

Gender Differentials in Sexual-Reproductive Risk Exposures among High School Students in Ejisu-Juaben Municipality, Ghana

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Abstract

The issue of adolescent sexual and reproductive health concern is a growing global public health issue that has recently received both national and international attention. The study adopted a non-interventional cross-sectional study design, aimed at assessing gender differentials in sexual-reproductive risk exposures among high school students in the Ejisu-Juaben Municipality of Ghana. The study enrolled 820 participants using structured questionnaire as primary data collection tool and focus group discussion. The study key findings are; no statistically significant difference was observed for ever had boy/girlfriends for male (51.2%) and females (49%). Males (54%) and females (46%) ever had sexual intercourse, with no significant difference ($p>0.005$). Mean age in years of sexual debut was 15.02 for males and 15.85 for females. Protection during sexual intercourse was 49% for males and versus 51% for females. Occurrence of pregnancy was 19.5% with 90.2% ending in abortion. Contraceptive use and family planning adoption were not statistically significant for males (58.0%) and females (42.0%) ($p>0.005$). Multiple sexual partner status was higher for males (54.2%) than females (30.5%). Anal or oral sex among males (60.5%) was more than females (39.5%). Males (68.0%) significantly reported higher involvement in masturbation than females (32.0%) ($p<0.005$). Same-sex relationship (homosexuality) was higher for males (57%) than females (43%) and was not significant ($p>0.005$). The study findings suggest inadequate reproductive health knowledge among students. Inclusion of sexual and reproductive health education in the curriculum of schools is essential.

Keywords: Gender, Students, Reproductive Risk, Ejisu-Juaben, Ghana.

Introduction

Sexual behaviour and sexuality are considered fundamental concepts for the total wellbeing and health of adolescents. Adolescence is a transitional period between childhood and adulthood which is associated with a lot of changes, both physical, physiological, intellectually, emotionally, and social (Biro & Dorn, 2006; Choudhury, Blakemore, & Charman, 2006). It also characterised by events for exploration with a wide range of behaviours, but opportunities for growth and development leads to a dramatic increase in risk-taking behaviour, which ultimately leads to negative and risky health outcomes and eventually death.

Over the past decade, adolescent sexual and reproductive health concerns have increasingly been on national agendas, which propels many countries by the high prevalence of HIV/AIDS among young people. In other countries, a central concern has been early childbearing, and still, others have focused predominantly on sexual behaviours among adolescents. Increasingly research and programme experience have shown that it is neither feasible nor productive to focus on one isolated behaviour without addressing a broader set of adolescent sexual and reproductive health concerns. Also, there is mounting evidence that the most effective interventions enhance protective factors of young people and do not simply attempt to reduce risk.

In Ghana, the latest population and household census for Ghana 2010 indicate that like in most developing countries the population is largely youthful, with young people between the ages of 15-24 making up 30.2% of the total population of Ghana. The increase in the proportion of this age group tends to shift most of the diseases burden related to infectious diseases, malnutrition, infant and early childhood mortality among others to a more emerging concept of sexual and reproductive health risk behaviours, substance misuse, mental health, injury and chronic diseases. Unintended pregnancy is high among teenagers resulting from risky sexual behaviour or early marriage.

Against this background, the present study sought to document the gender differentials on sexual and reproductive health risk behaviours among adolescents.

Research question

The study primarily was guided by the research question; ‘Is there a difference in sexual-reproductive risk exposures among students of different gender?’

Research hypothesis

The study tested this null hypothesis; there is no significant relationship between gender and sexual-reproductive risk exposures.

Methodology

Study type and design

This study employed a cross-sectional study design to assess gender differentials in sexual-reproductive risk exposures among a representative sample of junior and senior high school students within the age group of 12 and 20 years in Ejisu-Juaben Municipality, Ghana. The study involved the use of a structured self-administered questionnaire and focus group discussions.

Study population

An estimated student population of eight thousand (8,000) were eligible to participate in the study for both the junior and senior high schools selected for the study. The study population comprised of students with or without indications of sexual-reproductive risk behaviours of both JHS and SHS within Ejisu-Juaben Municipality. The study selected the target population among students of not less than 12 years of age in both sexes as at the time of the study and who were present at school during the survey. The assumption was that students of 12 years of age or above stand a chance of being at risk of sexual-reproductive behaviours. Exclusion criteria were limited to less than 12 years of age, voluntary refusal to participate in the survey and mental disability.

Sampling techniques, sample size and pre-testing

Due to the combined nature of the Ejisu-Juaben Municipality, the study zoned its activities into Ejisu and its sub-communities and Juaben and its sub-community. The study employed a multi-stage sampling technique which used a two-stage cluster probability sample design to produce representative samples of junior high school (JHS) and senior high school students. Each zonal sample included both private and public schools.

The first sampling stage randomly selected seven junior high schools from each of the zones. In the second sampling stage randomly sampled 30 students, 15 males and 15 females from each junior high school.

With senior high schools, the first stage sampling involved selection of four (4) SHS in the municipality. The second sampling stage involves random selection of 5 classrooms within each of the four selected schools, and all students in each class being eligible to participate in the study. The study enrolled twenty students each, ten males and ten females each of the selected class in all the four schools. In effect, a total of fourteen (14) JHS participated in the study as well as four (4) SHS.

A total of 820 students participated in the survey. A pilot test of the survey instrument was carried out on a sample of one non-participating school in the municipality with similar characteristics to establish adherence, control, skills and rate of questionnaire administering, which was meant to ensure effective correspondence and to help in the restructuring of the questionnaire.

Data collection instrument and techniques

Primary data was collected with the use of Modified Youth Risk Behaviours Survey (YRBS) questionnaire on formal interview basis in addition to focus group discussion. The Youth Risk Behaviour Surveillance System (YRBSS) was designed by the CDC to monitor six categories behaviours: those that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviour that contributes to unintended pregnancy and sexually transmitted diseases;

dietary behaviour; and physical activity (CDC, 2010b). The YRBSS is the only national surveillance system that continually generates information about sexual behaviours among youth and related health outcomes throughout the United States (Morris et al., 1993). The questionnaire is the most representative source of information on risk behaviours of high school students in the United States (CDC, 2010a).

This study considered only the reproductive aspects of the questionnaire as well as others that had direct or indirect contributions to the present study, as well as questions related to the local conditions and relevant to the study. Secondary data extracted and manipulated to yield an interpretable outcome included records from published journals.

Well-trained field enumerators assisted data collection. The response rate was excellent, except in few cases of observed incomplete questionnaires.

Data handling and analysis

Data collected were subjected to editing to exclude or minimise errors, re-organised, coded and manipulated with appropriate software for efficient analysis. Access to the data was limited to the principal researcher at the initial stage of the research till completion. Detailed analysis of data was done with the use of computerised software such as SPSS 18 (SPSS, Inc.) and Microsoft Excel 2010, all compatible with Microsoft Windows 8 version.

The frequency of distribution, proportion and percentages for qualitative variables, mean \pm SD, correlations and odds ratios and associated 95% confidence intervals were computed, p-values ≤ 0.05 was considered statistically significant. Results were presented primarily in the form of tables and interpretations of findings made accordingly. Presented below are series of tests performed.

Ethical consideration

Approval and administrative clearance for the conduct of the study were obtained from Educational Directorate, Health Directorate and Heads of all participating schools. The aims and processes of the research were fully explained to the participants before the study and their informed consent obtained for participation in the study. Participants were informed about the content of the interview to enable them to understand the study and to give their full approval. The importance of the study was made known to the participants as well as the low physical and psychological risk associated. Nevertheless, participation was made voluntarily. Thus participants were given the right to or not to take part in the study.

Only consenting individuals were eligible for the study. Confidentiality and anonymity were as well guaranteed to the respondents as they were being dealt with individually.

Result

Background characteristic

Table 3. 1. Background characteristic of participants

Variables	n (%)	p-value
Age		≤ 0.05
Mean Age (SD), Years	16.28 (1.6)	
Sex		1.00
Male	410 (50)	
410 (50)	410 (50)	
Total	820 (100)	
Education Status		0.48
SHS	400 (48.8)	
JHS	420 (51.2) SHS	
Total	820 (100)	
Residential Status		≤ 0.05
Day	580 (70.7)	
Boarding/Hostel		

Boarding/Hostel	240 (29.3)	
Total	580 (100)	
Religious Background		≤ 0.05
Christianity	753 (91.9)	
Muslim		
Traditionalist	8 (1.1)	
Others	3 (0.4)	
Total	819 (100)	
Perceived Religious Commitments		≤ 0.05
Somehow Faithful	156 (19.3)	
Faithful	326 (40.4)	
	325 (40.3)	
Total	807 (100)	

The study participant's background characteristics is shown in **Table 3.** above. Demographics measured include age, sex, education status, residential status at school, religious background and perceived religious commitments. A total of eighteen (18) schools were selected to participate in the study, fourteen (14) junior high schools and four (4) senior high schools. In all, 820 students were selected for the study, 410 males (50%) and 410 females (50%). Of these, a total of 420 (51.2%) and 400 (48.8%) participants were selected respectively from JSH and SHS cohort respectively. No statistically significant difference was observed among the groups regarding selected sample size [$p=0.485$].

By residency status at school, all the participants from JSH (100%) were day students where 40% and 60% were respectively day and boarding/hotel students for SHS. The minimum age of the participants was 12 years (female) whereas the maximum was 23 years (male). The mean age was 16.28 [$SD=1.6$], and modal age was 17 years (27.8%)

The majority were within the age bracket of 14 and 18 years (90.8%). Only 3% were less than age 14 years and 6.2% more than 18 years. Statistically, a significant difference was observed between gender and age [$p \leq 0.05$], males were older than their female counterpart. Majority of the participants were Christians (91.9%) with 6.6% being Muslims and 1.5% as traditionalist and others.

Gender differentials on sexual-reproductive risk

Research Question: Are there differences regarding sexual-reproductive risk exposures among students of a different gender?

Among the key sexual-reproductive risk behaviours measured by the study and stratified by gender is presented below [**Table 3. 2**]. Gender was not very much related to the majority of the risk behaviours except in few case (sexual partner and protection on debut), where a significant difference was observed. Thus, males were comparable as equal as would females would involve in the risk behaviours measured.

Table 3. 2. Sexual-reproductive risk behaviours by gender

Risk Behaviours	Males	Females	χ^2	p-value
	n (%)	n (%)		
Ever Had Boy/Girl Friend	408	405	0.444	0.505
Yes	209(51.2)	198(49)		
No	199(48.8)	207(51)		
Ever Had Sexual Intercourse	403	408	2.905	0.088
Yes	139(34)	118(29)		
No	264(66)	264(66)		
Protection on sexual debut	129	105	8.321	≤ 0.05
Yes	78(60)	82(78)		

No	51(40)	23(22)		
Ever Pregnant/Caused Pregnancy	128	103	0.962	0.327
Yes	22(17)	23(22)		
No	106(83)	80(78)		
Influenced Pregnancy Outcome	20	21	1.003	0.317
Aborted	19(95)	18(86)		
Delivered	1(5)	3(14)		
Sexual coercion	404	404	0.050	0.823
Yes	44(11)	46(11)		
No	360(89)	358(89)		
Sexual partners	118	95	12.029	≤ 0.05
Single	54(46)	66(69)		
Multiples	64(54)	29(31)		
Level of Protection On sex	115	92	0.349	0.840
All the times	44(38)	36(39.1)		
Sometimes	46(40)	39(42.4)		
Occasionally	25(22)	17(18.5)		
Contraceptive Use	406	408	0.864	0.353
Yes	18(4)	13(3)		
No	388(96)	395(97)		

The mean age at sexual debut among participants stratified by gender is presented in the table below [Table 3.3]. The study observes that females and males on the average initiated into sexual activity at an average age of 15.85 years and 15.02 years respectively. Females were statistically significantly different compared to males on average age of sexual debut [$SD=1.572$, $p=0.003$, $CI=-1.378$ to $-.287$].

Table 3.3. Student t-test analysis of age at sexual debut by gender

Gender	N	Mean	SD	t	df	p-value
Male	107	15.02	2.240			
Female	74	15.85	1.572			
Total	181	30.87	3.812	-3.009	199	0.003

Hypothesis: There is no significant relationship between gender and sexual-reproductive risk exposures

In testing for gender association on the sexual-reproductive risk behaviours, binary logistic regression analysis was conducted [Table 3.4]. No statistically significant association was observed on most of the sexual-reproductive risk behaviour variable on gender [$p>0.05$], except in few cases (non-protection on debut and multiple sexual partners) were statistically significant association were observed for gender respectively [$OR=2.331$, $p=0.004$ and $OR=2.697$, $p=.001$].

There is enough evidence in support of the null hypothesis which states ‘Gender is not significantly associated with sexual-reproductive risk exposures’, therefore we failed to reject the null hypothesis. The null hypothesis is rejected on non-protection on debut and multiple sexual partners.

Table 3. 4. Regression analyse of gender on sexual-reproductive risk behaviours

	β	SE	Wald	p-value	OR	95%CI
Sexual relationship	-.093	.140	0.444	.505	0.911	0.69-1.19
Sexual Intercourse	-.258	.151	2.900	.098	0.773	0.57-1.04
Non-protection on debut	.846	.297	8.130	.004**	2.331	1.30-4.17
Pregnancy	.326	.333	0.958	.328	1.385	0.72-2.66
Abortion	-1.15	1.20	0.922	.337	0.316	0.30-3.22
Sexual coercion	0.50	0.22	0.050	.823	1.051	0.68-1.63

Multiple sexual partners	.992	0.29	11.75	.001*	2.697	1.53-4.76
Non-use of contraceptives	-.343	.371	0.857	.355	0.709	0.34-1.67

* $p \leq 0.01$, ** $p \leq 0.05$, Regression analysis not conducted for some risk variables due to non-conformity of the assumptions

Other health-related risk behaviours

The study reported various forms of health-related risk behaviours. Questions were related to ever involved in oral or anal sex, masturbation, breast manipulation (females), history of homosexuality, aphrodisiac use and frequency of usage as well as the use of non-medically prescribed creams on the genitals were asked to participants [Table 3. 5]. Of these, 9.5% reported ever involved in either anal or oral sex as against 90.5% who never practised it. Thus the majority of the participant were more likely not to have practised oral or anal sex [$p \leq 0.05$]. Of the proportion that practised anal or oral sex, males (60.5%) were found to be males than females (39.5%) [$p = 0.051$].

A similar trend of masturbation among participants occurred in the case of oral or anal sex practice. 9.8% reported practised masturbation as against 90.2% who did not. Males again were found involved in masturbation than females (68.0% versus 32.0%) [$p \leq 0.05$].

Breast manipulation was investigated among only females. Of this, 30.7% against 69.3% were found to have experienced this practice from either their sexual or non-sexual partners. With regards to same-sex practice (homosexuality), 3.7% of the participants reported having underdone through such practice. When compared with gender, no statistically significant difference was observed, though males (57%) were found involved in homosexuals than females (43%) [$p = 0.429$].

Aphrodisiac use was reported to be 12.6% common among the participants. A statistically significant difference was observed for gender. Thus males were found to used aphrodisiac than females (69% versus 31%) [$p \leq 0.05$]. Of aphrodisiac use, it was recorded to be 20.7 % very regularly used by the participant as well as 33.3% for regular usage as opposed to 46.0% non-regular use. Of these, males were found both in very regular use and regular use compared to females, no statistically significant difference was detected among their means [$p = 0.183$].

A lesser proportion (15.1%) of the participants report having used a form of chemicals for genital care or other purposes other than medically prescribed. No statistically significant difference was observed for gender. Males were nearly equal as females to have involved in the practice (47% versus 53%) [$p = 0.360$].

Table 3. 5. Health related risk behaviours

Variables	n (%)	p-value
Ever Involved in Oral/Anal Sex		≤ 0.05
Yes 76 (9.5)	Yes 76 (9.5)	
No	724 (90.5)	
Total	800 (100)	
Ever Involved Masturbation		≤ 0.05
Yes	78 (9.8)	
No	721 (90.2)	
Total	799 (100)	
Manipulation of Breast (Females only)		≤ 0.05
Yes	122 (30.7)	
No	275 (69.3)	
Total	397 (100)	
Ever Involved in Homosexual	≤ 0.05	≤ 0.05
Yes	28 (3.7)	
No	739 (96.3)	
Total	767 (100)	

Ever /still taking any drug just to enhance sexual performance or result in breast/penis enlargement		≤ 0.05
Yes	89 (12.6)	
No	616 (87.4)	
Total	705 (100)	
Nature of Use of Sexual Stimulants		≤ 0.05
Not regular	40 (46.0)	
Regular	29 (33.3)	
Very regular	18 (20.7)	
Total	87 (100)	
Ever/Still Using Chemical for Genitalia Care or Other Purposes without Medical Prescription		≤ 0.05
Yes	109 (15.1)	
No	615 (84.9)	
Total	724 (100)	

Substance use and violent behaviours were also assessed by the study. Of the commonest ones and their percentage of occurrence are drug use (11.4%), violence (12.7%), smoking (6.1%), alcohol intake (13.9%), fighting (39.6%) and gambling (16.3%). Majority of the participants were more into fighting than any other types of the behaviours documented [Table 3. 6]. Of all the behaviours, males were found leading in their involvement than females except violence, though statistically significant difference was not observed [$P=0.105$].

The study also assessed the effects of these behaviours on sexual activity. Of these, 21.4% reported having been influenced for sexual activity having taken either alcoholic substance or drug substances. Of this proportion, no statistically significant difference was observed for gender [60% (males) versus 40% (females)] [$p=0.856$].

Table 3. 6. Substance use and violence behaviours

Variables	n (%)	p-value
Substance use and Violence Behaviours		≤ 0.05
Substance use/ drug use	28 (11.4)	
Violence	31 (12.7)	
Smoking	15 (6.1)	
Drinking of Alcoholic substances	34 (13.9)	
Fighting	97 (39.6)	
Gambling	40 (16.3)	
Total	245 (100)	
Ever influenced by Alcohol/Substance use for Sex		≤ 0.05
Yes	50 (21.4)	
No	184 (78.6)	
Total	234 (100)	

The study as well assessed some outcome variables that were associated with the predictors of participants risk behaviours. Participants were asked separately (males and females) if they have ever experienced any genital discharge [Table 3. 7]. For females, 52.4% as against 47.6% reported having had genital discharge and no discharge respectively. No statistically significant difference was observed

among the females that developed discharge to those who never developed discharge [$p=0.339$]. With regards to males, majority (70%) never developed genital discharges as against the minority (30%) who also developed genital discharge. Comparatively, females (52.4%) reported to have developed more genital discharge than males (30%)

Table 3. 7. Genital anomalies outcome measures

Variables	n (%)	p-value
Abnormal Genital Discharge (Females)		0.339
Yes	207 (52.4)	
No	188 (47.6)	
Total	395 (100)	
Abnormal Genital Discharge (Males)		≤ 0.05
Yes	114 (30)	
No	271 (70)	
Total	385 (100)	

Discussion

Gender disparities in reproductive health variables have been reported in many studies by various authors. In the present study, no statistically significant difference was observed for ever had boy/girlfriend for male (51.2%) and females (49%). Thus, males and females were likely to have equal chances of either had girl/boyfriend. In term of ever had sexual intercourse, the present study found no significant difference in prevalence for males (54%) and females (46%). Again, the study found a statistically significant difference in the mean age of sexual debut in years for males (15.02) and females (15.85).

This finding is consistent with that reported in the previous study in which the mean age at sexual debut for males was 14.7 ± 2.5 years and females was 14.6 ± 2.0 (Mmbaga, Leonard & Leyna (2012), though reverse trend was observed as also reported by Navarro (2013) in a study among youth in South Florida which recorded the average age of initial sexual experience for females who reported ever had sex as 14.63 against the average age of 13.9 for males. This means on the average, males initiate into sexual activity earlier than would females as observed by the present study, but this was not supported by the previous study (Mmbaga, Leonard and Leyna, 2012; Navarro, 2013).

Protection during sexual intercourse was also assessed by the study and found males as equally likely to protect themselves as females respectively (49% versus 51%). The proportion of participants offered protection on debuts were 68.4% against 31.6% who did not protect themselves and was significant, whereas the most widely used protection type reported by the study was condom (79.5%) either for males or females.

Results revealed 60% and 40% of the males offered protection and non-protection respectively, and 78% and 22% of the females offered protection and non-protection respectively on sexual debuts.

Comparatively, females protected themselves than would males do on intercourse at debut and vice versa. These findings do not confirm that reported in earlier study in Ghana in which only minority of sexually experienced respondents reported having used a condom during their first sexual encounter, 18% of males and 27% of females (Ali et al., 2003), though was comparable for females having higher protection on debut than males.

With regards to pregnancy, the study found 19.5% of the participants as being ever pregnant (females) or caused pregnancy (males). Of this proportion, no statistically significant difference was observed for males (49.0%) and females (51.0%).

The outcome of pregnancy was found to be 90.2% aborted and 9.8% delivered, of which most abortions (57.1%) were considered unsafe method. This confirms the finding reported in earlier studies in Africa among adolescents in which consistently high levels of unsafe abortion were recorded (Rogo 1993; Olukoya, 2004). Rate of abortion in the present study (90.2%) is consistent with that of Cadmus & Owoaje (2011) in their study in Nigeria which revealed 93.3% induced abortion among the proportion

of pregnant adolescent in their studies and again unsafe abortion rate of 57.1% was comparable, though lesser than that recorded in earlier study in Ghana among students which discovered 64.1% of self-induced abortion (Appiah-Agyekum, 2004). The present study found no significant difference taken into account the proportion of females (49%) who got pregnant and caused abortion and males (51%) who also advocated their female counterpart on being pregnant to cause an abortion.

Of sexual coercion, the prevalence among both males and females was not statistically significant. Males were as equally likely to force for sexual activity as would females do. Results from the present study revealed that, on sexual relation type, females reported to have single sexual partners than males, whereas males also reported having multiple sexual partners than females.

Of the respondents who were either sexually active or inactive, percentage contraceptive use prevalence and family planning adoption were not statistically significant for males (58.0%) and females (42.0%) and non-adoption for males (49.6 %) and females (50.4 %). The study revealed that on the basis of the total number of sexual partners participant could have, females (69.5%) reported to have single sexual partners than males (45.8%), and on the scale of multiple sexual partner status, males (54.2%) were significantly more than females (30.5%).

The finding indicates that males are at the double risk of contracting sexually transmitted infections among others attributable to multiple sexual partner habit.

Of the health-related risk behaviours measures, the study recorded anal or oral sex prevalence among males (60.5%) to be more than females (39.5%). Additionally, males (68.0%) significantly reported higher involvement in masturbation than females (32.0%). Finding from the present study is comparable in the same trend whereby males reported highest in masturbation but differ in magnitude to that of the previous Australian study in which 58% of males and 42% of females aged 15 to 18 years reported at least 1 lifetime episode of masturbation (Smith et al., 1996), and 53% of males and 25% of females in another retrospective study (Janus & Janus, 1993). Finding is also consistent in trend with findings of Robbins et al. (2011) among nationally representative samples of adolescents aged 14 to 17 years in the United States of America which documented the following; masturbation prevalence, both lifetime and in the past 90 days, being higher in males than females in all age groups. Among males, at age 14 years, 62.6% reported ever having masturbated, while 72.7% of 15-year-olds, 78.1% of 16-year-olds, and 80% of 17-year-olds reported ever having masturbated. This supports the fact that males are more into masturbation practice than females.

Of the proportion that practised same-sex relationship (homosexuality), results revealed no significant difference was observed for males (57%) and females (43%). Aphrodisiac use was found to be statistically significant for males (69%) and females (31%).

Concerning aphrodisiac use, males were found both in regular use compared to females. The use of chemicals for genital care or other purposes than medically prescribed was not statistically significant for males (47%) and females (53%). Substance use behaviours were assessed by the study and found the commonest ones as drug use (11.4%), smoking (6.1%) and alcohol intake (13.9%). Of all these behaviours, males were found leading in their involvement than females, though no statistically significant difference was observed.

The effects of these behaviours on sexual intercourse on the sexually active participants were assessed by the study and found no statistically significant difference for males (60%) and females (40%). This finding recorded by the present study far exceed that recorded in an earlier study in which 38.4% prevalence was observed in males and 20.6% in females as sex after drinking alcohol among the sexually active participants (Wondemagegn et al., 2014). Results showed an outcome effect associated with risky behaviours as genital discharges were prevalent among females (52.4%) than males (30%).

Binary logistic regression analysis was conducted to establish the relationship between sexual-reproductive risk behaviours and gender.

The result showed that no statistically significant association on most of the sexual-reproductive risk behaviour variable on gender, except in few case (non-protection on debut and multiple sexual partners) were statistically significant associated was observed on gender respectively, which serve to provide enough evidence in support of the null hypothesis which states 'gender is not significantly associated with sexual-reproductive risk exposures. The null hypothesis is rejected on non-protection on debut and multiple sexual partners as there existed a significant association between gender and non-protection

on debut and having multiple sexual partners. The study found no statistically significant difference regarding the level of reproductive health knowledge index on gender.

Conclusion

There is a growing body of evidence suggesting an increasingly widespread of adolescent's reproductive risk behaviours at the global level and location specific context.

Results from the current study are moderate levels of prevalence of various reproductive health risk behaviours were documented. Participants have engaged in abortion, unprotected sexual activity, early sexual debut, multiple sexual partner relationship, low level of contraceptive and family planning adoption.

The study reported various differentials in risk behaviours and other variables among males and females, though not statistically significant. Gender was not statistically significantly associated with most of the reproductive risk behaviours documented by the study.

On the basis of the results and conclusions drawn from the study, the following are recommended as possible to serve as an intervention; Incorporation of sexual and reproductive health education in the curriculum of both junior and senior high schools in the country to strengthen the knowledge-based and scope of the student on sexual reproductive health-related concepts.

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