

UNIVERSITY OF CAPE COAST

ADOLESCENTS' KNOWLEDGE AND USE OF CONTRACEPTIVES:  
A CASE STUDY IN THREE SELECTED SENIOR HIGH SCHOOLS IN  
SEKONDI-TAKORADI METROPOLIS

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2011

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CASE STUDY OF THREE SELECTED SENIOR HIGH SCHOOLS  
IN SEKONDI-TAKORADI METROPOLIS

BY

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Dissertation Submitted to the Department of Educational Foundations, of the  
Faculty of Education, University of Cape Coast, in Partial Fulfilment of the  
Requirements for the Award of Master of Education (Guidance and Counselling)  
Degree

MARCH 2011

## DECLARATION

### Candidates Declaration

*I hereby declare that this dissertation 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.*

Signature: ..... Date:.....

Candidate's Name: Maria-Goretti Dunyo Adibi

### Supervisor's Declaration

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

Signature: ..... Date:.....

Supervisor's Name: Dr. Koawo Edjah

## **ABSTRACT**

The objective of the study was to find out adolescents knowledge and use of contraceptives in the Sekondi Takoradi Metropolis. Three hundred adolescent male and female students were randomly selected from three senior high schools in the Metropolis to constitute the sample for the study. The instrument that was used to collect data was a questionnaire. Frequency distribution and percentages were used to summarise the data.

The findings from the study indicated that adolescents have much knowledge about contraceptives but few use them. They are familiar with condoms and femidom and most of them use them because they are easy to use. Some parents, guardians and church members disapprove of the use of contraceptives. They obtained information on contraceptives from their peers at school. They submitted that contraceptives are important for them since they prevent unwanted pregnancies and contraction of HIV/ AIDS and other sexually transmitted diseases.

The researcher recommended that there should be guidance and counselling programmes in the schools to counsel the adolescent students on issues concerning their reproductive health and the use of contraceptives to prevent unwanted pregnancy, sexually transmitted diseases and HIV/AIDS.

## **ACKNOWLEDGEMENTS**

I hereby wish to express my profound gratitude to all whom in diverse ways contributed to the success of this research work.

My sincere thanks and appreciation go to my supervisor Dr. Koawo Edjah for his commitment, contribution and support throughout the study. His constructive inputs have really made this work a success. I am very grateful.

Appreciation also goes to the headmaster, head mistresses and students of Fijai, Bompeh and Ahantaman Senior High Schools in Sekondi-Takoradi Metropolis for having spared me their precious time to administer my questionnaire.

My gratitude goes to Ms. Florence Oppong for painstakingly typing the manuscripts of this research work.

## **DEDICATION**

This research work is dedicated to my husband Roy, and my children Esenam, Dzifa and Kofi and my parents.

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **Background to the Study**

Adolescence is a transitional period which is characterized by many processes. Socially, it is a transitional period from dependent childhood to self sufficient adulthood. Psychologically, it is a marginal situation when adjustment has to be made, namely those that distinguish childhood behaviours from adulthood. Adolescence spans from approximately 12 years to the early 20s with individual and cultural variations. For most people, adolescence is an intermediate state between being a child and being an adult. The state is a conflicting one since the adolescent feel like breaking the childhood ties by becoming independent and autonomous. In the course of freeing themselves from emotional dependency, they go through a period that they reject parents and teachers ways of doing things which result in conflicts.

According to Bootzin, Bower, Crooker and Hall (1991), adolescence is a period of profound change in every aspect of life; during which both boys and girls experience a lot of bodily changes. An example is the development of primary sex characteristics which include complex changes in the genital, uterus, fallopian tubes and ovaries for the girls. The most obvious signs for boys' primary sex characteristics include development of the penis, scrotum and testis.

For many adolescents, menstruation, and nocturnal emission involves a certain degree of embarrassment and inconvenience. For that matter adequate information about these changes need to be made clear for them to accept the bodily changes. Those changes affect the way adolescents think about things and relationship with family and their peers which often produce stress. Adolescents frequently find themselves facing problems about alcohol, breaking parental rules and having sex. Peer attachment also caused emotional problems.

Cogen, Birgra and Hans (1993) assert that sex plays an important role in adolescents' feelings, fantasies and social relationships. At this stage, adolescents are influenced by experimentation of sexual activities that is why the issue of sexually transmitted diseases, HIV/AIDS and teenage pregnancy are on the ascendancy.

According to Cogen et al (1993), one factor contributing to the high rate of teenage pregnancies and births is the relatively low level of contraceptive use. Less than half of all adolescents regularly use some form of contraceptive. In Ghana, for example, the 20<sup>th</sup> June, 1991 edition of the "*Daily Graphic*" indicated that as many as 20 - 30% of all pregnancies between 1985 and 1990 were adolescents (Oppong, 1991). Many of these young people are at risk or already struggling with the consequences of an unwanted pregnancy or sexually transmitted diseases and HIV/AIDS. Flora, Maibach and Maccoby (1980) assert that most teenagers believe that contraceptives can guard against unwanted pregnancies; yet the sexually active ones do not use contraceptives.

According to Hofferth and Hayes (1987), many adolescents do not use contraceptives the first time they have sex and many particularly younger adolescents delay for a year or more after first intercourse before using contraceptives. In the view of Hofferth and Hayes (1987), adolescents do not use contraceptives for varying reasons. Contraceptives are expensive and unavailable when needed. They are messy and reduce pleasure or increase levels of anxiety because of inexperience in their uses. Other factors that may contribute to lack of contraceptive use include accessibility, knowledge as well as difficulty in using them.

Hofferth (1987), as cited in Santrock (1987), purports that another factor that may contribute to lack of contraceptive use include adolescents developmental issues such as reluctance to acknowledge ones sexual activity, a sense of invincibility (belief that they are immune from the problems or issues surrounding sexual intercourse or pregnancy) and misconceptions regarding the use of appropriate contraception. According to Hofferth (1990), adolescents who come from a low income family also lack knowledge and use of contraceptives.

Chilman as cited in Zimbard and Weber (1999), indicates that adolescents who indulge in a steady, committed dating relationship are also associated with lack of contraceptive use. In addition, adolescents with poor coping skills, lack of a future orientation, high anxiety, poor social adjustments and a negative attitude towards contraceptives are not likely to use contraceptives.

According to America Academy of Paediatrics (1999) an adolescent level of knowledge about how to use contraception effectively does not necessarily

correlate with consistent use. Some of the reasons given by adolescents for the delay in using contraception are fear that their parents will find out, ambivalence, and the perception that birth control is dangerous. The rate of birth among adolescents in the United States is four times higher than in Western Europe accounting for 13% of all births in the United States. Between 1985 and 1990 the cost to the public of teenage child-bearing was \$120 billion. The age-specific levels of sexual activity are similar to those of teenagers in other countries, raising the question of whether contraception is being underused in the United States. Most teenage mothers (83%) come from poor or low-income families as do most of the teenagers who have abortions (61%). However, 38% of all teenagers come from poor or low-income families. Having a child as a teenager triggers poverty in 28% of teenage mothers by the time they are in their 20s and 30s compared with only 7% of women of comparable age who give birth after adolescence. There are 12 million adolescent girls in the United States. Each year, almost one million of them become pregnant – that is, one in five of all sexual active teenage girls. More than 50% of these girls give birth, and 30% have an abortion. Almost 80% of these pregnancies are unpleasant and more than half of them occur in 18 and 19 year olds. About 25% of teenage mothers will have a second child within 2 years of their first birth (American Academy of Paediatrics: Contraception and Adolescents, 1999).

Only 29.8% of sexually active girls and women aged 15 to 19 use contraception, and many of them use it inconsistently. More adolescents are said to be using contraceptives at the time of first intercourse, mainly because of the

increasing use of condoms (American Academy of Paediatrics: Contraception and Adolescents, 1999). Result from Ghana National Reproductive Health Survey (GYRHS, 1998) indicates that 15 – 19 years old representing 78% of women and 88% of men are aware of at least one modern family planning method. Although about two-thirds of 15 – 19 years adolescents (female and male) approved of family planning but most sexually active teenagers do not use contraceptives.

Among sexually active adolescents, 80% of female and 63% of male say that they could not insist on using a condom if their partner did not want to use one (Ghana Demographic and Health Survey, 1998). The vast majority of adolescents who have had sex know where to obtain a condom and sizeable proportions (29% of females and 55% of males) have used one. Among those who had used a condom the last time they had sex, only about half of young women and one quarter of young men did so to prevent the transmission of HIV/AIDS – indicating that preventing unwanted pregnancies may be a greater concern among sexually active adolescents (Ghana Demographic and Health Survey 1990).

Persuading sexually active youth to use condom is fraught with challenges. Many young people do not feel sufficiently secure in their relationships to insist on condom use (Guttermacher Institute Research, 2004). In Nigeria, lack of sexual health information and services place young people at the risk for pregnancy, abortion, sexually transmitted infections (STDs) and HIV/AIDS. Over 16% of teenage females reported first sexual intercourse by the



age of 17 years. Among teenage women, 37.5% knew some method of contraception; 36% knew a modern method. Among sexually experienced youth aged 18 – 24 years, 72% percent of males and 18% of females had used contraceptives; males (43%) used condoms and females (13%) used the rhythm method. Other sexually active teenagers gave reasons for non use of contraception for fear of complications. Some also believe that condom use would reduce sexual pleasure (Ghana Demographic and Health Survey, 1998).

### **Statement of the Problem**

Adolescents incorporate their emerging sexuality in their social relationship. Boys as well as girls believe that dating relationship should involve emotional as well as physical intimacy. Adolescents' sexual intercourse may serve a variety of psychological needs such as mastery of psychological development, rebellion, peer group identification and validation. Most adolescent girls dropout of school because of unwanted pregnancies as a result of lack of education on the use of contraceptives at this stage (American Academy of Pediatrics, 1999).

According to Hayes as cited in Lawrence and Belsky (1991), nearly half of all sexually active teens use contraceptive sporadically, and when they use it, it has little to do with the girl's time of peak fertility. Periodically, older adolescents use contraception more than younger teens do, and contraception is more likely when sex is planned to occur spontaneously.

There are psychological reasons for not using contraception. Many young people under estimate the seriousness of pregnancy and child bearing

(Lawrence & Belsky, 1991). When teenagers see these as disastrous to them they are much more careful to indulge in sex. This willingness to take chances is also encouraged by adolescent egocentrism and personal fable that they are not susceptible to the problem that befalls other people. Steinberg and Belsky (1991) reported that adolescents are also more likely to reject birth control because it seems calculated. One may be compelled to conclude that sexual activity is an innate drive. This is because even though sexual activities among the adolescent are inevitable, openly talking about sex is deemed a taboo upon which society frowns. This means that adolescents thus need education on the use of contraceptives to prevent any unforeseen circumstances relating to sexuality.

However, it appears parents, teachers as well as adolescents have different perception about the need to provide information on contraception as a result of cultural and religious beliefs. It was against this background that the study was conducted.

### **The Purpose of the Study**

The purpose of study was to examine adolescents' knowledge and use of contraceptives in Senior High Schools in Sekondi-Takoradi Metropolis. Specifically the study sought to;

1. Investigate the sources of information on contraceptives for adolescents male and female.
2. Find out adolescents knowledge on the importance of contraceptives
3. Identify the type of contraceptives used by the adolescents
4. Determine barriers to adolescents' use of contraceptives.

5. Find out solutions to the barriers to adolescents' use of contraceptives

### **Research Questions**

The following research questions served as a guide for the study:

1. Where do adolescents get their information on contraceptives?
2. Do male and female adolescents know about the importance of contraceptives?
3. What types of contraceptives do adolescents use?
4. What are the barriers to the use of contraceptives by adolescents?
5. What are the solutions to the barriers to adolescents' use of contraceptives?

### **Significance of the Study**

The study would make students aware of places in their communities where they could obtain adequate and relevant information on the use of contraceptives in the Sekondi Takoradi Metropolis. This would enable those who cannot abstain from sex to protect themselves from unwanted pregnancies and also from contracting sexually transmitted diseases by using the contraceptives to protect themselves.

Furthermore, it would draw the attention of the general public to acknowledge the fact that adolescents and young people are actually sexually active and they ought to be helped in order to prevent themselves from the many social and health problems like illegal abortion and contracting HIV/AIDS. In addition, the study would alert the government and parents for the need to put measures in place that would enable young people and adolescents have free

access to quality information about sexual and reproductive health. This can be done by counselling and talk by health personnel.

Finally, the study would enable Ghana Education Service and Ministry of Education in collaboration with Ministry of Health to come out with a plan of action which would make it possible for teachers to discuss with students issues concerning their reproductive health in the schools so as to curb the problem of teenage pregnancy and STD's infection among the adolescents.

### **Delimitation**

The scope of the study was delimited to three selected secondary schools; Fijai Senior High School, Bompeh Senior High School and Ahantaman Senior High School all in the Sekondi-Takoradi Metropolis because they are all mixed institutions and fall within the same age group. The study focused on adolescent boys' and girls' knowledge and use of contraceptives.

### **Limitation**

Assess to information on the use of contraceptives by adolescents was a problem since adolescents thought discussing the use of contraceptives may mean that they are promiscuous. There was also the problem of time. Failure for the respondents to respond to the questionnaire promptly was major problem for the researcher.

### **Operational Definitions**

The following words have been operationally defined.

Sex : Refers to the individual biological maleness or femaleness

- Adolescence : It is the process through which an individual makes the gradual transition from childhood to adulthood.
- Adolescent : Is a person between the ages of 12 – 20 years.
- Contraceptive: This is any of the various devices or drugs, which is intended to prevent pregnancy (e.g., condom).
- Sexuality : Sexuality is the ability of a woman or a man to experience or express his /her sexual feeling.

### **Organization of the Rest of the Report**

Chapter two consists of the review of literature related to the topic. This includes what researchers have said about contraceptives, types of contraceptives and the advantages and disadvantages of contraception.

Chapter three focuses on the methodology used to conduct the study. This deals with the research design, the population and sampling procedure, research instrument that was used to collect data, data collection procedure, and the data analysis procedure. Chapter four is made up of results and discussions. It shows vivid description of how the data that was collected was systematically presented and discussed. Chapter five, the final chapter, entails the summary of the findings, conclusions that were drawn and recommendations for further improvement in the study.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **Introduction**

In this chapter the theoretical and empirical issues that explain adolescents' behaviour were considered. The main focus in this chapter was considered under the theoretical and empirical areas.

#### **Theoretical Review**

Some relevant theories that helped to explain adolescents' use of contraceptives were reviewed. The theories are:

- Social learning theory
- Classical conditioning theory
- Operant conditioning theory
- Instrumental conditioning theory

#### **Social Learning Theory**

Through the theoretical writing and extensive research of children and adults, Bandura has become an eloquent champion on social learning to attitudinal change (Bandura & Walters, 1986). This approach combines principles of learning with an emphasis on human interaction on social settings. According to Bandura, as cited in Bandura and Walters (1986), human beings are

driven by neither inner forces nor environmental influences but by maintaining the impact of their behaviour on the people in the environment and on themselves. In addition to learning from our own experience, we learn vicariously by observing other people. His theory also evaluates behaviour according to personal standards and provides counsellors with reinforcement such as self reproach.

Bandura and Walters (1986) point to a complex interaction of individual factors, behaviour and environmental stimuli. Each factor can influence or change the other, and the direction of change is rarely one-way, reciprocal or bi-directional. The observational learning according to Bandura focuses on the process, by which a person changes his behaviour based on observations of another person's behaviour (Hilgard & Alkinson, 1999).

It would be inferred from the theory that through observational learning, adolescents may acquire an enormous range of information about their social environment; that is, what gets rewarded and what gets punished or ignored. The sexual life in a certain society may affect contraceptive use. For instance in a community where the use of contraceptive is accepted, the adolescent may use it and where it is not accepted they may not which may contribute to high rate of adolescent pregnancy and child birth. The implication is that adolescents may acquire attitude and beliefs simply by watching what others do and the consequences that follow (Zimbard & Weber, 1994).

## **Classical Conditioning Theory**

The classical conditioning is the form of learning in which two stimuli are associated so that the first evokes the responses that normally follows the second. Hilgard and Alkinson cite Pavlov's (1927), illustration in classical conditioning that any stimulus that naturally elicits a reflexive behaviour is called an unconditional stimulus (UCS) because learning is not a necessary condition for controlling the behaviour. The behaviour elicited by the unconditional stimulus is called the uncontrolled response (UCR). Pavlov on his work on digestion noticed that dogs in his laboratory salivated not only when they ate food but also as soon as food was placed in front of them, before they had taken a bite. By experimenting, Pavlov discovered that if he regularly rings a bell, the conditional stimulus (CS) just before he left the dogs begun salivating, and they eventually eat, the conditional response (CR) each time the bell sounded, as though they had learned to anticipate for the food. In Pavlov's experiment the organism learned to associate two specific kinds of stimuli in a temporal series, in this case: first the bell, then the food. During conditioning trials, a neutral stimulus such as tone (CS) is repeatedly paired with the unconditional stimulus so that it's predictably follows the neutral stimulus. The classical conditioning discovered by Pavlov is used for investigating relationship between stimulus and events. It is a form of basic learning in which one stimulus or basic event predicts the occurrence of another stimulus or event. The organism learns a new association between two stimuli (that did not previously elicit the response) and a modern powerful stimulus (that elicit the response itself, (Bootzin, Bower and



Crocker (1991). It implies that when a sexually active adolescent admires a girl, he will have a desire for sex. The girl serves as the (UCS) and the desire for sex is (UCR). The sight of a condom by an adolescent will equally lead to the desire for sex. The condom is the (CS) and the desire for sex is the (CR).

### **Operant Conditioning Theory**

Operants are actions which animals' initiate or voluntary responses. According to Skinner operant conditioning occurs whenever the consequences following an operant either increases or decreases the probability that the operant will be performed again in a similar situation. In other words, the relative frequency or strength of an action is likely modified during operant conditioning. The basic principle behind operant conditioning is that if a given operant is repeatedly followed by outcomes that are pleasing to the learner, the act is likely to be performed more often under similar conditions. If on the other hand, the behaviour is generally followed by unpleasant consequences, it is apt to be repeated less often under corresponding circumstances. In our daily lives, operant are continually being conditioned, usually without (Davidoff, 1987). It implies that if the use of contraceptives by adolescents is pleasurable because the desired satisfaction is achieved, they will continue to use it whenever they want to have sex

### **Instrumental Conditioning**

According to Davidoff (1987), Thorndike argued that some responses were learned not simply because they were associated with an exiting stimulus-response connection but because they produce pleasant consequences. This was

known as the law of effect and formed the basis for investigation of a different type of learning. This law indicates that if the response in a connection is followed by a satisfying state of affairs, the strength of the connection is considerably increased, where as if followed by an annoying state of affairs then the strength of the connection is marginally increased. In this vein behaviours that are followed by good consequences are likely to be repeated in future. Thorndike placed food –deprived cats in puzzle boxes from which the animals could escape by simple acts such as manipulating a cord or pressing a lever. As an incentive to solve the problem, food was placed outside the cage where it could be seen and smelled. Thorndike observed that, to reach the food, a cat had to learn to pull the loop that released the cage door. Thorndike believed that all animals including human solve problems by trial and error learning. Successful behaviours become more frequently “stamped in”, by the pleasure of success. At the same time unsuccessful acts are “stamped out” because they do not produce desirable results (Davidoff, 1987). This implies that when the consequences of using contraceptives are rewarded by the approval of parents and guardians, it will encourage the adolescent to use them.

### **Empirical Review**

This aspect of the literature review discusses some empirical issues under the following headings

- History and social issues of Birth control
- Knowledge and Use of Contraceptives
- Types of contraceptives

- Sources of Contraceptives
- Access to contraceptives
- Barriers to contraceptives
- Risk factors

### **History and Social Issues of Birth Control**

According to a report by Encarta (2006), a variety of birth control methods have been used throughout history and across cultures. In ancient Egypt, women used dried crocodile dung and honey as vaginal suppositories to prevent pregnancy. One of the earliest vaginal suppositories appears in the Elders Medical Papyrus, a medical guide written between 1550 and 1500BC. The guide suggests that a fibre tampon moistened with a herb moisture of acacia, dates, colocynth and honey would prevent pregnancy. The fermentation of this mixture can result in the production of lattice which today is recognized as a spermicide.

Before the introduction of the modern contraception like birth control pill, women ate or drank various substances to prevent pregnancy. The seeds of Queen Anns lace, pennyroyal giant fennel, and many other concoctions of plants and herbs were used as oral contraceptives. However, such folk remedies can be dangerous or fatal (Encarta, 2006).

Women in other parts of the world have used all forms of method to control birth. Chinese women drank mercury – now known to be toxic to achieve contraception. The Greeks consumed diluted copper ore; the Italians

sipped a tea of willow leaves with mule's hoof, whilst the Africans drank gun powder and camel foam (Zimbard & Weber, 1994).

Contraception or birth control is deliberate prevention of pregnancy using any of several methods. Birth control prevents female sex cell from being fertilized by a male sex sperm cell and implanting it in the uterus. In United States of America, about 64% of women aged 15 – 40 years practice some form of birth control. When no birth control is used, about 85% of sexually active couple experience pregnancy within one year (American Academy of Pediatrics, 1999).

There are a variety of birth control methods to choose from, although most options are for women. Selection of a method is a personal decision that involves consideration of many factors including convenience, side effect and reversibility that is (whether the method is temporary or permanent). For instance, some people may prefer a birth control option that provides continuous protection against pregnancy, while others may prefer a method that only prevents pregnancy during a single act of sexual intercourse. Because of contraceptives, men and women have been able to control the number of children they produce while still fulfilling their own adult relationships. In the past, contraceptives were symbols of control for women, as they allowed more control over how many children they gave birth to, which was a major health issue for many years. In recent years, birth control has been more widely accepted and used although some religious groups, as well as individuals, disagree with the use of birth control methods and drugs.

According to a study by American Academy of Paediatrics (1999), modern birth control is to prevent unintended pregnancy in the safest manner possible. Manufactured contraceptives are made to be as effective as possible, with little to no side effects. Some contraceptive also help women control, if not eliminate menstrual cycles and even facial acne. This is made possible by manipulating the release of estrogen and other chemicals that are absorbed in the body (American Academy of Paediatrics, 1999).

Some people might have past illness or medical condition that prevents them from using certain types of birth control methods. Others may find out that certain birth control methods cause uncomfortable side effects such as irregular menstrual bleeding, weight gain or mood changes. A person with multiple sexual partners may prefer a birth control method that also offers protection from sexually transmitted infections (STD's). Another important consideration is whether a person ever plans to have children. Most birth control methods are reversible and they do not affect person's ability to reproduce once the method is halted. But surgical birth control methods (vasectomy) cannot in most cases be reversed (American Academy of Paediatrics, 1999). In addition to choosing the type of method to prevent pregnancy, men and women are faced with a number of choices.

Adolescent pregnancy is related to early initiation of sexual activity and non use of contraception. According to GDHS (1998), the age-specific fertility rate (ASFR) for adolescents 15 -19 was 119 in 1993 and 90 in 1998. For example, the ASFR for married women age 19 was 241, for unmarried women

age 19, it was 49 GDHS (1998). This shows that clear differences exist between the ASFR for married and unmarried young people in Ghana. With early age at first sex and increasing indulgence in premarital sex, adolescents are becoming sexually experienced prior to marriage. Age at first sex was found to be as early as 10 years in a study conducted by Nabila and Fayorsey (1996) as cited in Ghana Demographic and Health Survey (1998) of adolescents in Accra and Kumasi.

### **Knowledge and Use of Contraceptives**

Depot medroxyprogesterone and subdermal implants of levonorgesrel are effective contraceptives that require little knowledge from patients in terms of use. This makes them attractive alternatives for adolescents. Depot medroxyprogesterone acetate is administered as a 150 injection every 3 months. According to Davtyan (2000), 11% of 15 to 19 years olds are sexually active. The levonorgestrel implant consists of six silastic capsules inserted subdermally; they provide up to 5 years of effective contraception. The implant is used by 2% of sexually active adolescents. These methods are excellent choices for adolescents with developmental disabilities for teenagers who have difficulty taking their pills regularly.

A report by Davtyan (2000) shows that adolescents who choose the depot reparation or levonorgestrel implants have usually either already tried other methods or been pregnant. Forty-three percent of teenagers who have been pregnant are likely to choose depot medroxyprogesrone acetate; 34% who have been pregnant are likely to choose levonorgestrel implants, and only 12% are

likely to use oral contraceptives. Continuation rates with these methods at 6 months are higher than with oral contraceptives: 87% for the implant compared with 50% for oral contraceptives and 78% for the depot preparation. Convenience, long-term protection, and problems with previous contraception are the most frequent reasons that adolescents choose these methods.

Primary care physicians providing contraceptive services to adolescents should keep syringes of the depot preparation in their office for immediate injection and should make reinjection visits quick (nurses can give them) to increase the chance of adolescents adhering to the regimen. The discontinuation rate among adolescents for depot medroxyprogesterone acetate is fairly similar to that among adults. About 78% continue to use it at 1 year. The most frequent reasons for discontinuation are irregular bleeding, amenorrhea, weight gain, nausea, and depression (Davtyan, 2000). It is important to explain to the teenager who chooses a long-term progestin method for contraception that the menstrual changes that occur are not harmful and that any weight gain is likely to be modest.

Davtyan (2000) reported that these long-acting progestins are used less frequently in Europe than in the United States, mainly because European teenagers are more consistent in their pill taking and have better rates of continuation. The confidential, in-expensive, and accessible contraceptive services in Western Europe contribute to the better education about contraceptives among teenagers and indirectly to increased compliance with their method of choice.

There are other long-term methods of hormonal contraception that soon can be available and may increase compliance among adolescents. A once-a-month combination hormonal contraceptive injection, a once-a-week combination hormonal patch), a two-implant system that provides effective contraception for 3 years after insertion, and a progestin implant that is available in Europe and is effective for 2 years. Possible future improvements in delivery systems include the availability of transdermal progestin cream, which would be applied to the skin daily; a device for self-injection of a dose of progestin and the electronic pill reminder device, which sounds and alarm when the pill should be taken, (Davtyan, 2000).

In Ghana about 76% of women and 88% of men know at least one modern method of contraception (Awusabo-Asare, Kumi-Kyereme & Abane, 2004). In spite of this high level of knowledge, contraceptive use remain low with 22% of all women using any method and only 5% of men relying on a modern method.

Sexual behaviour and contraceptive knowledge and use among adolescent women across a number of developing countries in Africa, Asia and Latin America reveals some unexpected region patterns in sexual activity and marriage in the majority of countries, and a greater tendency for contraceptive use among adolescents which result in method discontinuation due to failure or reason as side effects that leave the user in need of a method (Ghana Demographic and Health Survey, 1990).



According to McCauley and Salter (1995), countries for which contraceptive knowledge have been studied, the majority of adolescent women recognize at least one contraceptive method, and in 21 countries, eight in ten or more young women know about at least one method. Greater variability is found in the levels of knowledge among adolescents women in sub-Saharan African than in the other regions. Levels are low in Madagascar and Nigeria, where fewer than half of all teens know about any method, and highest in Kenya, Rwanda and Zimbabwe, where at least 90% have knowledge about contraceptives based on reproductive health surveys conducted by local institutions with technical assistance from the centres for disease control prevention.

Blanc and Way (1993) reported that the use of modern contraceptive method is highest in Kenya and lowest in Tanzania. In Ghana, current contraceptive use is much higher among adolescent males than females. For males, it ranges from 7.2% in Ghana to 24.5% in Kenya. In general, the use of modern methods of contraception is higher than that of traditional methods. Among females, the predominant, contraceptive method in Ghana and Zambia is the condom while in Kenya and Tanzania it is the pill. The most predominant, method used by males in all the four countries is condom.

According to Cogen, Birga, and Hans (1993), adolescents' indulgence in unsafe sexual activities is on the increase as sex plays an important role in their feelings, fantasies and social relationships. Many teenage pregnancies are the result of inadequate or no contraception. One factor contributing to the high rate

of teenage pregnancies and births is the relatively low level of contraceptive use. Less than half of all adolescents regularly use some form of contraceptives. Agyei, Epoma & Lubega (1992) and Havanon, Bennet & Knodel (1993) reported that adolescents believe that condoms are unnatural. They reduce pleasure or sensation, meaning they do not get the desired satisfaction since it is artificial.

Blanc and Way (1998) said another key concern in considering contraceptive use pattern among adolescents is the extent to which sexually active, unmarried ones use a method. The level of current use is frequently higher among married teenagers. For example, in most countries in sub-Saharan Africa, current use rates are generally substantially higher among sexually active unmarried adolescents than among those who are married. In fact, in ten of 19 sub-Saharan African countries, unmarried women constitute more than 50% of all teenage users of contraceptive. In contrast, in Latin America and the Caribbean (except Haiti), married adolescents are substantially more likely to be practicing contraception than are sexually active, unmarried teens.

### **Types of Contraceptives**

According to the Academy of American Pediatric (1999), there are many brands of oral contraception used throughout the world that generally contain both synthetic estrogen and progesterone. Oral contraceptive may be categorized as either monophasics, which contain a constraint amount of hormones, or multiphasics, which vary the amount progestin and sometimes estrogen, over the course of a 21- day's cycle. The multiphasics (also called triphasics) offer no significant advantage over monophasics pills (American Academy of Pediatric,

1999). There are many types of contraceptives. The barrier methods actually stop sperm from entering a woman's uterus and fertilizing her ovum. They include the men and women condoms, diaphragm, Intrauterine Device and cap.

The hormonal methods consists of pills, patches and implant injections, the Intrauterine System and rings. They make contraception difficult by changing levels of reproductive hormones in women. Others are intended to slay the sperms inside her body like the spermicides and they can be gels and foams inserted in to the vagina. They are contained in a unique sponge that covers the cervix. The best method of contraception that is a hundred percent secure against venereal diseases and unexpected pregnancies is complete abstinence. At times these contraceptives except abstinence will fail and if a woman is fertile at such periods, she then gets pregnant.

If her partner's condom burst she can also risk sharing with him some of his venereal diseases and viruses in case he is infected. The most common side effects of contraceptives are weight gain, breast tenderness, mood swings and headaches but vary from one woman to another. Because women must do something to control birth, the best thing to do is to visit their doctors for advice on their specific case. The types of contraceptive that adolescents use are discussed below.

### Condoms

The use of condoms tripled among adolescents in the 1980s, mainly prompted by the fear of AIDS. Still, many adolescents find condoms

embarrassing to buy or obtain from clinics and may not use one for each act of coitus (Academy of American Pediatrics, 1999).

The male condom is mechanical barrier method contraception. Its effectiveness is enhanced by use of spermicidal. Latex condoms significantly reduce the transmission of STDs and should, therefore, be used by all sexually active adolescents regardless of whether an additional method of contraception is being used. In an era of HIV infection, use of the condom as protection against Sexually Transmitted Infection (STIs) in addition to its use as family planning method has become important. As with other methods of contraceptive, adolescent's awareness of the male condom is high, but despite the fact that it is one of the most commonly used method, overall levels of condom used are still low (American Academy of Pediatrics, 1999). Examples of the condoms are male condom and the female condom (femidom).

Male condoms have several other advantages. They allow male to share in the responsibility for contraception. They are easily accessible and available. They can be obtained without prescription, are inexpensive and they can be legally purchased by minors. The major advantage of condoms as a choice of contraception is that they protect against sexually transmitted diseases and, indirectly, protect against infertility and cervical cancer (American Academy of Pediatrics, 1999). The female condom (Femidom), on the other hand, is also a barrier method of contraception. Available data suggest it may be effective in the prevention of STD's and pregnancy.

### Medroxyprogesterone Acetate Injection (DEPO-PROVERA)

According to the American Academy of Pediatrics (1999), medroxyprogesterone acetate is a long-acting progestin given every 12 weeks as a single dose. For adolescents, this contraceptive method has many benefits, including effective pregnancy prevention convenience (require no daily drug regiment, no need for planning before intercourse), lack of estrogen related side effects, and protection against endometrial cancer and iron deficiency anaemia. The major disadvantages of these contraceptive methods for adolescents are menstrual cycle irregularities, weight gain, headaches, bloating, depression and mood changes.

This contraceptive method may be safely recommended for adolescents who have chronic illness (i.e., seizures, sickle cell disease). Condoms must be used in conjunction with medroxyprogesterone acetate for protection from STDs. (American Academy of Pediatric 1999).

### Intrauterine Device (IUDs)

The intrauterine device is an effective long-term contraceptive but it is not suitable for many adolescents because they are at high risk of contracting sexually transmitted diseases. Older teenagers, perhaps those with children or in monogamous relationships, may be better candidates. Many teenagers are concerned that intrauterine devices reduce fertility. They need to know that nulliparity is not a contraindication to using an intrauterine device and fertility is preserved after discontinuing its use.

Davtyan (2000) conducted a study and Brenda W was used as an experiment. Brenda W already uses a condom, which she plans to continue to use to protect against sexually transmitted diseases. During the experiment she was to avoid using lubricants that are petroleum based because they weaken latex. She and her boyfriend were not to use a female and a male condom at the same time. She could add a spermicide to increase the contraceptive efficacy of the condom. The failure rate of this combined method was 3.14% at 1 year of use.

Adolescents who develop an allergy to or local irritation from spermicides can try non spermicidal condoms. Diaphragms and cervical caps are not popular among adolescents and women because they are perceived to interfere with intercourse and require manipulation of their genitals. They provide less protection against sexually transmitted diseases than condoms.

When used appropriately, IUDs are safe, effective methods of contraception. IUDs should be reserved for adolescent females who cannot use other contraception methods and whose sexual behaviour does not put them at risk of STDs. Some controversy exists as to whether IUDs are an appropriate method of contraception for adolescents. Condoms must be used in conjunction with IUDs for protection against STDs (American Academy of Pediatric, 1999).

#### Diaphragm and Cervical Cap

The diaphragm and cervical cap are effective barrier methods of contraception that requires use of spermicides and condoms. These contraceptive methods have limited usefulness in adolescents as they require a

prescription, a visit with a health care professional for a fitting, and a motivated adolescent who is comfortable and skilled with insertion. Consistent and correct use of diaphragm and cervical cap are critical (American Academy of Pediatric 1999).

#### Oral Contraception: The Combine Pill

There have been changes in the formulation of oral contraceptives over the past four decades. The oestrogen content of OCPs has decreased. Triphasic pills with a reduced total amount of progestin content per cycle have been introduced and new forms (third generation) of progestins have been developed. The pill has been shown to be a safe and effective contraceptive, especially for the adolescent age group. There are many brands of oral contraceptives used throughout the world that generally contain both synthetic oestrogen and progestin. In the United States, birth control pill brands contain 20, 30, 35, or 50 µg of ethinyl estradiol as the estrogen. Mestranol is now rarely used (American Academy of Pediatric, 1999).

According to the American Academy of Pediatric (1999), several different progestins are used. These are ethynodiol diacetate, norethindrone acetate, norethindrone (first generation), norgestrel, levonorgestrel (second generation); anddesogestrel, norgestimate, and gestodene (third generation). Gestodene is not available in the United States. Compared with the older progestins, the newer third generation progestins have the same contraceptive efficacy, ability to regulate the menstrual cycle, and incidence of break-through bleeding. These newer progestins may have a lower incidence of acne vulgaris

and hirsutism, while having the same effect on blood coagulation parameters as the older progestins. OCPs in general improve acne vulgaris. One brand, Ortho Tri-Cyclen, has been approved by the Federal Drug Administration (FDA) for treatment of acne since 1997 (American Academy of Pediatric 1999).

Combined oral contraceptives prevent ovulation by inhibiting gonadotropin-releasing hormone leading to follicle-stimulating hormone and luteinizing hormone (LH) inhibition. Other secondary mechanisms by which OCPs provide contraception include progestin-induced changes (e.g., thickening in cervical mucus viscosity, endometrial atrophy, and changes in the tubal transport mechanism). If the OCP is used correctly, the failure rate is less than 1%. However, a more typical failure rate is approximately 3% in adults, and 5% to 15% in adolescents (American Academy of Pediatric, 1999).

#### Vaginal Spermicides

The American Academy of Pediatric (1999) indicated that vaginal spermicides include creams, jellies, foams, films, and suppositories. They are used with other barrier methods (condom, diaphragm, cervical cap, sponge, female condom). Failure rates are higher if used alone. Vaginal spermicides used without condoms can reduce the risk for cervical gonorrhoea and Chlamydia. However, protection against HIV infection, if vaginal spermicides are used alone, has not been demonstrated. Vaginal odour, local irritation, allergic reactions, and a possible increase in urinary tract infections are side effects of this method. A link to birth defects has not been found.



The main spermicide used in these products is nonoxynol-9, a chemical surfactant which destroys the sperm cell wall. Another is octoxynol. Other potential spermicide that can inhibit HIV replication is under study. Other spermicides include chlorhexidine, benzalkonium chloride (found in contraceptive sponges), propanol, and acrosin inhibitors (e.g., nifedipine). Nifedipine prevents sperm recognition of ovum and sperm penetration into the zona pellucid. Research is also being conducted on seminal liquefaction inhibitors, chemicals preventing release of sperm from semen.

#### Implant Contraceptive: Norplant

In 1990, norplant was released as a contraceptive method in which 6 elongated silastic capsules are inserted subcutaneously into the upper arm. Another implant that will be released soon in the United States is the norplant II; this is a 2-rod implant system which has release rates, pregnancy rates, and side effects similar to the 6-rod system. Norplant allows slow release of levonorgestrel (85 µg/d for 8 months and 30 µg/d thereafter) and provides effective contraception for 5 years. The mechanism of action is similar to DMPA, and the failure rate is only 0.2%. The frequency of ovulatory cycles is approximately 39% over 5 years (11% in the, first year, 28% at the third year and 52% at year 5). There is increased cervical mucus viscosity, impaired oocyte maturation, and atrophic endometrial effects (American Academy of Pediatric, 1999).

Most pregnancies in the first year of use are attributable to unrecognized pregnancy at the time of insertion. In a study of adolescent mothers, 2% of the

norplant users become pregnant in the first year of use, compared with 38% of oral contraceptive users. In this same study, 95% of 48 adolescents who used no method had a pregnancy within 1 year, when compared with 33% of 50 adolescents on oral contraceptives. The continuation rates vary. One study reported a continuation rate of 96% after one year, in contrast to 83% for DMPA and 49 for oral contraceptives. In another study 14% of teens requested removal of their norplant within 6 months of insertion.

Side effects of norplant include irregular menses (greater than 40% in the first year), amenorrhea, mild headaches, and weight gain; anaemia does not usually occur, despite the irregular bleeding.

### **Sources of Information on Contraceptives**

Various studies on the sources of information on sexual and reproductive health for young people show that many sources are utilised for information. According to the result from the 1998 Ghana Demographic and Health Survey (GDHS, 1998), 26% of 15-19 years olds had heard of family planning from both radio and television. Of the people who were exposed to radio message on family planning, 75% approved of the message. Results from GDHS (1998), shows that less than half of adolescent males and females have heard or seen anything about family planning in the mass media via community fora. The results suggest that mass media continues to be another main source of information for young people. There is also relatively weak reliance on interpersonal communication with parents or family members for sexual and reproductive health information. This is because older people especially parents do not know answers to questions

about issues relating to sexual health. Young persons would be branded as “bad” by their parents for even asking questions about contraceptive use. Boys in particular were uncomfortable talking with a mother or father about sexual matters than with girls. Fathers in general were perceived as being less available and patient than mothers. Data from GDHS (1998) shows that, relatively, there is low level of communication between adolescents and their parents. However, romantic partners and best friends were the most common type of people with whom Ghanaian adolescents talked to about contraceptives and other sexual issues.

Adolescents believe that condoms are unnatural. They reduce pleasure or sensation and that their use indicates a general lack of respect for the female partner (Agyei, Epoma & Lubega, 1992 and Havanon et al, 1993). The monetary cost of condom use appears to be even higher among girls than among boys. Some girls feel that a partner’s wish to use a condom suggests that they, the girls, are not clean and that they are commercial sex workers or that they are involved in more sexual relationship (Feldman, O’Harry, Baboo, Chitatu and Ying Lu, 1997).

In the view of Kiragu and Zabins (1995), many adolescents believe that they are too young to become pregnant. Many also refuse to use contraceptives and instead rely on the probability of conceiving at a given time of the month or knowledge of their ovulation period.

Edem and Havey (1995) apparently made a similar observation. For them, girls who carry condoms around may be perceived as being sexually

available; a situation that would reduce their eligibility as potential wives. Such beliefs have been found to produce a strong negative attitude to past condom use and to current intentions to use condoms among university students in Nigeria.

### **Access to Contraceptives**

Sex plays an important role in adolescent feelings and social relationships. Many teenage pregnancies are result of inadequate or no contraception. According to Hofferth and Hayes (1987), many teenagers do not use contraceptives the first time they have sex and many, particularly, younger adolescents delay for a year or more after first intercourse before using contraceptive.

Most teenagers also believe that contraceptives can guard against unwanted pregnancies, yet the sexually active ones do not use contraceptives. Adolescents' inability to access contraceptive is as a result of socio-cultural factors that serve as disincentive for them to patronize contraceptive use as has been mentioned earlier. Misconceptions about the risks of contraceptive methods, fear of the pelvic exam, and concerns about confidentiality keep many teenagers from seeking advice from their physicians. Better communication with adolescents – within families, at school, and within the medical system – can help them overcome these barriers. Clinicians usually don't bring up the issues of sexually transmitted diseases and contraception but these are subjects that most teens would like to discuss with their providers. Teenagers will discuss their sexuality and contraceptive needs with their physician if they know that these discussions are confidential.

## **Barriers to Contraceptive Use**

According to McCauley and Salter (1995), barriers to contraceptives use by the adolescent include lack of information about methods, difficulties in obtaining services from providers influenced by cultural mores which prohibit use among young women, concerns about side effects, and inability to negotiate with partners. Another barrier that serves as disincentive to adolescent use of contraceptive is lack of knowledge about sexual and reproductive health issues, especially family planning (GDHS, 1990). In some countries, unmarried teens are denied access to contraceptive services and information, leaving them without support when making reproductive health decisions. A report from Ghana Demographic and Health Survey (1998) indicated that irregular use of contraceptives is common with adolescents because of poor communication with parents, lack of knowledge of parental contraceptive experience, experience of friends who become parents, low educational achievement and aspirations, low self-esteem and feelings of fatalism and alienation. The traditional and cultural stereotyped idea that sex is for the adult makes it practically difficult for adolescents to freely communicate and discuss with parents issues concerning sex and contraception use. Similarly, because of the stereotyped idea that family planning clinics are the domain of women, counsellors lack experience in conveying information on sexuality and contraception to men.

Blanc and Way (1993) reported that contraception is often inaccessible to teens due to social taboos, financial or geographical barriers, a lack of confidential services and inadequate knowledge about contraceptives and where

to obtain them. Other factors such as cultural based gender roles that reinforce male control over sexual and productive decision-making may contribute in an important way to young girls' inability to make decisions about condom and contraceptive use and also their vulnerability to the risk of manifested pregnancy and sexually transmitted disease (including AIDS). In a study conducted by Mensah and Lloyd (1998) economic and social inequality and age disparity between partners can create a situation of unequal power within relationships which can in turn, reduce girls ability to negotiate whether intercourse should take place and whether condom or contraceptives should be used. In many instances, the threat of male violence also puts pressure on teenage girls to acquiesce to unsafe sexual practice.

Baker and Rich (1992) have postulated that adolescents find talking about sex with parents and adult family members uncomfortable or impossible therefore, peers often constitute the reference group for transmitting information about sexual activity and birth control. Teens may not feel comfortable discussing their reproductive health needs with female providers. There is also the fear of lack of confidential services.

Lack of knowledge about sexual and reproductive health issues and especially family planning, has contributed to an increase in adolescent pregnancies. According to the 1998 Ghana Demographic and Health Survey (GDHS), current use of modern contraceptive was only 4.8% among all adolescent females age 15 – 19 years. However, a large segment of adolescents still use traditional method rather than modern family method (3.8% in 1998). A

large proportion of adolescent males than females in Tanzania and Ghana were found to have knowledge of contraception. The percentage that has knowledge of modern methods ranges from 76.3 percent in Tanzania to 94.6 percent in Ghana among adolescent male, whereas for females it ranges from 65 in Tanzania to 91 in Kenya (GDHS,1990).

Cogen, Birga & Hans (1993) in a study at Burkina Faso noted that adolescent reluctance to use contraceptive stemmed from the fear that their use might cause infertility and other damaging side effects. Forgetting to take a pill before sex was a serious risk. Besides, acquiring contraceptives can be embarrassing for an adolescent. They are often associated with bad morals and training. According to Blanc & Way (1998), the majority of teens were exposed to the risk of pregnancy the first time they had sex. The older the age at first intercourse, however, the more likely adolescents are to practice contraception. In addition, compared with adult women, failure for contraceptive use among adolescents is more likely to result in an undeniable outcome of unplanned pregnancy.

Overt social disapproval of premarital sexual activity and the general lack of privacy at clinics deter adolescents' from the use of contraceptives. Many adolescent girls according to Cogen et al (1993) feel that when they attempt to procure contraceptives, they become objects of gossip and elicit negative attitudes from health personnel. Among adolescents in Zimbabwe, concerns that condoms are off-putting and apprehensions that insisting on condom use

suggests that one have AIDS were important predictors of intended condom non use among mates (Wilson & Lavelle, 1992).

Contraceptive use among sexually active unmarried adolescent females is higher than it is among married teenagers. Blanc and Way (1998) reported similar findings based on Demographic Health Survey (DHS) for the early 1990s for 19 sub-Saharan African countries. In Ghana, 44% of sexually active unmarried adolescent females are currently using a family planning method compared to a contraceptive rate of 25% for currently married adolescent females.

However, the evidence is thin on consistency and correct use of condom among adolescents in Ghana. Therefore, new strategies are needed to increase the acceptability and effective use of condoms, especially in high risk sexual encounters. While condom use is an effective protective mechanism for sexually active people, the vast majority of sexually active adolescents are not using condoms (Ghana National Reproductive Health Survey, 1998).

### **Risk Factors**

The adverse health consequences including elevated risks of pregnancy-related and unsafe abortion complications, maternal death as well as negative educational and precarious economic consequences cannot be overlooked. Gage-Brandoh and Meekers (1993) have noted that adolescents are exposed to the risk of premarital pregnancy. This is associated with negative outcome such as having to leave school or resort to unsafe abortions. The physical or health consequences for teenage mother and her child are more universally recognized



as problematic, especially in communities where anaemia and malnutrition are common and where access to health care is poor.

Bruce and Ann (1995) attest that the severity of the social and personal consequences of adolescent child bearing is also likely to be greater the younger the age at birth. The level of schooling a young adolescent achieves is likely to be lower. She is more likely to depend on her family for support if they accept her and the baby. Moreover, she is less likely to have the opportunity to develop her own identity.

According to Santrock (1998), difficulty in using contraceptive has resulted in high risk of HIV/AIDS among adolescents. Most individuals in their early twenties with AIDS diagnosis were infected with HIV during adolescence.

Among the sexually active youth in a study, 87% of males and 78% of females knew that having sex with a stable partner and using condoms consistently could prevent HIV infection (Ghana National Reproductive Health Survey, 1998)

The first case of HIV/AIDS was reported in Ghana in March 1996. Since then the cumulative number of reported AIDS cases has risen from 42 at the end of the 1996 to 52, 916 as of December, 2001. In 2002, 104 cases of AIDS were reported for 15 – 19 years olds, representing 2.3% of reported cases. Current general awareness about HIV/AIDS is nearly universal with 97% of both females and males aged 15 to 19 reporting in 1998 that they had heard of HIV/AIDS (Ghana National Reproductive and Health Survey 1998).

## Summary of Literature Review

Different methods have been used throughout history and across cultures to control birth. For example in ancient Egypt, women used dried crocodile dung and honey as vaginal suppositories to prevent pregnancy. Chinese women drank mercury to achieve contraception.

Modern birth control prevents unintended pregnancy in the safest manner. Manufactured contraceptives are made to be as effective as possible and there is little or no side effects. Some contraceptives also help women control, if not eliminate menstrual cycles and facial acne. Some of modern types of contraceptives are used as barrier methods that stop sperm from entering a woman's uterus and fertilising her ovum, e.g., women condoms, diaphragm, Intrauterine Device and cap. There are also many brands of oral contraception used throughout the world. The hormonal methods consists of pills, patches and implants injections, the Intrauterine System and rings. Others slay the sperms inside the woman's body like the spermicides. They can also be gels and foams which are inserted in her vagina.

In spite of this high level of knowledge, contraceptive use remains low. In Ghana, current contraceptive use is much higher among adolescent males than females. Sources of information on sexual and reproductive health for young people include family planning clinics, hospitals, radio and television. Adolescent males and females receive information about family planning in the mass media via community fora.

There is relatively weak reliance on interpersonal communication with parents or family members for sexual and reproductive health information. Adolescents are branded as “bad” by their parents for asking questions about contraceptives use. Boys in particular were uncomfortable talking with their mothers or fathers about sexual matters than with girls. Girls who carry condoms around are perceived as being sexually available, a situation that reduces their eligibility as potential wives. Other barriers to contraceptive use by adolescent include lack of information about methods, difficulties in obtaining services from providers and influence by cultural mores which prohibit contraceptive use among young women.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Introduction**

This chapter describes the method used to gather data for the study. It describes the research design, population and sampling procedure used. It also describes the instrument used to collect data, the administration of the instrument, method employed to analyze the data and problems encountered.

#### **Research Design**

The research design used by the researcher for the study was the descriptive survey. Descriptive survey specifies the nature of a given phenomenon. It determines and reports the way things are, thus it involves collecting data in order to test hypothesis or answer research questions concerning the current status of the subject of the study (Osuala, 1982). The reasons for the choice of the design were that the researcher was interested in what adolescents think about and do with contraceptives. The survey also enabled the researcher to question a large group of persons about a particular issue. The descriptive survey was appropriate for the study due to the fact that it enabled the researcher to discover the attitude of boys and girls towards contraception.

## The Study Population

The study population was adolescents in all the second cycle schools in Sekondi-Takoradi Metropolis. The accessible population was students from three selected Senior High Schools namely, Fijai Senior High School, Bompeh Senior High School and Ahantaman Senior High School. The three schools were purposely selected due to the promiscuous life style in the Metropolis.

Table 1

**Population of Students in Each Selected School**

<b>Population</b>	<b>Male No</b>	<b>Female No</b>	<b>Total</b>
Fijai Senior High School	415	612	1027
Bompeh Senior High School	408	607	1015
Ahantaman Senior High School	431	591	1022
<b>Total</b>	<b>1254</b>	<b>1810</b>	<b>3064</b>

## Sample and Sampling Procedure

The researcher used the chart designed by Kericie and Morgan (1970) on how to determine sample size for research purposes. According to their chart for every population of 3000, the sample size should be 341. The total enrolment of students in the three selected Senior High Schools in the region was 3064, comprising of 1027 students in Fijai Senior High School, 1015 students in Bompeh Senior High School and 1022 in Ahanataman Senior High School.

Going by the chart designed by Kericie and Morgan (1970), one hundred students were selected from Fijai Senior High School, one hundred and one students from Ahanataman Senior High School and ninety nine students from Bompeh Senior High School. The researcher used 300 as the sample size for the study which is approximately in line with Kericie and Morgan's mode of determining sample size. Thus, 10 percent of the students were selected for the study in each school.

To obtain the sample for each school, the simple random sampling method (lottery method) was used. All class attendance registers were collected and names given serial numbers. The numbers were put in a container and a number picked at random at a time. Numbers that were drawn were not put back in the container. This was to give every student equal chance of being selected. It is worth noting that this was done in two phases. That is, names were grouped into females and males. Again this was to ensure fair representation of both sexes on the sample selected.

Various authorities assert that there is no fast rule regarding sampling procedure in research. A case in point is Nwadinigwe (2002) who says simple random sampling could be used alongside other sampling procedures. He asserts that simple random sampling could be used to pool members to form stratum. As in the case of this study, there existed males and females. The simple random sampling was used to get the number required for each sex in each school.

Table 2 shows the sample distribution of the three schools selected for the research. The sample of Fijai Senior High School consisted of 34.1% of the males and 32.7% of the females. Whereas the sample of Bompeh Senior High School consisted of 30.4% of the males and 35.2% of the females, Ahantaman Senior High School consisted of 35.5% of the males and 32.1% of the females.

Table 2

**Sampling Distribution**

<b>Population</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Sample</b>
	<b>No</b>		<b>No</b>		
Fijai Senior High School	46	34.1	54	32.7	100
Bompeh Senior High School	41	30.4	58	35.2	99
Ahantaman Senior High School	48	35.5	53	32.1	101
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>

**Instrumentation**

The researcher used a questionnaire to collect data for the study. The questionnaire was designed for the respondents since they were students and could read and write. Questionnaire is a written instrument that contains a series of statement called items that attempt to collect information on a particular topic. According to Sarantakos (1988), questionnaires produce quick results, they are less expensive than other methods. Questionnaires can be completed at the

respondent's convenience. They offer greater assurance of anonymity. They also offer less opportunity for bias or errors caused by presence or attitude of the interviewer. The questionnaire had four sections. Section A had items related to personal data. This comprised of age, sex, level of the students and religion. Section B of the instrument posed questions on adolescents' knowledge and source of information. In section C, the respondents were asked questions on why they think adolescents should use contraceptive and how they got their contraceptives. Section D was made up of questions to find out some of the barriers or difficulties in using contraceptive and how they would solve these difficulties.

## **Validity and Reliability**

### **Validity**

To ensure that the research instrument was valid the instrument was subjected to expert examination at the University of Cape Coast. Some of the drafted items were reframed. For instance, item 11 of the questionnaire which read "Do your parents agree to the use of contraceptive was reframed as "Will your parents be happy if they know that you use contraceptives." Also item 15 which read should adolescents use contraceptives was rewritten as "Why do you think the use of contraceptives is necessary for adolescent?" In the long run, the draft items that numbered thirty (30) were scaled down to twenty four (24). These items were then administered to the respondents.



## **Reliability**

Frankel and Wallen (2000) explain that reliability refers to the consistency of scores obtained from one administration to another and from one set of items to another. Miles (2001) on the other hand explains reliability as the ability of a measure to give consistent scores. From these two authorities, one can infer that reliability is something that recurs under identical or very similar condition. The Cronbach's alpha reliability of the instrument after pre-testing was 0.78.

## **Pre-Testing**

The researcher pre-tested the instrument in Takoradi Senior High School. The reason for choosing this school for the pre-test was that students in this school and students in the three chosen schools for the study share the same characteristics since they were all in mixed institutions and were all in the adolescent stage in the same Metropolis. Before the pre-test, the researcher sought permission from the headmaster. In the whole process, 50 students participated. This number comprises of twenty (20) males and thirty (30) females.

The researcher used the Statistical Package for Social Sciences version 15.0 to run the data collected for the pre-test. The Cronbach's alpha was used to determine the reliability of the whole instrument. The Cronbach's alpha reliability for the overall instrument was 0.78. The responses that were gathered from the pre-test helped to modify ambiguous items.

### **Data Collection Procedure**

Data collection began on November 12, 2008 and ended on November 30, 2008. Before the questionnaires were administered to the selected students, the researcher sought permission from the headmaster and headmistresses in each of the selected schools. After permission has been granted, the researcher explained the purpose of the study to the students and administered the questionnaire to them. Data was first collected at Fiji Senior High School and then at Bompeh Senior High School and Ahantaman Senior High School respectively. The students were given thirty minutes to respond to the items and were allowed to respond to the questionnaire individually. The researcher assured them of confidentiality. After the thirty minutes, the questionnaires were collected and each of the questionnaires was edited to make sure that they have responded to all the items.

### **Data Analysis**

Data collected were organised, coded and analysed using the Statistical Package for Social Sciences (SPSS). The researcher used simple frequencies and percentages in all the analysis. The reason is that frequencies and percentages present data in a simple manner that makes it easier to read and understand.

### **Problems Encountered**

The researcher encountered some challenges when collecting the data. The headmistresses of Ahantaman Senior High School, Bompeh Senior High School and Assistant Headmaster of Fijai Senior High School were reluctant to

co-operate because they saw the questionnaire to be very sensitive. But after explaining the idea behind the research to them, they co-operated in the exercise. Moreover some of the students were also feeling reluctant to fill the instrument because according to them, filling the questionnaire amount to the use and practice of contraceptive and most of them wanted to avoid that situation. The males were unwilling to participate in the exercise. Their reason being that contraceptive is for women.

## **CHAPTER FOUR**

### **RESULTS AND DISCUSSION**

#### **Introduction**

This chapter looks at the biographic characteristic of respondents, knowledge, sources of contraceptives, type of contraceptives adolescents use and difficulties they face in the use of contraceptives. The chapter also looks at the discussion of the main findings in relation to the research questions posed in the study.

#### **Background of Respondents**

The background of the respondents covers the sex, age distribution and the religious state of the respondents.

#### **Sex Distribution of Respondents**

Table 3 reveals that 45% and 55% of the respondents are males and females respectively. This difference shows that most of the respondents are females.

Table 3

**Sex of Respondents**

<b>Sex of respondents</b>	<b>No.</b>	<b>%</b>
Male	135	45.0
Female	165	55.0
Total	300	100.

**Age Distribution of Respondents**

Table 4 shows that the age distribution of the 300 respondents ranged from 12 years to 20 years. It was observed that 51.7% of the males and 51.5% of the females were within 15-17 years age group. Also, 37.2% and 39.4% of the males and females, respectively, were between 18 and 20 years. This shows that majority of the respondents were within the age distribution of 15-17 years. The mean age of boys and girls was 17.2 years.

Table 4

**Age Distribution of Respondents**

<b>Age of Respondent (in years)</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>No.</b>	<b>%</b>
12-14	15	11.1	15	9.1	30	10.0
15-17	70	51.9	85	51.5	155	51.7
18-20	50	37.2	65	39.4	115	38.3
Total	135	100.0	165	100.0	300	100.0

### Religious Denomination of Respondents

Table 5 shows the students' responses on their religious denomination. It was found that 78.3% of the respondents were Christians and only 9.3% were Moslems.

Table 5

#### Religious Denomination of Respondents

Religion State of Respondents	No	%
Christian	235	78.3
Moslem	28	9.3
Traditionalist	21	7.0
Buddhist	16	5.4
Total	300	100.0

### Students' Use of Contraceptive

Students use contraceptives for several reasons. In Table 6, it was observed that 44.4% of the males and 47.3% of the females said they use contraceptives to prevent sexually transmitted diseases and pregnancy. There were 29.6% and 37.6% males and females, respectively, who also indicated that their purpose for the use of contraceptives is to prevent pregnancy. Another group of students consisting of 18.5% of the males and 5.4% of the females said they use contraceptives because they are easier to use. Prevention of sexually transmitted diseases and pregnancy as well as contraceptive being easier to use were the main reasons the students assigned for using contraceptives. By using

contraceptives to prevent sexually transmitted diseases and pregnancy, students are able to concentrate on their academic work and improve on their performances. This confirms a result of a research conducted by American Academy of Pediatrics (1999) in which they reported that condoms have several advantages than other contraceptives because they are accessible, easy to use and prevents pregnancy as well as sexually transmitted diseases.

Table 6

**Reasons Why Respondents Prefer a Particular Contraceptive**

<b>Reasons why students use a Particular Contraceptive</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>
	It prevents pregnancy	40	29.6	62	37.6	102
It prevents sexually transmitted diseases and pregnancy	60	44.4	78	47.3	138	46.0
It is easy to take	10	7.4	16	9.7	26	8.7
It is easy to use	25	18.5	9	5.4	34	11.3
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100.0</b>	<b>300</b>	<b>100.0</b>

## **Perception of Respondents to Parents' Reaction to Respondents' Use of Contraceptives**

From the responses in Table 7 it was found that 30.4% of the males and 29.7% of the females indicated that they do not want their parents to know that they use contraceptives because it is not time for them to indulge in sex. Their parents expect them to indulge in sex when they have completed school and are legally married. Also, whereas 28.1 % of the males and 29.7% of the females responded that their parents will be angry with them for using contraceptives. However, 23.0% of the males and 27.9% of the females said it is not good for a teenager to indulge in sex using contraceptives for fear of complications. This finding supports the assertion by the American Academy of Pediatrics (1990), that one of the major reasons given by adolescents for delay in using contraceptives is that they fear their parents will be aware that they are using contraceptives. This also shows that the adolescents do not want to incur the displeasure of their parents.



Table 7

**Perception of Respondents to Parents' Reaction on Respondents' Use of Contraceptives**

Response	Male		Female		Total	
	No.	%	No.	%	No.	%
It is not time for me to enter into sex	41	30.4	49	29.7	90	30.0
It is not good for a teenager to indulge in sex	31	23.0	46	27.9	77	25.7
They will not be happy with me	25	18.5	21	12.7	46	15.3
They will be angry with me	38	28.1	49	29.7	87	29.0
Total	135	100	165	100	300	100.0

**Age at Which Respondents Should Use Contraceptive**

From Table 8, it was found that 54.0% of the male respondents and 51.5% of the females said contraceptives should be used when students are at the university level. However, 34.1% of the males and 37.6% of the females said contraceptives should be used at the Senior High School level. The results of the study show that contraceptives are used by older adolescents especially those in the Universities and Senior High Schools. This finding confirms that of Morris et al as cited in Blanc and Way (1998) that contraceptives are used by older adolescents.

Table 8

**Age at Which Respondents Should Use Contraceptive**

Response	Male		Female		Total	
	No.	%	No.	%	No.	%
Junior High School	16	11.9	18	10.9	34	11.3
Senior High School	46	34.1	62	37.6	108	36.0
University	73	54.0	85	51.5	158	52.7
Total	135	100	165	100	300	100.0

**Sex Related Problems**

Three hundred students responded to the item on sex related problems. Table 9 shows that 23.7% of the male and 23.6% of the female respondents indicated that they have had sex related problems before. For those who had had sex related problems, the girls outnumber the boys. However, 76.3% of the males and 76.3% of the females stated that they have not had any sex related problems before. From the results, it is clear that most of the students have not had sex related problems before and this may be due to the use of contraceptives. This confirms findings by Blanc and Way (1993) that, in Ghana, the use of contraceptives is high among adolescents and has reduced the transmission of sex related problems among the youth.

Table 9

**Distribution of Respondents who have had Sex Related problems**

Response	Male		Female		Total	
	No.	%	No.	%	No	%
Yes	32	23.7	39	23.6	71	23.7
No	103	76.3	126	76.3	229	76.3
Total	135	100	165	100	300	100.0

**Types of Sexual Problems Respondents are Aware of**

From the 300 respondents, it was found that pregnancy, sexually transmitted diseases, abortion and rape were the most common sex related problems respondents are aware of. Table 10 reveals that 35.6% of the males and 30.3% of the females are aware of pregnancy as sex related problem. Whereas 22.2% of the males and 27.9% females are aware of sexually transmitted diseases as sex related problem, 22.9 % of the males and 24.8% of the females are aware of abortion as sex related problem in the Metropolis. It is clear that pregnancy is a major sex related problem in the Metropolis that adolescents are aware of. The result affirms Cogen et al's (1993) assertion that there are many teenage pregnancies among adolescents as a result of inadequate or no use of contraceptives by adolescents.

Table 10

**Types of Sex Related Problems Respondents are Aware of**

<b>Type of Sex Problem</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	<b>No.</b>	<b>%</b>	<b>No.</b>	<b>%</b>	<b>No.</b>	<b>%</b>
Sexually Transmitted Diseases	30	22.2	46	27.9	76	25.3
Pregnancy	48	35.6	50	30.3	98	32.7
Abortion	31	22.9	41	24.8	72	24.0
Rape	26	19.3	28	17.0	54	18.0
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>

**Service Providers from Whom Students Buy Contraceptives**

From the results of the study, it was found that students buy most of the contraceptives they need to prevent pregnancy and sexually transmitted diseases from the chemical shops within the communities where they live. Apart from the chemical shops, students buy contraceptives from the pharmacy shops. The place where they seldom buy contraceptives from was clinics. This implies that the pharmacists at the pharmacy shops and the chemical sellers at the drugs stores have been instrumental in selling contraceptives to students in the Metropolis to help them protect themselves from unwanted pregnancies and contraction of sexually transmitted diseases. Therefore, if there is any information on the use of contraceptives to be disseminated to students, the service providers should be actively involved.

### **Reasons for Choosing a Particular Service Provider**

Table 11 presents the distribution of reasons provided by respondents for choosing particular providers. The results of the study shows that 40.0% of the males and 37.6% of the females, respectively, said they choose particular service providers because of their friendly attitude towards them. Another reason they assigned for choosing particular service providers was that the prices for the contraceptives were low. This reason was provided by 23.0% and 25.50% of the males and females respectively. However, 19.3% of the males and 17.6% of the females said they chose particular service providers because of the information and guidance attached to the services they provided. The friendly attitude of service providers encouraged the students in the Metropolis to use contraceptives.

Table 11

#### **Reasons for Choosing a Particular Service Provider**

<b>Reasons for Choosing a Particular Service Provider</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	<b>No.</b>	<b>%</b>	<b>No.</b>	<b>%</b>	<b>No</b>	<b>%</b>
Low price	31	23.0	42	25.5	73	24.3
Friendly attitude of service provider	54	40.0	62	37.6	116	38.7
Short distance	15	11.1	21	12.7	36	12.0
Information and guidance attached to service	26	19.3	29	17.6	55	18.3
Convenience	9	6.7	11	6.6	20	6.7
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>

**Research Question 1: Where do adolescents get their information on contraceptives?**

Table 12 shows the responses of the respondents on the source of information on contraceptives for the adolescents in the Sekondi Takoradi Metropolis. It was found that 42.2% of the males and 23.6 % of the females obtain their knowledge on contraceptives from their school. Also, another group of adolescents representing 19.4% of the males and 13.0% of the females obtained their knowledge on contraceptive use from their friends. Besides, 12.6% of the males and 13.9% of the females obtained their knowledge from television. This reveals that the school, friends, television and radio are the major sources of information for the adolescents and can be the best means that can be used to educate the adolescents on issues concerning contraceptive use. The religious bodies and Planned Parenthood Association of Ghana (PPAG) have been doing very little to educate the students on the use of contraceptives in the Metropolis. They have not been doing much to disseminate information on contraceptive use to adolescents. They may fear that when information on contraceptive use is disseminated to the adolescents it would rather encourage them to spend much of their time in indulging in sex rather than concentrating on their academic work.

Table 12

**Sources from which Students Learn about Contraceptives**

Sources of contraceptives	Male		Female		Total	
	No	%	No.	%	No.	%
Parents	14	10.4	21	12.7	35	11.7
School	57	42.2	39	23.6	97	32.3
Friends	26	19.4	39	23.6	65	21.7
Radio	17	12.6	20	12.1	37	12.3
Television	17	12.6	23	13.9	40	13.3
Religious Bodies	1	0.7	11	6.7	11	3.7
Planned Parenthood Association of Ghana	3	2.2	12	7.4	15	5.0
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>

**Respondents' Knowledge on Contraceptive**

Different people have different views about what contraceptives are. The views of the 300 respondents consisting of 135 males and 165 females have been shown in Table 13. From the study it was realised the 92.6% of the males and 92.1% of the females said contraceptives are the various devices or drugs that are used to prevent pregnancy but the remaining 7.4% of the males and 7.9% of the females responded in the negative. Furthermore 96.3% of the male and 97.0 % of the female respondents indicated that contraceptives are drugs that are used by

women to prevent pregnancy. However, the remaining 3.7% of the males and 3.0% of the females also responded in the negative..

In addition, 57.0% of the males and 60.6% of the females, respectively, were of the view that contraceptives are devices used by women to prevent fertility but the remaining male and female respondents, representing 43.0% of the males and 39.4% of the females were of different view. Finally, 51.9% of the male and 54.5% of the female respondents also see contraceptives as drugs used by sexually active people whereas the remaining respondents consisting of 48.1% of the males and 54.5% Of the females responded in the negative.

Flora et al (1980) reported in their studies that most adolescents know that contraceptives can guard against unwanted pregnancies yet some sexually active ones do not use them. Consequently most adolescents continue to have unwanted pregnancies and sexually transmitted diseases which have adverse effects on their education and their opportunities to have good jobs.



Table 13

**Respondents Knowledge on Contraceptive**

Meaning of contraceptive	Male				Female			
	Yes		No		Yes		No	
	No	%	No	%	No	%	No	%
They are the various devices or drugs to prevent pregnancy .	125	92.6	10	7.4	152	92.1	13	7.9
Devices used by women to prevent pregnancy.	130	96.3	5	3.7	160	97.0	5	3.0
Drugs used to prevent fertility .	77	57.0	58	43	100	60.6	65	39.4
Drugs used by sexually active people.	70	51.9	65	48.1	90	54.5	75	45.5

**Research Question 2: Do male and female adolescents know the importance of contraceptives?**

The views of the respondents on the importance of contraceptives to adolescents are presented in Table 14. Whereas 45.2% of the males and 38.8% of the females said contraceptives are important because they protect them against sexually transmitted diseases, 39.3% of the males and 38.8% of the females said contraceptives prevent pregnancy. It can be observed from Table 14 that adolescents use contraceptives mainly to prevent pregnancy and sexually

transmitted diseases. This finding confirms the GYRHS (1998) report on the use of contraceptives. It was reported that in an era of HIV infection, condom is used for protection against sexually transmitted infection in addition to its use as a family planning method has become important.

Table 14

**Reasons Why Male and Female Adolescents Use Contraceptives**

Statements	Male		Female		Total	
	No.	%	No.	%	No.	%
It prevents pregnancy	50	37.1	64	38.8	114	38.0
Protects them against sexually transmitted diseases	60	44.4	64	38.8	124	41.3
Peer group influence	20	14.8	30	18.2	50	16.7
Enable them complete their education	5	3.7	7	4.2	12	7.9
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>

**Research Question 3: What types of Contraceptives do Adolescents Males and Females use?**

Condom, oral contraceptives, vaginal spermicidal contraceptives, injectable contraceptives, intrauterine devices and femidom are the types of contraceptives adolescents are familiar with and use. It was observed from Table 15 that condom, oral contraceptive and virginal spermicidal contraceptives are the contraceptives adolescents often use. Those who indicated they often use

condom constituted 75.6 % of the male and 27.3 % of the female respondents. Again, whereas 13.3% and 19.4% of the male and females respondents, respectively, indicated they often use oral contraceptives, 7.4% of the males and 10.9% of the females use vaginal spermicidal contraceptives.

From the results of the study, it was found that the use of condom is very popular among the males. Femidom on the other hand was the least used contraceptive by the males. This may be because femidom is a type of contraceptives specially designed to be used by females. The above finding supports that of Blanc and Way (1993). In a similar study, they reported that males predominantly use condom. Edem and Harvey (1995) on the other hand similarly reported that girls who carry condoms around may be perceived as being sexually available, a situation that reduces their eligibility as potential wives. Such beliefs have been found to produce strong negative attitudes to past condom use and to current intention to use condoms among university students in Nigeria.

Table 15

**Types of Contraceptives Respondents are Familiar with and Use**

Contraceptives	Male		Female		Total	
	No.	%	No	%	No	%
Condom	102	75.6	45	27.3	143	47.7
Femidom	1	0.7	39	23.6	35	11.7
Intrauterine Device (IUDS)	2	1.5	16	9.7	12	4.0
Oral Contraceptive	18	13.3	32	19.4	28	9.3
Vaginal Spermicidal	10	7.4	18	10.9	14	4.7
Injectable Contraceptives	2	1.5	15	9.1	11	3.7
Total	135	100	165	100	300	100.0

**Research Question 4: What are the Barriers to the Use of Contraceptives?**

Table 16 shows the respondents' responses on the barriers to the use of contraceptives. The barriers to the use of contraceptives by adolescents in the Sekondi Takoradi Metropolis were lack of funds, lack of confidential service, adolescents being ridiculed by their friends for using contraceptives, strong adherence to religious and cultural practices in their communities, fear of being punished by their parents, adherence to social taboos, fear of experiencing complications and lack of information on the use of contraceptives. Of these barriers, lack of funds, lack of confidential services and fear of experiencing complications were found to be the most prevalent among student.

The issue of lack of funds as a barrier to contraceptives use was confirmed by 38.5% and 32.7% of the males and females respectively. They are being cared for by their parents and as a result even though they may have the desire to use contraceptives but may not be able to buy them. Another group of respondents, representing 26.7% of the males and 27.3% of the females mentioned lack of confidential services as a barrier to the use of contraceptives. They are afraid that the service providers may reveal their identities to their parents, relatives and friends. Because of this they may not like to use contraceptives. Furthermore, 11.9% of the males and 23.6% of the females indicated fear of experiencing complications was a barrier to their use of contraceptives. This group of adolescents fear that in the course of using the contraceptives they may develop complications and their precious lives as well as education will be at stake. In this regard, it is evident that most adolescents are confronted with challenges. The above findings affirm the findings made by Mensah and Lloyd (1995). They reported that contraception is often inaccessible to teens due to lack of confidential services, social taboos and geographical barriers. The American Academy of Pediatrics (1990) on their part reported that adolescents do not want to use contraceptives due to fear of their parents.

Table 16

**Barriers to the Use of Contraceptives**

<b>Barriers to the use of contraceptives</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	<b>No</b>	<b>%</b>	<b>No.</b>	<b>%</b>	<b>No</b>	<b>%</b>
Fear of parents	2	1.5	3	1.8	5	1.7
It is a taboo to use contraceptives	5	3.7	6	3.6	11	6.7
Fear of complication	16	11.9	39	23.6	39	16.0
Ridicule from friends	10	8.8	12	7.3	22	7.3
Religious and cultural practices	8	5.9	17	10.3	25	15.2
Lack of funds	52	38.5	54	32.7	106	35.3
Lack of confidential services	36	26.7	45	27.3	81	27.0
Lack of information about use of contraceptives	6	4.4	7	4.2	13	4.3
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>

**Research Question 5: What are the solutions to the barriers of adolescents' use of contraceptives?**

The respondents indicated that the barriers to the use of contraceptives can be mitigated by (a) parents need to encourage the sexually active adolescents to use

contraceptives to prevent unwanted pregnancies and STDs., (b) parents, PPAG and teachers should readily provide the adolescent with information on contraceptives, (c) Parents and teachers should advise the adolescent to lead chaste life and abstain from sex and (d) including adolescent reproductive health in the Senior High School curriculum. From Table 17, whereas 59.3% of the males and 54.5 % of the females were of the view that the solution to the barriers of adolescents use of contraceptive was by Parents and teachers advising the adolescent to lead chaste life and abstain from sex, 14.8% of the males and 13.3% of the females indicated the problems can be solved if parents encourage the sexually active adolescents to use contraceptives to prevent unwanted pregnancies and STDs. Similarly, 13.3% and 9.7% of the males and females respectively felt the problems could be solved when parents, PPAG and teachers should readily provide the adolescent with information on contraceptives use. It is generally acknowledged that by advising the adolescents to lead chaste life and abstain from sex can protect them against contraction of sexually transmitted diseases such as HIV/AIDS and prevents pregnancy and as well enable them to concentrate on their academic work. They can pursue higher academic studies and help to provide the nation with the requisite efficient human resources for national development.

Table 17

**Solutions to the Problems Respondents Face when buying Contraceptives**

<b>Solution to Students</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
<b>Problem</b>	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>
Parents need to encourage the sexually active adolescents to use contraceptives to prevent unwanted pregnancies and STDs.	20	14.8	22	13.3	42	14.0
Parents, PPAG and teachers should readily provide the adolescent with information on contraceptives	18	13.3	16	9.7	34	11.3
Parents and teachers should advise the adolescent to lead chaste life and abstain from sex.	80	59.3	90	54.5	170	56.7
Including adolescent reproduction health in the senior high school curriculum	17	12.6	37	22.5	54	18.0
<b>Total</b>	<b>135</b>	<b>100</b>	<b>165</b>	<b>100</b>	<b>300</b>	<b>100.0</b>



## **CHAPTER FIVE**

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

#### **Introduction**

This chapter presents a summary, conclusions, and recommendations of the study as well as suggestions for further studies.

#### **Summary of the Study**

This research was conducted to find out adolescent knowledge and use of contraceptives in the Sekondi Takoradi Metropolis. The sampled population consisted of selected Senior High Schools, namely Fijai Senior High School, Bompeh Senior High School and Ahantaman Senior High School. Stratified sampling based on school and sex was used to select the required sample. Three hundred students made up of one hundred and thirty five (135) males and one hundred and sixty five (165) females were selected. The descriptive research design was used to conduct the study. Questionnaire was the main instrument used to collect the data.

#### **Major Findings**

On the bases of the research questions it is evident that the students obtain their knowledge on the use of contraceptives from their school, friends and television. Contraceptives protect students against sexually transmitted diseases and prevent unwanted pregnancy.

The types of contraceptives adolescents are familiar with and use are condom, oral contraceptives, vaginal spermicidal contraceptives, injectable contraceptives, intrauterine devices and femidom. Condom, oral contraceptives and vaginal spermicidal contraceptives are contraceptives adolescent use most.

The barriers to the use of contraceptives by adolescents were lack of funds, lack of confidential service from the service providers, being ridiculed by their friends, strong adherence to religious and cultural practices in their communities, fear of being punished by their parents, social taboos, fear of experiencing complications and lack of information on the use of contraceptives. Lack of funds, lack of confidential services and fear of experiencing complications were the most prevalent among the students.

Measures that can be used to mitigate the barriers include education of the students on the adolescents' reproductive health by the parents, provision of adequate information on the use of contraceptives by the service providers, education on the need for adolescents to abstain from sex by parents and teachers and inclusion of adolescent reproductive health in the Senior High School curriculum.

### **Conclusions**

Adolescents have diverse views on what contraceptives are. Most of them perceive contraceptives as devices or drugs that are used to prevent pregnancy. Others also perceived contraceptives as drugs women use to prevent pregnancy. The adolescents have been using contraceptives to prevent unwanted

pregnancy and sexually transmitted diseases to enable them pursue their education to higher levels so that they can be gainfully employed in future.

They obtain much of their information on contraceptives use from their friends and mass media especially television. Contraceptives that they commonly used are condom, oral contraceptives, vaginal spermicidal and femidom. The use of condom is very popular with males and femidom, females.

Factors that sometimes make some adolescent feel reluctant to use contraceptives were lack of funds, lack of confidential services from the service providers and fear of experiencing complications. These problems can best be addressed if parents educate their adolescents on adolescents' reproductive health. It is important for the parents and teachers to advise the adolescent to be chaste.

### **Recommendations**

Based on the findings and conclusions made so far, the researcher has put in the following recommendations and suggestions.

1. From the findings it is evident that most of the respondents obtain information about contraceptives from the school and from their friends. In this vein, for any effective education to be carried out, the school should be the best platform to educate the adolescents on contraceptive use. This also calls for the introduction of sex education in our schools, especially Senior High Schools, to sensitise the adolescents on the proper use of contraceptives to solve the many questions bothering them.

2. Since the condom is the common contraceptive used by the adolescents, they should be encouraged to patronize it. This will be the best option to help curb the problem of teenage pregnancy and sexually transmitted diseases among the adolescents, because the adolescent is sexually active and cannot abstain from sex.
3. Parents should try and educate their adolescents well on the use of contraceptives rather than shirking their responsibilities on the bases that the adolescents should not use contraceptives because they are not adults. Parents should change their attitudes from traditional beliefs about sex and contraception to the realities of modern times. These measures would go a long way to curb the problem of teenage pregnancies and HIV/AIDS.
4. A combined approach to discussing sexuality, which includes family, school, and the media, could be successful in increasing the number of teenagers who abstain from intercourse. The role of the community is critical in promoting abstinence because it can provide teens with hope for the future that they may not want to risk.
5. Moreover, the PPAG in collaboration with the Ministry of Education could organize programmes for adolescents to address issues related to the challenges of the use of contraceptives.
6. Lastly, there should be guidance and counselling programmes in the schools to counsel the adolescents on issues concerning their reproductive health and the use of contraceptives. This is because contraceptive

### **Suggestions for Further Studies**

Subsequent research on adolescents' knowledge and use of contraceptives should cover more schools, so that many adolescents would be involved in the research. Also, other instruments such as interviews could be used other than questionnaire in future research of such nature so that more views could be solicited from the general public concerning adolescents use of contraceptives.

Finally, further studies could be conducted on the impact of adolescents' knowledge and use of contraceptives on students' academic performance in Senior High Schools in Sekondi-Takoradi Metropolis.

## REFERENCES

- Agyei, W. K., Epoma, E.J.M & Lubega, M. (1992), Contraception and Prevalence of Sexually Transmitted disease among adolescents and Young adults in Uganda *International Journal of Epidemiology*, 21, 5: 981 – 988.
- American Academy of Pediatrics (1999), Committee on adolescence, adolescent pregnancy – Current trends and issues, *Journal of American Academy of Pediatrics*: 103: 516 – 520.
- Awusabo – Asare, K., Abane, A. M. & Kumi – Kyereme, A. (2004). Adolescent sexual and reproductive health in Ghana: A Synthesis of Research Evidence, *Occasional Report*, No. 13.
- Baker, G.K. & Rich, S (1992) Influence on adolescent sexuality in Nigeria and Kenya: Findings from recent focus-group discussions. *Studies in Family Planning* 23. 3: 199 – 210.
- Bandura, A. & Walters, R. H. (1986). *Social learning and personality development*, New York: Holt Rinehart and Winston.
- Blanc A. K. & Way A. A. (1993). *Levels and Trends in Reproductive Behaviour. Macro International Inc.*, 11785 Beltsville Drive, Calverton MD 20705.
- Bootzin, R. R., Bower, G.H., Crocker J., & Hall, E. (1991), *Psychology Today: An introduction (7th ed.)* McGraw-Hill, Inc., U.S.A.
- Bruce J., Lloyd, C. B. & Ann, L. (1995) *Families in Focus. New Perspectives on Mothers, Fathers and Children.* New York.
- Casey, K., (2001), *Adolescents in Ghana: Sexual and Reproductive Health. Advocate for Youth.* Accra, Afram Publishers Limited, Ghana.
- Cogen, R., Birga. M., & Hans, J. D., (1993), Problem Related to School Girls Pregnancies in Burkina Faso. *Studies in Family Planning* 24, 5: 282 – 294.
- Daily Graphic (1991, June, 20) Adolescents' attitude towards sex education; A Study of Senior High Schools in Kumasi Metropolis, "Daily Graphic, No. 116773, 8
- Davidoff, L. L (1987). *Introduction to psychology (3<sup>rd</sup> Ed)*, McGraw-Hill Inc, USA .

- Davtyan, C. (2000). *Contraception for adolescents* Department of Medicine, University of California, Los Angeles
- Edem, C.U., & Harvey, S.M. (1995) Use of health belief model of predict condom use among University Students in Nigeria. *International Quarter of Commonwealth Health Education* 15, 1:3-14.
- Encarta (2006). *Birth control*, Redmond, WA: Macrosoft
- Feldman, D.A., O' Harry P., Baboo., K.S., Chitatu, N.W. & Ying Lu (1997). HIV Prevention among Zimbabwean adolescents: Developing a value utilization/norm change model. *Social Science and Medicine* 44, 4:455 – 468.
- Flora, J. A., Maibach, E.W. & Maccoby, N., (1980). The role of the media across four levels of health promotion intervention. *Annual Review of Public Health*. 10:181 – 201.
- Frankel J. R. & Wallen, N. E. (2000). *How to design and evaluate research in education* (4<sup>th</sup> ed.) McGraw-Hill Companies, Inc. New York.
- Gage-Brandon, A.J.S., & Meekers D., (1993). Sex, Contraception and Childbearing before marriage in sub-Saharan African, *International Family Planning Perspective*, 19.1:14.
- Ghana Demographic and Health Survey (1990). Assessment of reproductive health needs in Ghana. Accra, Afram Publishers Limited, Ghana.
- Ghana Demographic and Health Survey (1998). *Contraceptive use*. Ghana Youth Reproductive and Health Survey, Accra, Afram Publishers Limited, Ghana.
- Ghana Demographic and Health Survey (1999). *Adolescent sexual and reproductive experience*, Ghana Demographic and Health Survey, Accra, Afram Publishers Limited, Ghana.
- Ghana National Reproductive Health Survey (1998). *Adolescents Reproductive Health*, Guttmacher Institute Research ,2004.
- Havanon, N. Bennet, A. & Knodel, J. (1993). Sexual networking in Provincial Thailand. *Studies in family Planning*, 24, 1; 1-17.
- Hilgard E. R., Atkinson R.L., & Arkinson R.C., (1999), *Introduction to Psychology* (7<sup>th</sup> ed.) Harcourt Brace Jovanouch, Inc. 1757. Third Avenue, New York, NY 10017 U.S.A..

- Hofferth, S., & Hayes, (1987). *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing Vol.2* working papers and statistical reports Washington D.C. National Academy Press.
- Kericie, R. V. & Morgan, D. W. (1970). *Determining sample size for research activities: Educational and Psychological Measurement*, Sage Publication Inc, London.
- Kiragu, K., & Zabins, L.S. (1995). Contraceptive use among high school students in Kenya. *International Family Planning Perspective* 21. 3:103 -113.
- McDevitt, T. (1996). *Trends in Adolescents Fertility and Contraceptive use in the Developing world*. U.S. Bureau of the Census Report 1P/a5-1 Washington, D.C. U.S Government Printing Office.
- McCauley, A P., & Salter C., (1995). Meeting the Needs of Young Adults.*Population Reports Series Journal. 41, 2: 123-128*.
- Mensah, B.S.& Llyod, C.B. (1998). Gender differences in schooling experience of adolescence in low income countries. The case of Kenya. *Studies in Family Planning* 29,2:167-184
- Miles, J. (2001). *Research methods and statistics*, Britain. Belland Bain Ltd.
- Moreno, L. (1993). Differences by residence and education in contraceptive failure rates in developing countries. *International Family Planning Perspective* 19, 2:24 – 60, 71
- Nwadingwe, I. K. (2002). *Fundamentals of research methods and statistics*, Lagos. Sibon Books Ltd.
- Oppong, F. S. (1991, 20<sup>th</sup> June). Adolescents’ attitude towards sex education; A Study of Senior High Schools in Kumasi Metropolis, “**Daily Graphic**”, No. 116773, 8.
- Osuala, E.C. (1990). *Introduction to Research Methodology*. African – Fep Publishes Limited. 791 Awka Road, PMB 1639, Omisha, Nigeria.
- Salia A.K. (June 20, 1992). Teenage pregnancy among the youth. *Daily Graphic No. 18018 Pp1 & 3*.
- Santrock, J. W. (1987). *Adolescence: An Introduction (7th ed.)*. McGraw –Hill Companies, Inc. U.S.A.
- Sarantakos, S. (1988). *Social Research (2nd ed.)* New York, Palgrave Publishers Ltd. pp 348.



- Steinberg, L. Belsky, J. (1991), *Infancy, childhood and adolescence*. Von Hoffman Press Inc., USA.
- Whitely, B. E. (1996). *Principles of research in behavioural science*. California, Mayfield Publishing Company.
- Wilson, D. & Lavelle S. (1992). Psychosocial Predictions of Intended Condom use among Zimbabwean adolescents. *Health Education Research* 71:55 – 68.
- Zimbard, P.G. & Weber, A.L. (1999). *Psychology*, Harper Collins College Publishers 10 East 53rd Street New York N.Y. 10022.

**APPENDICES**

**APPENDIX A**

Department of Educational foundation

University of Cape Coast

Cape Coast

February 11, 2008

Dear Sir/Madam

**LETTER OF INTRODUCTION**

The bearer of this letter, Maria Dunyo Adibi, is a final year student from the University of Cape Coast. She is conducting a research into adolescent use of contraceptives in Senior High Schools in the Seckondi Takoradi Metropolis. Your school has been selected as one of sample schools.

Kindly permit her to administer her questionnaire to the selected student in your school to enable her collect data for her study.

I would be very grateful if you would permit her to collect data from your school.

I count on your usual cooperation

Thank you.

Yours faithfully

.....

Koawo Edjah

**APPENDIX B**

**UNIVERSITY OF CAPE COAST**

**DEPARTMENT OF EDUCATIONAL FOUNDATION**

**QUESTIONNAIRE FOR STUDENTS**

This is a research work being undertaken by the researcher from the above named Department. You are kindly requested to read through the items and respond to them.

You will be one of the many students responding to this questionnaire. It is purely for academic purpose and absolute confidentiality is assured.

**SECTION A**

**BIOGRAPHIC DATA**

*Write or Tick [] the appropriate box that correspond to your choice concerning each statement below.*

1. Form: .....
2. Sex: Male [] Female []
3. Age: 12 – 14 [] 15 – 17[ ] 18 – 19 [ ]
4. Religion: Christianity []  
Islam []  
African traditional religion []  
Others (Specify): .....

**SECTION B**

**KNOWLEDGE AND SOURCE OF CONTRACEPTIVES INFORMATION**

*Instructions: Tick [ ✓ ] the appropriate option*

Meaning of contraceptives	Yes	No
Contraceptives are any of the various devices or drugs which are intended to prevent pregnancy		
Contraceptives are devices used by women to prevent pregnancy		
Contraceptives are devices to prevent fertility		
Contraceptives are devices used by sexually active people.		

**6.** From which source(s) did you learn about contraceptives?

*Tick [ ✓ ] as applicable*

1. Parents [ ]
2. School [ ]
3. Friends [ ]
4. Radio [ ]
5. T.V. [ ]
6. Religious bodies (e.g. Church) [ ]
7. Planned Parenthood Association of Ghana (PPAG) [ ]
8. Others (Specify) .....

7. Which of the following contraceptives are you familiar with?

*Tick [✓] as many as you know.*

- 1. Condom [ ]
- 2. Femidom [ ]
- 3. Intrauterine device (IUDS) [ ]
- 4. Norplan System [ ]
- 5. Oral contraceptives (Pills) [ ]
- 6. Vaginal Spermicidal [ ]
- 7. Injectable contraceptives [ ]

8. Which of these contraceptives have you used before?

*(Optional)*

- 1. Condom [ ]
- 2. Femidom [ ]
- 3. Norplan System [ ]
- 4. Intrauterine device (IUDS) [ ]
- 5. Oral contraceptives (Pills) [ ]
- 6. Vaginal Spermicidal [ ]
- 7. Injectable contraceptives [ ]

9. Which of them do you prefer most?

.....

10. Give reason(s)

.....

.....

11. Will your parents be happy if they know you use contraceptives?

1. Yes [ ]

2. No [ ]

12. If your answer to question 11 is Yes, what was their reaction?

.....  
.....

13. If your answer to question 11 is No, why don't you want them to know?

.....  
.....

### SECTION C

#### ACCESS TO CONTRACEPTIVES

In this section, adolescent refers to a person between the ages of 12 – 19.

14. At what stage should adolescents use contraceptives?

1. Junior High [ ]

2. Senior High [ ]

3. University [ ]

15. Why do you think the use of contraceptives is necessary for adolescents?

.....

16. Have you ever had any sex related problems? Tick []

1. Yes [ ]

2. No [ ]

17. Which of these sex problems are you aware of?

1. Sexually transmitted disease [ ]

- 2. Pregnancy [ ]
- 3. Abortion [ ]
- 4. Rape [ ]

18. Which of the following contraceptive information providers do you have in your community?

*Tick [✓] as applicable*

- 1. Chemical shops [ ]
- 2. Clinics [ ]
- 3. Hospitals [ ]
- 4. Pharmacy [ ]
- 5. Planned Parenthood Association of Ghana (PPAG) [ ]
- 6. Others (Specify) .....

19. Which of the service providers in Q18 would you like to buy contraceptives?

*List them in order of choice*

- 1. ....
- 2. ....
- 3. ....

20. Give reason(s) for choosing a particular service provider to Q19.

- 1. Low price [ ]
- 2. Friendly attitude of service provider [ ]
- 3. Short distance [ ]
- 4. Information and guidance attach to service [ ]

5. Convenience [ ]

## SECTION D

### BARRIERS OR DIFFICULTIES IN USING CONTRACEPTIVES

*Instruction: Indicate Yes or No*

21. Do you face any problem when you want to buy any contraceptive (e.g. condom)?

1. Yes [ ]

2. No [ ]

Instruction: Tick [  ] the appropriate option.

22. Which of these problems are you likely to face when you wanted to buy a contraceptive?

1. Not natural [ ]

2. Fear of parents/guardian [ ]

3. Expensive to buy [ ]

4. Attitudes of service providers [ ]

5. Ridicule from friends [ ]

6. Difficult to use [ ]

23. How will you solve the problem(s)?

1. Abstinence

2. Including adolescent reproductive health in the senior high school curriculum

3. Service providers should provide information on contraceptives



4. Parents should educate the adolescents on sexual and reproductive health

24. Which of the following sources would you like to engage in the education on contraceptive use?

1. Clinics

2. Radios

3. Parents

4. Television

5. Planned Parenthood Association of Ghana

6. Others (specify).....

Thank you.

