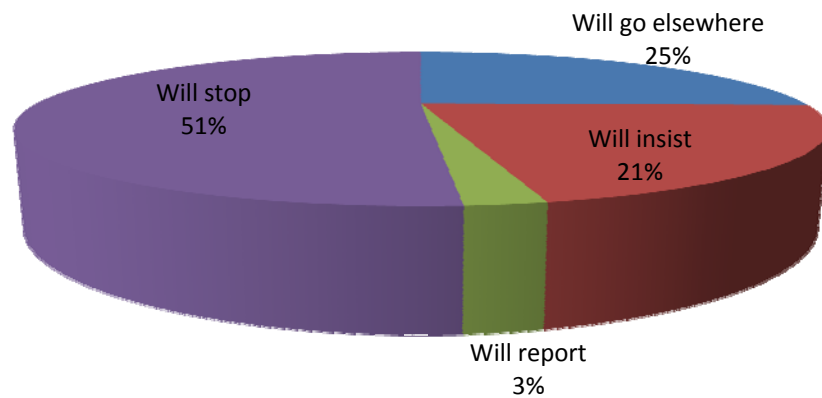
Source: Fieldwork, 2011

### **Likely reaction upon a denial of condom purchase**

A contraceptive such as the sheath (condom) is acquired in various outlets but the most popular is the pharmacy. This is a 'drug' which could be purchased without any prior prescription by a physician. However, the stigma attached to it



is great (Juarez & Simons, 1997). With this background, adolescents were questioned as to how they would assert their right to this service despite their age and low status in the society. Results from Figure 12 indicate that a little over half of respondents (51%) said if an attendant refuses to sell condom to them for reason of they being too young or spoilt, they would stop the purchase. That is, they would not try any other place at any other time to purchase it. For a quarter of respondents, they would go elsewhere to get it. One-fifth of respondents however indicated that they would insist that they be served.



**Figure 12: Reaction upon denial of condom purchase**

Source: Fieldwork, 2011

For 3% of respondents, they would report such conduct to the regulatory body under whose auspices such a pharmacy shop operates. A chi square test statistic revealed a strong relationship between age of respondents and the tendency to stop ( $X^2=16.974$ :  $df=4$ ,  $p=0.002$ ) as well as the tendency to insist ( $X^2=16.932$ :  $df=4$ ,  $p=0.002$ ).

### **Likely reaction upon imposition of SRH decision by partner**

In a hypothetical scenario, adolescents were asked of their reaction if it happened that there were differences in opinion on some issues concerning reproductive self-determination (see Table 13). 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 union.

From the results, it emanated that apart from adoption of family planning (where more than 54.1% of respondents said they would succumb to what their partners preferred), less than half of respondents said they would succumb to imposition of sexual decisions on them. A similar observation could be made within all the socio-demographics, except in few cases. That is, more than 50% of the proportion of African traditional religion respondents are willing to succumb to their partner on when to have sex, and similar proportion of respondents with no formal education, as well as those at primary school level are willing to succumb to the decision on the number of children, adoption of birth control and pregnancy from their partners.

Furthermore, it could be realized that a greater proportion of female respondents, compared to males, said they would succumb to 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 com-

**Table 13: Readiness to succumb to SRH decisions**

|            | Non-<br>consensual sex | Number of<br>children | Adoption of<br>family planning | Pregnancy |
|------------|------------------------|-----------------------|--------------------------------|-----------|
| 1          | 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

ply with the number of children their partner would want to have, only 25.7% of males said same. Also, whereas 56.5% said when their partner insists on family planning they would heed, closely 52% of males said likewise.

Another trend that could be seen concerning education was that, but for the decision as to the number of children (where 75% respondents in the primary school level as against 50% with no formal education said they would succumb), a greater proportion of those with no formal education admitted they would succumb to what their partner decides. Going further the continuum of formal education, proportionately more respondents in the primary school level said they would succumb to reproductive decisions from their sexual partners than those in the higher levels (JHS, SHS and tertiary). A case in point is whereas 76.2% of those in primary school said they would succumb to the number of children their partner would want; only 21% of those in the tertiary level said same.

Again, the table portrays that apart from the decision as to when to have sex; more Moslems were willing to succumb to imposition of sexual and reproductive health decisions than the other religions.

A chi square statistic revealed a significant relationship between respondents' sex and their willingness to succumb to 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 ( $X^2=15.703$ :  $df=4$ ,  $p=0.003$ ) and one's preparedness to succumb to a partner's decision on the number of children.

There was also a significant relationship between education and respondents' readiness to succumb to sole decision of a partner on when to

become pregnant ( $X^2=15.508$ :  $df=4$ ,  $p=0.004$ ), and the number of children ( $X^2=20.804$ :  $df=4$ ,  $p=0.000$ ).

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **Introduction**

This chapter deals with summary of the study, summary of the main findings the conclusions, recommendations and areas for further research. The summary focuses on the various chapters of the study. The conclusions are derived from the main findings of the study, which tried to answer some important issues which were raised. The recommendations for policy makers and implementers, on the other hand, are based on the conclusions. The section on area for further research covers areas that can be studied to increase the existing knowledge of Sexual and reproductive Health Rights.

#### **Summary**

The general objective of the study was to assess adolescents' knowledge and perception of Sexual and Reproductive Health Rights. It was hypothesized that there was no significant relationship between socio-demographic background of respondents and their knowledge of sexual and reproductive health rights issues. The study used a cross-sectional, exploratory study design which focused on Yamoransa, a community in Mfantseman Municipal, as a case study. The study adapted a conceptual framework designed by Wouhabe (2007) which outlines the factors affecting knowledge and perception at the micro, meso and

macro level. A questionnaire was used to collect data from the field. The analyses were based primarily on the result of the data collected. Simple frequencies, percentage distribution, means, cross-tabulations and Pearson Chi-Square statistic were used to analyze the data. Because the data was categorical, the Chi-Square Statistic was deemed the most effective tool to test the significant association between the dependent variables such as the sex, age, religion and current educational level of respondents.

Sex, age, religious affiliation, current educational level, marital status and living arrangements were the main socio-demographic background characteristics of respondents which the study explored. There were more females (51.7%), 17-18 year old respondents (35.4%), Christians (78.0%), and adolescents at the Senior High School level (39.7%). Also, nearly all the respondents for the study (98.0% males and 90.7% females) had never married and about one-third lived with both parents. It also emerged that basic needs such as food, clothing and fees mostly were catered for by the mothers of the respondents.

Approximately 66% of respondents still saw themselves as children with reasons such as still staying with their parents or not married. This figure includes adolescents who have attained or passed the national voting age. Also, the study revealed that only 7.0% of male respondents 36% of female respondents had undergone an initiation rite within their adolescence period where they were taught issues about adult life in general and sexuality in particular, and given some tasks and guidelines to follow. It also emerged that about a quarter of female Fante respondents had undergone initiation rites. About 79% males and

69% female respondents cited the radio as a major source of SRH information. Health officials were rather the least admitted by adolescents as a source of SRH information.

The level of adolescents' knowledge of sexual and reproductive health rights is high. Over 80% of both male and female respondents confirmed having heard of human rights and some basic rights of individuals. Altogether, over four out of five respondents admitted that lack of one's human rights could lead to vulnerability. In specificity to SRH rights, three-fifth of both male and female respondents generally agreed that an individual should have the freedom to enter into a relationship whilst some believe adolescents should have the freedom to discuss sexuality issues. A greater proportion of both male and female respondents believed that reproductive health decisions of when to have sex, give birth, number and spacing of children should come from the couple in the marital union. However, proportionately more respondents opted for the man being the main decider as compared to those who opted for the female. Whereas male respondents ranked 'not being in the mood', fear of pregnancy and unfaithfulness as reasons to deny one's partner sex, female respondents gave menstruation, when not in the mood and fear of pregnancy as reasons or situations to deny a partner sexual intercourse.

The findings of the study revealed that adolescents were generally aware of acts that constitute SRHR abuses. Mention was made of acts such as 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 as some of those acts which could be described as such. Forced was the most tagged act constituting sexual and reproductive health rights abuse, whilst discrimination due to STI status was the least tagged.

Regarding the sexual and reproductive health rights abuses ever experienced, the use of sexually insulting words and denial of reproductive health services emerged as the highest for males whereas the former and non-consensual touching of sensitive parts was the highest for females. To about 90% of males and 82% of females, the police service is the most appropriate agency where cases of sexual abuse could be reported to. More than half of respondents are against the view that sexual issues be discussed as 'home matter'.

The findings revealed that concerning the actual asserting of SRH rights, only a few could. Generally, less than half of respondents expressed their readiness to succumb to an imposition of sexual and reproductive health decisions on them by their partners in any marital union.

The socio-demographic variables that were subjected to test were sex, age, religious affiliation and current educational level. These were the independent variables. Among the dependent variables tested were knowledge of appropriate institutions to report abuses to, readiness to succumb to impositions of SRH decisions and reaction when denied SRH services. The Chi-Square statistic was the tool used to test the hypothesis stated. Age and current educational level had significant relationships with most of the dependent variables tested (refer to appendix).

## Conclusions

Based on the results of the study, the main conclusions that emerged were as follows:

- Initiation rite, which is even losing its acceptance in this contemporary era, is the only programme to usher adolescents into the world of adulthood. There is no other major programme both at the family and community level. The radio is adolescents' major source of SRH information. They however, hardly source information from health professionals;
- There is an appreciable awareness of sexual and reproductive health rights: the right to own one's body, the right to enter into relationship, the right to sexual consent among others. Situations or conditions under which one could deny the sexual partner intercourse were also known by some respondents. This notwithstanding, even though respondents admitted that in every marital union, some key reproductive decisions should be taken and agreed upon by both parties, they would succumb to instances where certain reproductive health decisions are imposed on them by their partners;
- Respondents demonstrated their knowledge of acts that constitute infringement of one's sexual and reproductive health rights and the appropriate institutions to report such acts to. A few had suffered some of these acts. They overwhelmingly oppose some instances where cases of sexual abuse are settled as "home matter"; and

- Age and education demonstrated a significant relationship with adolescents' knowledge of sexual and reproductive health rights as opposed to sex and religion.

### **Recommendations**

Based on the findings and conclusions of the study, it is recommended that:

- Reproductive health outreach programmes targeted at adolescents should be continuously made available through the radio and other emerging social media such as facebook, twitter to relate suitably with the information and communication technology era.
- Concerted efforts should be made by parents and communities to revisit the positive aspects of culture and traditions that officially ushered children through the period of adolescence.
- Government should encourage institutions that promote the reproductive well-being of adolescents to establish outlets in rural and peri-urban communities such as Yamoransa. Services at health institutions should attract adolescents to patronize them.
- Enough education (both formal by educational authorities and informal by the family settings) should be made to bridge the gender gap between males and females. Behavioural Change Communication strategies should be geared towards correcting the perceived gender stereotypes which transcends into sexual relations. Adolescents should be made aware of the fact that every sexual being has unalienable and indivisible sexual rights

and is not secondary to another person by reason of differences in socio-demographic and economic status; and

- Again, educational authorities must incorporate human rights, civil rights and responsibilities and issues of sexual and reproductive health rights into sex education syllabus;
- Government is also duty-bound to ensure that agencies where redress could be sought for infringement on one's rights such as the Police Service, Domestic Violence and Victims Support Unit (DOVVSU) are made available and well resourced. This would empower adolescents and give them more confidence to always assert their rights.

#### **Areas for further research**

In the light of these findings, the following problem areas should be given special attention for further research:

- The effects of knowledge of sexual and reproductive health rights on fertility.
- The relationship between awareness of sexual and reproductive health rights and domestic violence in marital unions.
- Knowledge of sexual and reproductive health rights and contraceptive negotiation.

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## APPENDICES

### Appendix A

#### Chi-square test analysis

##### 1. Sexuality decisions

#### Sex \* number of children

#### Chi-Square Tests

|                              | Value    | df | Asymp.<br>Sig. (2-<br>sided) | Exact<br>Sig. (2-<br>sided) | Exact<br>Sig. (1-<br>sided) |
|------------------------------|----------|----|------------------------------|-----------------------------|-----------------------------|
| Pearson Chi-Square           | 7.982(b) | 1  | .005                         |                             |                             |
| Continuity Correction(a)     | 7.185    | 1  | .007                         |                             |                             |
| Likelihood Ratio             | 8.076    | 1  | .004                         |                             |                             |
| Fisher's Exact Test          |          |    |                              | .006                        | .004                        |
| Linear-by-Linear Association | 7.944    | 1  | .005                         |                             |                             |
| N of Valid Cases             | 209      |    |                              |                             |                             |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 35.76.

**Age \* number of children**

**Chi-Square Tests**

|                              | Value     | df | Asymp. Sig. (2-sided) |
|------------------------------|-----------|----|-----------------------|
| Pearson Chi-Square           | 15.703(a) | 4  | .003                  |
| Likelihood Ratio             | 16.923    | 4  | .002                  |
| Linear-by-Linear Association | 3.041     | 1  | .081                  |
| N of Valid Cases             | 209       |    |                       |

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.68.

**Current educational level \* number of children**

**Chi-Square Tests**

|                              | Value     | df | Asymp. Sig. (2-sided) |
|------------------------------|-----------|----|-----------------------|
| Pearson Chi-Square           | 20.084(a) | 4  | .000                  |
| Likelihood Ratio             | 19.572    | 4  | .001                  |
| Linear-by-Linear Association | 13.275    | 1  | .000                  |
| N of Valid Cases             | 209       |    |                       |

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 1.42.

**Current educational level \* pregnancy**

**Chi-Square Tests**

|                              | Value     | df | Asymp. Sig. (2-sided) |
|------------------------------|-----------|----|-----------------------|
| Pearson Chi-Square           | 15.508(a) | 4  | .004                  |
| Likelihood Ratio             | 14.775    | 4  | .005                  |
| Linear-by-Linear Association | 5.510     | 1  | .019                  |
| N of Valid Cases             | 209       |    |                       |

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 1.38.

**Age \* will stop**

**Chi-Square Tests**

|                              | Value     | df | Asymp. Sig. (2-sided) |
|------------------------------|-----------|----|-----------------------|
| Pearson Chi-Square           | 16.974(a) | 4  | .002                  |
| Likelihood Ratio             | 17.305    | 4  | .002                  |
| Linear-by-Linear Association | 9.122     | 1  | .003                  |
| N of Valid Cases             | 209       |    |                       |

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.63.

**Age \* will insist  
Chi-Square Tests**

|                              | Value     | df | Asymp. Sig.<br>(2-sided) |
|------------------------------|-----------|----|--------------------------|
| Pearson Chi-Square           | 16.932(a) | 4  | .002                     |
| Likelihood Ratio             | 19.916    | 4  | .001                     |
| Linear-by-Linear Association | 6.843     | 1  | .009                     |
| N of Valid Cases             | 209       |    |                          |

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.11.

**Age \* Ability to buy contraceptive even with parent present  
Chi-Square Tests**

|                              | Value     | df | Asymp. Sig. (2-sided) |
|------------------------------|-----------|----|-----------------------|
| Pearson Chi-Square           | 19.114(a) | 4  | .001                  |
| Likelihood Ratio             | 21.087    | 4  | .000                  |
| Linear-by-Linear Association | 13.315    | 1  | .000                  |
| N of Valid Cases             | 208       |    |                       |

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.38.

**Appendix B**

**Questionnaire**

**UNIVERSITY OF CAPE COAST  
DEPARTMENT OF POPULATION AND HEALTH  
M.PHIL (POPULATION AND HEALTH)**

The general objective of the study is to assess Adolescents' knowledge and perception of sexual and reproductive health rights in Yamoransa. I shall be grateful if you would answer them to the best of your ability. This is purely an academic exercise and your anonymity is guaranteed.

*Tick (✓) the appropriate responses to the questions. Unless otherwise stated, responses range from Yes, No, SA (Strongly Agree), A (Agree), NO (No Opinion), D (Disagree) and SD (Strongly Disagree).*

**SECTION A**

**Socio-demographic Background**

1. Sex M [ ] F [ ]
2. Date of Birth: Day [ ] [ ] Month [ ] [ ] 199[ ]
3. Religion: Christianity [ ] Islam [ ] ATR [ ] Other  
.....
4. Ethnicity .....



5. You live with: Both parents [ ] Mother only [ ] Father only [ ]  
 Other, specify .....

6. Marital status: Never married [ ] Widowed [ ]  
 Married [ ] Divorced [ ] Separated [ ]

***If never married skip to 9***

7. How old were you when you first married? .....

8. How was your partner chosen? Entirely by self [ ] Myself  
 with help of family [ ]  
 Entirely arranged by family [ ] Other, specify .....

9. Indicate who provides you with the following needs and if satisfied (S) or  
 not satisfied (NS):

|                       | Father | Mother | Partner | Sibling | Self | Other |
|-----------------------|--------|--------|---------|---------|------|-------|
| Food                  |        |        |         |         |      |       |
| Clothing              |        |        |         |         |      |       |
| School/Apprentice fee |        |        |         |         |      |       |
| Pocket Money          |        |        |         |         |      |       |

10. What is your current level of education?

***If not a school drop-out, skip to 16***

11. What caused you to drop out of school? Pregnancy/impregnated a girl [ ]  
 Lack of interest in school [ ] Financial problems [ ] Class  
 repetition [ ] Other, specify .....

12. What vocational or technical skills have you acquired after dropping out of school? .....
13. What economic activity are you engaged in? .....
14. Do you belong to any youth development association? Yes [ ] No [ ]
15. What is your mother's educational attainment?
16. What is your father's educational attainment?
17. What is the major occupation of your father?
18. What is the major occupation of your mother?

**SECTION B**

**Part I: Contemporary Transitional Issues**

19. Do you consider yourself a child or an adult?
20. Why: .....
21. Who has ever given you an orientation into adolescence?
22. What are some of the things he/they discussed with you
23. Do you freely discuss your sexual concerns with the following people and what is the level of response?
- a. Parents/guardian      No [ ]      Yes [ ],
  - b. Partner                      No [ ]      Yes [ ]
  - c. Teacher (*if in school*) No [ ]      Yes [ ]
  - d. Nurse                      No [ ]      Yes [ ],

e. Pastor No [ ] Yes [ ],

24. Has any system of initiation rites been performed on you?

**PART II: Knowledge and experiences of SRH**

25. Have you ever had sexual intercourse? Yes [ ] No [ ]

26. At what age did you have your first sex?

27. If your parents discover that you are not a virgin what will they do?

28. Let's say you have broken your virginity, would you be bold enough to tell your parents to educate you more on safe sexual practice? Yes [ ]

No [ ]

29. Which of these contraceptive methods have you ever heard of?

Condom [ ] Pill (Secure) [ ] Injection [ ] IUD [ ]

Withdrawal [ ]

Foam/jelly/Diaphragm [ ] Rhythm/periodic abstinence [ ]

Other .....

30. Where did you hear from? (*Check as many as apply*).

Radio [ ] T.V [ ] Newspapers [ ] Peers [ ]

Teachers [ ] Parents [ ]

31. Where could one access the contraceptives/Family planning methods mentioned above? .....

32. Would you attempt buying a contraceptive if your parent or guardian was within the premises? Yes [ ] No [ ]

33. What constitute your Reproductive System (sex organ)?

.....

34. What do you think can cause your Reproductive system (sex organ) not to perform their supposed functions?

.....

35. If your whole body is healthy and strong but your sex organs are not functioning well, then you are still healthy.

36. Where in this community could you go to if you need more information about sexual issues? .....

.....

**PART III: Issues about Rights**

37. A. Have you ever heard of human rights?

B. What about Sexual and Reproductive Health Rights?

38. Which of the following constitute an abuse of your SRH rights:

- a. You want to seek information about sexual issues from your parents but they deny you on grounds that you are too young.
- b. You are made to marry someone against your will
- c. Someone forces to have sex with you against your will
- d. Somebody uses loose sexual language on you
- e. Someone touches your sensitive parts without your approval

- f. You are scolded or punished for discussing sexual issues with your friends
- g. Your parents oppose your decisions to be sexually active
- h. You are a gay or bisexual so the people don't despise you
- i. It is suspected that you have STI(s) and so you are forced to take a test

39. Which of the above have you personally experienced?

- a    b    c    d    e    f    g    h    i

40. Is it true that if you don't know about sexual issues, somebody may mislead you into something unfortunate? Yes [ ] No [ ]

41. In every relationship or marriage, who should decide on the following:

a. When to have sex

The Man [ ]            The Woman [ ]            Both [ ]

b. When to give birth

The Man [ ]            The Woman [ ]            Both [ ]

c. Number of Children

The Man [ ]            The Woman [ ]            Both [ ]

d. Spacing of children

The Man [ ]            The Woman [ ]            Both [ ]

e. Birth control

The Man [ ]            The Woman [ ]            Both [ ]

42. Choose the appropriate response to the following issues about rights:

| No. | ITEM  | SA | A | NO | D | SD |
|-----|---|----|---|----|---|----|
| a.  | Individuals should be free to enter into relationships.   |    |   |    |   |    |
| b.  | Girls who become pregnant whiles schooling should be expelled.  |    |   |    |   |    |
| c.  | Males who impregnate school girls should be held fully responsible for the upkeep of the girl and the child |    |   |    |   |    |
| d.  | It is not moral for adolescents to discuss sexuality matters.   |    |   |    |   |    |
| e.  | Considering your age, if you resist sexual advances from an adult, it implies you are disrespectful.        |    |   |    |   |    |
| f.  | Sexual offences should be treated as family/home matter.  |    |   |    |   |    |

43. On what grounds can one refuse the partner sexual intercourse?

.....  
 .....

44. What are some appropriate institutions for one to report to when his or her (SRH) rights are infringed upon?

.....

.....  
45. If an attendant refuses to sell a contraceptive to you on grounds that you are 'bad' or too young, what will be your reaction?  
.....  
.....

46. Let's say it is your partner who provides you with all your needs, is higher than you in education and social status, what will you do when:

a. He / She wants sex and you are not ready:

Will agree [ ]                      Will disagree [ ]

b. He/she wants more or fewer children than you want:

Will agree [ ]                      Will disagree [ ]

c. He/she wants (you) to use condom (family planning) during intercourse but you don't:

Will agree [ ]      Will disagree [ ]

d. He/she wants a pregnancy but you don't:

Will agree [ ]                      Will disagree [ ]

e. He/she wants a relative to raise your kids instead of you:

Will agree [ ]                      Will disagree [ ]

THANK YOU!