UNIVERSITY OF CAPE COAST

# PERCEPTION OF CONTRACEPTIVES USE AND ITS IMPACT ON THE SEXUAL BEHAVIOURS OF ADOLESCENTS IN SENIOR HIGH SCHOOLS IN THE KRACHI-EAST DISTRICT

BY

ROWLAND DEY KWAMI

Thesis submitted to the Department of Education and Psychology of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfillment of the requirements for the award of Masters of Philosophy degree in Educational Psychology

OCTOBER 2020

DECLARATION

**Candidate's Declaration**

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

Candidate's Signature …….. Date ……..…

Name:……..

**Supervisor's Declaration**

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

Principal Supervisor's Signature …… Date ……

Name: ……

Co-Supervisor's Signature;……..Date……

Name:……...

## ABSTRACT

The study investigated the impact of contraceptive use on the sexual behaviours of adolescents in Senior High Schools. The study espoused a descriptive survey research method with the quantitative paradigm. Perception and Contraceptive use on Sexual Behaviour questionnaire (PCSB) was administered to a sample of 340 out of 2063 Senior High School students. Means and standard deviation were used to analyse the data for the research questions. The hypotheses were tested using independent samples t-test and ANOVA to test. The study revealed that adolescents' knowledge level on contraceptives use was adequate and was above average. Again, it was established that those sources through which they get the information included hospitals, peers, sexual partners, internet and watching television. It was again found that adolescents agreed that contraceptives knowledge and its usage would help prevent sexually transmitted infections and unintended pregnancies among the adolescents. On the basis of gender, there was no statistically significant difference between male and female adolescent students in relation to contraceptive use. The researcher recommends that, there is an urgent need for teachers, Ghana Education Service, NonGovernmental Organizations (NGOs) and parents to undertake programmes that would empower adolescents, especially females, to become assertive in negotiating contraceptive use any time they want to have sex or engage in unprotected sex.

ACKNOWLEDGEMENTS

I would like to express my utmost gratitude to Dr Dramanu Bakari of the Department of Education and Psychology, who as my principal supervisor made major contributions to the work, and offered professional guidance, advice, and encouragement towards the success of this research work. I am really grateful.

I wish to also recognize and acknowledge my indebtedness to Prof. Kwao Edjah of the Department of Education and Psychology who as my cosupervisor made immense contribution, and offered professional guidance for me in line with the supervision of the work. I say a very big thank you.

Finally to my friends Yayra, Chris, Lady Barbara and Kafui for their support and encouragement.

DEDICATION

To my lovely wife Fafali Amehe, my late mother Victoria Akplah Dey, my father Mr N. K. Dey, my sons, brothers and sisters.

TABLE OF CONTENTS

# LIST OF TABLES

# LIST OF FIGURES

# CHAPTER ONE

# INTRODUCTION

## Background to the Study

Pauline, Migosi and Mwania, (2013) reported that the population of adolescents has been on the increase globally, representing more than 17 percent of the total population and more than 90 percent of this adolescent population lives in developing countries that includes Ghana. The Youth Net estimated based on the trend in human population that by the year 2025, adolescent population in the world will have doubled. This unprecedented increase in adolescent population may pose enormous social and economic challenges to nations globally (Pauline, Migosi & Mwania, 2013).

Generally, adolescence is an inevitable stage in human development as it serves as a turning point in the life of everyone growing up. Adolescence by definition is the transition from childhood to adulthood. It is the gap or stage between the childhood and adulthood (Lewin-Bizan, Bowers & Lerner, 2010) According to Larson and Wilson (2004), a thorough understanding of adolescence as a period in human development in society depends on information from various perspectives, including psychology, biology, history, sociology, education, and anthropology. All these perspectives view adolescence as a transitional period between childhood and adulthood, whose cultural purpose is the preparation of children for adult roles. Coleman and Roker (1998) were of the view that adolescence is a period of multiple transitions involving education, training, employment and unemployment, as

well as transitions from one living circumstance to another. Adolescence is believed to be marked by increased rights and privileges for individuals as a result of developmental changes. While cultural variation exists for legal rights and their corresponding ages, considerable consistency in their development is found across cultures. According to Fields, Bogart, Smith, Malebranche, Ellen and Schuster (2012) many cultures define the transition into adult-like sexuality by specific biological or social milestones in an adolescent's life. For instance, menarche (the first menstrual period of a female), or semen arches (the first ejaculation of a male) are frequent sexual defining points for many cultures. In addition to biological factors, adolescents' sexual socialisation is highly dependent upon whether their culture takes a restrictive or permissive attitude toward teen or premarital sexual activity. In the United States specifically, adolescents are said to have raging hormones that drive their sexual desires. These sexual desires are then dramatized regarding teen sex and seen as a site of danger and risk; that such danger and risk is a source of profound worry among adults (Fields et al, 2012).

Arnett (2007), in her view asserts that adolescence can be defined biologically, as the physical transition marked by the onset of puberty and the termination of physical growth; cognitively, as changes in the ability to think abstractly and multi-dimensionally; or socially, as a period of preparation for adult roles. Major pubertal and biological changes include changes to the sex organs, height, weight, and muscle mass, as well as major changes in brain structure and organisation.

According to Bailey (2003), the National Association of Social Workers defined adolescence as the inception of bodily/erotic development and

procreative ability in people. Adolescence is a developmental stage that is characterised by many developmental changes that people are bound to adapt and to learn new things. The changes in adolescence sometimes become problematic due to societal factors which need to be understood and tackled. These developmental changes compel adolescents to try new things that include responses to their sexual urges which eventually lead adolescents to avoidable problems. Bingenheimer, Asante and Ahiadeke, (2015) indicated, that reproductive and sexual health problems attributable to sexual behaviours among adolescents such as early initiation into sex, lack of contraceptives or other contraceptive use, multiple partners, and high risk partners are widespread among adolescents and young adults in sub-Saharan Africa. They explained that adolescents within this part of the world are believed to be less knowledgeable about contraceptives.

In fulfilling the biological need while developing as an adolescent, different behaviours are depicted and this espouses sexual behaviours. Research indicates that there is an urgent need for effective strategies to reduce the number of problems in adolescence for the developing adolescents (Hilliard, Powell, & Anderson, 2016). To develop such strategies, drivers of adolescents' sexual behaviour and contraceptive use must be identified. In Latin America adolescents start sexual activity at earlier ages and only few sexually active youths take any measures for preventing pregnancy (Ali & Cleland, 2005). Adolescents live within various backgrounds (family, peers, community etc.) and their sexual behaviour is determined by diverse factors from these different contexts that influence attitudes, knowledge, skills and norms (Pilgrim & Blum, 2012).

According to the American Academy of Pediatrics (2001), the trend in the sexual behaviours of adolescents have changed as latest statistics reveal welcoming signs that primary and secondary prevention efforts may be starting to have an effect as existing rates of sexual activity, pregnancy, and sexually transmitted diseases (STDs) among adolescents remain a public health concern. American Academy of Pediatrics, (2001) reported that when evaluating available data for female and male adolescents, the increase in infections that have taken place throughout time is greater, and this endorses the ongoing reasons for concern on issues about adolescence. Doku (2012) reported that apart from HIV infection, population explosion due to high birth rate in sub-Saharan Africa is a global public health concern because adolescents constitute the largest percentage of people in the developing countries, especially in sub-Saharan Africa. To Doku (2012), promotion of safe sex and encouragement of contraceptive use would contribute immensely to the reduction in sex-related morbidity and mortality caused by teenage pregnancy, abortion, HIV/AIDS and at the same time reduce population explosion.

According to Sonenstein, Pleck and Ku (1989), changes in sexual activity among adolescent males have become surprising as the rate of 17 to 19 years old adolescents living in urban areas reported having sexual intercourse with percentage increase from 66% to 76%. This revelation was followed by similar studies that revealed a decrease in the number of adolescents aged between 15 to 19 years old reporting having had sexual intercourse, from 60% in 1988 to 55% in 1995 (Sonenstein, Ku, Lindberg, Turner & Pleck, 1998). Although these are empirical evidence to show that adolescents engage in sexual activities, it is believed that there exists little to no regularisation regarding

adolescents having sex in the U.S., which causes conflict in how adolescents are taught about sexual developmental changes and sex education. There is also a continuous debate about whether abstinence-only, sex education or comprehensive sex education should be taught in schools and this stems back to whether or not it is being taught is permissive or restrictive.

According to Connolly, Craig, Goldberg and Pepler (2004), restrictive cultures openly discourage sexual activity in unmarried adolescents or until an adolescent undergoes a formal rite of passage. These cultures may attempt to restrict sexual activity by separating males from females throughout their development, or through public shaming and physical punishment when sexual activity does occur. According to Chein, Albert, O'Brien, Uckert and Steinberg (2011), in less restrictive cultures, there is more tolerance for displays of adolescent sexuality, or of the interaction between males and females in public and private spaces. Less restrictive cultures may tolerate some aspects of adolescent sexuality, while objecting to other aspects. For instance, some cultures find teenage sexual activity acceptable but teenage pregnancy highly undesirable. Other cultures do not object to teenage sexual activity or teenage pregnancy, as long as they occur after marriage. In permissive societies, overt sexual behaviour among unmarried teens is perceived as acceptable, and is sometimes even encouraged (Chein, et al. 2011). Regardless of whether a culture is restrictive or permissive, there are likely to be discrepancies in how females versus males are expected to express their sexuality. Cultures vary in how overt this double standard is, in some, it is legally inscribed, while in others it is communicated through social convention (Diamond, & Savin- Williams, 2009).

The American Academy of Paediatrics (1998) indicated that, approximately half of all adolescents are sexually active, have high rates of adolescent pregnancies and STDs remain a significant concern for the fact that about 900 000 adolescents become pregnant each year, with up to two thirds of these pregnancies occurring in women 18 to 19 years old and one third in women 17 years or younger. Kirby, (2002) reported that the menace of AIDS, as well as the threat of other Sexually Transmitted Diseases(STDs) and pregnancy, have called for concern and many schools across the world without school-based sex education have started making contraceptives available through school counsellors, nurses, teachers, vending machines, or baskets. This step is laudable but it seems to be different in Ghana because it seems culturally impracticable whereby students would be given contraceptives through school counsellors to prevent sexual-related problems. The Ghanaian culture seems to frown upon even the mere discussion of sex related issues, let alone supplying goodies that may in one way or the other bring about a seeming wholesale welcoming of sexual activities among adolescents.

Although it is unknown as to whether contraceptives are given to adolescents in schools to control sexual behaviour, yet it is possible to believe that adolescents may be using contraceptives and this may not be known by many due to the lack of sex education and research in this domain in Ghana. Consequently, although sexual health promotion including HIV/AIDS prevention in Ghana, abstinence, being faithful to one's partner and the use of Contraceptives, the former is most emphasised because of religious and cultural values. The extent to which these cultural, religious values and abstinence

messages promote delay of sexual debut among young people as well as adolescent sexual behaviours in general is less known (Doku, 2012).

**Statement of the Problem**

Issues about adolescence as a transitional period of development are known to be an age-long thing yet many people are believed not to be equipped with the challenges that hover around this period of development in humans. Boamah (2012) indicated adolescence as a stage of life, can be a challenging phase in life. People growing up at this stage have the responsibility of identifying themselves in the society they are found. Their youthful vigour predisposes them to lots of exploration and risk taking behaviours in all aspects of life that is limitless including the use of contraceptives (Aras, Orcin, Ozan, & Semin, 2007). It is believed also that the inadequacy of knowledge and information related to adolescent development has been compounding.

The lack of useful adolescent sexual health education globally has brought about the high rates of adolescent-related problems such as unplanned pregnancies and sexually transmitted diseases among this group of people (American Academy of Paediatrics 1998). A study conducted by the Department of Primary Care in Brazil in 2011 revealed that virtually all adolescents can identify a contraceptive method but its use has hardly been altered. This information demonstrates that there are other factors responsible for contraceptive use, thus, adolescents are now able to identify what a contraceptive method is, but then, their sexual health and sexual behaviours remain unchanged (Almeida, Estela, Lynne & Robert, 2003).

According to the American Academy of Paediatrics (2001) policy document, the medical and social consequences of adolescent sexual activity

are a national health concern for many countries globally, has been associated with unplanned pregnancies and the contraction of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV). The problem now is how best to decrease unplanned pregnancies and STDs rates among adolescents. It has become a topical issue and has attracted much debate worldwide, but with particular misunderstandings surrounding the roles of sexuality education and contraceptives availability for the teeming youthful population of the world (American Academy of Paediatrics, 2001). It is therefore convincing to believe that contraceptives use among adolescents may be common and possible as their attitudes and behaviours towards sexual encounters or activities and their associated problems or challenges remain questionable globally.

Krachi-East District is a community that is also burdened with issues of adolescents' sexual behaviours which results in teenage pregnancies and other crippling consequences. A data collected from the Krachi-East District hospital showed that, among the pregnant women in the district, majority of them are between the ages of 12 to 19 years. It is based on this conviction that I have investigated the perceptions of adolescents' contraceptives use and its impact on sexual behaviour among senior high schools in the Krachi-East District in the Volta Region of Ghana.

**Purpose of the Study**

Generally, the study investigated the perception of contraceptives use and its impact on adolescents' sexual behaviour. Specifically, the study sought to find out:

1. The knowledge level of adolescents' contraceptive use.

2. Sources from which adolescent students get information about contraceptives use.
3. The influence of contraception use on sexual behaviour of adolescent students.
4. Whether gender difference influence the perception of contraception use.
5. Whether there is a difference in perception on contraceptive use among public and private Senior High School adolescent students.
6. Whether age difference among adolescent students influence contraceptive use.
7. Whether perception of contraceptives use can improve the sexual behaviour of adolescent students.
8. The contraceptives that are well known by the adolescent students.

**Research Questions**

1. What is the knowledge level of adolescent students about contraceptives use?
2. What are the sources of information on the usage of contraceptives among adolescents?
3. What are the effects of the perception of contraceptives use on the sexual behaviour of adolescent students?
4. What is the impact of the perception of contraceptives use on the sexual behaviour of adolescent students?
5. What contraceptives are well known to the adolescent students?

**Research Hypotheses**

1. **$H_0$:** There will be no statistically significant difference between male and female students' perception on the use of contraceptives.

   **$H_A$:** There will be a statistically significant difference between male and female students in their perception on the use of contraceptives.

2. **$H_0$**: There will be no statistically significant difference in the perception of contraceptives use among students in private and public schools.

   **$H_A$:** There will be a statistically significant difference in the perception of contraceptives use among students in private and public schools.

3. **$H_0$:** There will be no statistically significant age difference in the perception of contraceptive use among adolescent students.

   **$H_A$:** There will be a statistically significant age difference in the perception of contraceptive use among adolescent students.

**Significance of the Study**

The study was about how adolescents perceive contraceptives, their knowledge of its usage and how such knowledge impacts on their sexual behaviours.

The study findings may also direct the attention of stakeholders in sexual health education and mainstream education, towards the introduction of sex education in schools. In light of this, adolescents would be exposed to genuine information about contraceptive use and how to control their sexual behaviours in the positive dimension.

Corporate organisations such as Non-Governmental Organizations that share interest in adolescent reproductive health can tap into the findings of the study and use the result to educate adolescents in the country.

Being the first of its kind in the district the study may serve as a wake-up call for parents to push for the introduction of a sex education curriculum in schools to educate their adolescents at this crucial developmental stage in their lives.

Above all, the study may add up to literature and also serve as a point of reference to other researchers in similar study focus.

**Delimitation**

The study was delimited to the private and public senior high schools in the Krachi East District of the Volta Region. This is because it is believed that, those in the senior high schools fall within adolescence. It is also delimited to the use of Contraceptives that are available to adolescents. The study mainly focused on the second year senior high school students only. This is because, the third years have entered the critical period of their final examination and the first years have not gained enough experience as far as adolescence life is concerned especially at the senior high school.

**Limitations**

Like all other studies, this study may be susceptible to methodological errors resulting from responses of the study participants. Having that in mind as a researcher, there were modalities to curtail all methodological hitches in order to come out with accurate and reliable findings. Such methodological strategies included accurate representative sample from the population in order to arrive at a reliable result and to empirically describe the phenomenon in the study. The instrument for data collection was dully pre-tested.

## Definition of Terms

The following words have operationally been defined.

**Adolescence:** It is the period following the onset of puberty during which a young person develops from a child in to an adult.

**Perception:** This refers to the organization, identification, and interpretation of sensory information in order to represent and understand the presented information.

**Sexual behaviour:** This refers to a broad spectrum of behaviours in which adolescents display their sexuality.

**Contraceptives:** These are pills or devices, used during or after sexual intercourse to reduce the probability of pregnancy or a sexually transmitted infection (STIs). There are both male and female contraceptives.

## Organization of the Study

The study comprised of five chapters where the chapter one precedes this level and will include the background to the study, statement of the study, purpose of the study, research questions, and hypotheses, significant of the study, delimitation and limitations. The chapter two was about the literature review which included the theoretical review, conceptual review and empirical review. Chapter three espoused the research methods and the foundational and this includes the research design, population, sampling procedure, data collection, validation, ethical consideration, data collection processes and data processing and analysis. Chapter four considered results and discussion and chapter five wrapped up the study with summary and conclusions.

# CHAPTER TWO

# LITERATURE REVIEW

## Introduction

The main purpose of the study was to investigate the impact of contraceptive use on the sexual behaviours of adolescents in Senior High Schools. The literature was reviewed under three sub-headings based on the research questions. (1) Theoretical review (2) Conceptual review and (3) Empirical review.

## Theoretical Reviews

### Sigmund Freud's Psychosexual Theory of Development (1905)

The psychosexual theory held the view that, every transition in all the stages from infancy to adult results in specific modes of need-gratification. One has to be changing and modifying the ways of satisfying desires otherwise stagnation on regression may occur Freud (1905).

Freud's theory is part of the psychodynamic family who has the general conviction about the unconscious mind and how it influences personality. More specifically, Freud's concentration was on pleasure, anxiety or fear that people encounter as they keep growing. As a pioneer and proponent of psychosexual development, Freud viewed human development to be characterised by five (5) distinct stages namely oral, anal, phallic, latency and the genital stages (Myre, 1974). Freud opined that human beings from birth are with innate sexual energy built through the stages of development as the individual progresses on the growth ladder (Bullock & Trombley, 1999).

To Freud, the human mind is structured into three (3) distinct layers namely id, ego and superego that work in tandem to determine the behaviour people put up in their interaction with societal factors. The id is believed to be animalistic as its concentration is about satisfying sexual energies instantly without recourse to societal norms and their consequences. The ego tagged as the mediator operates on the reality direction by valuing situations through mutual coherence before executing any intended action initiated and motivated by instinctual drives. The superego works with morals by putting negative thoughts at bay and championing the cause of societal values.

According Freud (1905), people present behaviours and personalities that are as a result of early childhood experiences because personality to Freud is formed around age 5 where the id needs to be controlled to suit demands of the society people live. The understanding is that, peoples' behaviours and personalities today come from the way they were nurtured in early years of life. If children are not nurtured in good ways that conforms to established norms within their environment, such children might be tagged with maladaptive descriptive adjectives.

According to Freud, each developmental stage comes with challenges that need to be resolved separately because development to him is discontinuous. Success at any stage brings about good attributes to personality and the failure brings about maladaptive personality attributes. For the case of the present study, the concentration is on the latency and genital stages of the psychosexual development because that stage represents the stage of adolescence. With respect to the psychosexual development, in early stages of adolescence, people reach the genital stage from latency stage and throughout

the adolescence the genital phase is maintained. The sexuality, which remains dormant during the latency stage becomes active during the genital phase. During adolescence, the need for closeness and love making with the opposite sex increases and adolescents explore about different appropriate ways to express love and intimacy (Kar, Choudhury, & Singh, 2015).

According to Ott (2010), applying psychosexual views in adolescence indicate that the development of an adolescent does not occur in isolation, rather in the background of the family, society in a defined culture that meaningfully influences the adolescent's sexuality. Society's attitude and cultural perception of sexuality largely have an influence on the families in which an adolescent nurtures and his or her sexuality values.

The genital stage marks the end of Freud's psychosexual theory of personality development and has its genesis from puberty. According to McLeod (2008), the stage is a period of adolescent sexual experimentation, the successful resolution of which is settling down in a loving one-to-one relationship with another person in late adolescence. Sexual instincts are directed to opposite sex pleasure, rather than self-pleasure. For Freud, the proper channel of the sexual instincts in adults is through the opposite sex intercourse. Fixation and conflict may prevent this with the consequence that sexual perversions may develop. For example, fixation at the oral stage may result in a person gaining sexual pleasure primarily from kissing and oral sex, rather than sexual intercourse (McLeod, 2008).

This theory is relevant to this study because, regarding contraceptive use, it is well thought that sexual behaviours adolescents put up are as a result of their earlier (childhood) interactions with their environment. Any risky sexual

behaviour detected might be caused by parents as they were nurturing the growing child. The actions of parents and family members have toll on the individual's personality based on the kind of approval or disapproval meted out such behaviours during childhood years. Children can be rebuked for sexual wrong doings per Freud's view but it should be in a welcoming way so that children would feel unoffended. If they become offended, the worse might happen as they grow. Ideally, parents need to be truthful to their adolescents when it becomes evident that they are showing signs of sexual maturity so that they can learn appropriate sexual behaviours that will aid their smooth development to adulthood.

Taking this theory into consideration, being realistic as a parent with issues in human sexuality is very critical as attitudes in children are developed based on what they experience. Again, parents should try to avoid overemphasis on some sexual behaviours shown by adolescents, as this alone can cause adolescents to experience fear in attempting those sexual behaviours even if it becomes ideal for them when they are grown and can lead to sexual dysfunctions in later life.

**Margaret Mead's Cultural Anthropological Study of Adolescence in Samoa (1928)**

Mead (1928) was interested in the effect of early childhood influences on adult personality and behaviour. Her investigations cantered on the interplay between biological and cultural factors, based on Freud's notion that childrearing practices had profound effects on adult personality. Her attempts to separate the biological and cultural factors that control human behaviour and

personality development led to establishing the cultural configuration and national character approaches in American anthropology.

Felder (2003) studied the sexual life of adolescents in Samoan society in the early 20th century, and theorizes that culture has a leading influence on psychosexual development. Due to her academic relationship studying with Boas, who influenced Mead to answer the debate of whether adolescence was a universally traumatic and stressful time due to biological factors or whether the experience of adolescence depended on one's cultural upbringing.

To answer the above questions, she conducted a study among a small group of Samoans in a village of six hundred people on the island of Tau. Mead based her research and study on youth, primarily adolescent girls. She got to know, lived with, observed, and interviewed 68 young women between the ages of 9 and 20 in three villages of Tau Island. Once she had an understanding of Samoan culture she delved into the specifics of how adolescent education and socialisation are carried out in Samoan culture and contrasted it with western culture that is a bit restrictive in terms of adolescence sexuality (Mead, 1928). In her findings, she reported that adolescence was not a stressful time, compared with the expectation of adolescent "stress" in Western societies. She attributed this difference to cultural factors. She argued that, living in a small culture where people shared a similar value system, Samoan adolescent girls did not face numerous conflicting personal choices and demands concerning issues of human sexual behaviours. This conclusion was based on the observations that Samoan cultural patterns were very different from those in the United States.

Mead's theory was associated with general discussion of the problems facing adolescents in modern society and the various approaches to understand

these problems thus religion, philosophy, educational theory and psychology. Mead (1928) posits that the transition from childhood to adulthood through adolescence in Samoa was a smooth changeover, not constraint with emotional or psychological distress, anxiety or confusion as seen in Western World and the Americas. This portrays a society characterised by a lack of deep feelings and by a lack of conflict, neuroses, and difficult situations. Mead concluded that this was due to the Samoan girl's belonging to a stable, monoculture society, surrounded by role models where nothing concerning the basic human facts of sexual intercourse, child birth, bodily functions and death were hidden.

To Mead the Samoan adolescent girl was not pressured to choose from among a variety of conflicting values, as was the Western or the American girl. Mead maintains that, generally, the major task facing adolescents today is the search for a meaningful identity. This task is immeasurably more difficult in a modern democratic society than in a primitive society like Samoa. The behaviour and values of parents no longer constitute models, since they are outmoded as compared to the models provided by the mass media and other contemporary figures. Furthermore, the adolescent in the process of freeing the self from dependency on parents is not only unresponsive, but frequently antagonistic to their value system. Since the adolescent has been taught to evaluate his or her behaviour against that of his age-mates, he or she now throws out the parents value system and exchanges it for the customary of peers. According to Muuss (1975), rapidity of social change, exposure to various secular and religious value systems, and modern technology make the world appear to the adolescent too complex, too relativistic, too unpredictable, and too ambiguous to provide him with a stable frame of reference.

Mead (1928), in describing the personality and sexuality of Samoans posits that, the psychology of the individual Samoan is simpler, more honest, and less driven by sexual neuroses than the west. Mead describes Samoans as being much more comfortable with issues such as menstruation and more casual about non-monogamous sexual relations and part of the reason for this is the extended family structure of Samoan villages.

Mead does advocate greater freedom for the adolescent and less conformity to family, peer and community expectations to allow the adolescent to realise his creative potential. Muuss (1975) retorted that people can attempt to alter out whole culture, and especially their child-rearing patterns, so as to incorporate within them a greater freedom for and expectation of variations. Mead criticized the American family for its too intimate organisation and its crippling effect on the emotional life of the growing youth as she believed that too strong family ties handicap the individual in his or her ability to live his own life and make his own choices. Mead suggested that it would be desirable to alleviate, at least in some slight measure, the strong role which parents play in children's lives and so eliminate one of the most powerful accidental factors in the choices of any individual life.

Mead describes some specific skills the children must learn related to weaving and fishing and then almost casually interjects the first description of Samoan sexuality saying that in addition to work for adolescent girls "All of her interest is expended on clandestine sex adventures". This comes directly after a passage where Mead describes how a reputation for laziness can make an adolescent girl a poor candidate for marriage, implying that for Samoans a work ethic is more important criteria for marriage than virginity.

In the Samoan household according to Mead (1928), male adolescents undergo various kinds of both encouragement and punishment to make them competitive and aggressive. For the males there are many different possible jobs, for instance a house builder, a fisherman, an orator, a wood carver in the community. Status is also a balance between prowess and achievement and appearing humble and also, social prestige is increased by his romantic or sexual exploits. For the female adolescents, status is primarily a question of who they will marry as Mead described adolescence and the time before marriage as the high point of a Samoan female adolescents' life: but the 17year-old female adolescent does not wish to marry because it is better to live as a girl with no responsibility but a rich variety of experience in terms of sexuality (Mead, 1928).

**Samoan Life and Education according to Mead**

Mead describes child education starting with the birth of children which is celebrated with a lengthy ritual feast. After birth however, children are mostly ignored, for girl children sometimes explicitly ritually ignored, after birth up to puberty. She describes the various methods of disciplining children. Most involve some sort of corporal punishment such as hitting with hands, palm fronds, or shells in a hierarchical order. However, the punishment is mostly ritualistic and not meant to inflict serious harm. Children are expected to contribute meaningful work from a very early age. Initially, young children of both sexes help to care for infants. As the children grow older however the education of the boys shifts to fishing while the girls focus more on child care. However, the concept of age for the Samoans is not the same as the west. They do not keep track of birth days and they judge maturity not on actual number of

years alive but on the outward physical changes in the child. As a child gets bigger and stronger he or she gets more work and responsibility.

Mead describes some specific skills the children must learn related to weaving and fishing and then almost casually interjects the first description of Samoan sexuality saying that in addition to work for adolescent girls "All of her interest is expended on clandestine sex adventures". This comes directly after a passage where Mead describes how a reputation for laziness can make an adolescent girl a poor candidate for marriage, implying that for Samoans a work ethic is more important criteria for marriage than virginity. Male adolescents undergo various kinds of both encouragement and punishment to make them competitive and aggressive. For the males there are many different possible jobs, for instance a house builder, a fisherman, an orator, a wood carver in the community. Status is also a balance between prowess and achievement and appearing humble. Also, social prestige is increased by his amorous exploits. For the adolescent girls, status is primarily a question of who they will marry. Mead also describes adolescence and the time before marriage as the high point of a Samoan girls' life: But the seventeen-year-old girl does not wish to marry. It is better to live as a girl with no responsibility, and a rich variety of experience. According to Mead, this is the best period of her life (Mead, 1928).

According to Mead, a Samoan village is made up of some thirty to forty households, each of which is presided over by a head man. Each household is an extended family including widows and widowers. The household shares houses communally, each household has several houses but no members have ownership or permanent residence of any specific building. The houses may not all be within the same part of the village. The head man of the household has

ultimate authority over the group. According to Mead, the extended family provides security and safety for Samoan children. Children are likely to be near relatives no matter where they are and any child that is missing will be missed quite rapidly. The household also provides freedom for children including girls. According to Mead if a girl is unhappy with the particular relatives she happens to live with, she can always simply move to a different home within the same household. Mead also describes the various and fairly complex status relations which are a combination of factors such as role in the household, the household's status within the village, the age of the individual. There are also many rules of etiquette for requesting and granting favours (Mead, 1928).

Despite the freedom offered for adolescents in terms of adolescent's sexual behaviour, it is flawed on the following grounds: Muuss (1975) points out that even though Mead objects to the pattern of the American family produces conformity and dependency in its children, she considers the family a tough institution and demonstrates that it is nearly universal. Mead knows of no better way to produce wholesome individuals than through a tolerant family system in which father says "yes" and mother says "no" about the same thing and in which the adolescent can disagree with his parents without a resulting loss of love, self-respect, or increase of emotional tensions.

Freeman (1983), in his criticism challenged all of Meads major findings. He claimed Mead failed to apply the scientific method and that her assertions were unsupported He participated in the filming of Margaret Mead in Samoa, directed by Frank Heimans, which claims to document one of Mead's original informants, now an elderly woman, swearing that the information she and her friend provided Mead when they were teenagers was false; one of the girls

would say to Mead on videotape years later: We girls would pinch each other and tell her we were out with the boys. We were only joking but she took it seriously. As you know, Samoan girls are terrific liars and love making fun of people but Margaret thought it was all true (Heimans, 1987). Pinker (2009) has also contested many of Mead's claims, and argued that she was hoaxed into counterfactually believing that Samoan culture had more relaxed sexual norms than Western culture.

In the light of Mead's theory to the perception of contraceptive use and its impact on adolescents' sexual behaviour, the Ghanaian homes and families can mostly be related to the Western culture where transition from childhood to adulthood through adolescence is not a smooth changeover, filled with emotional or psychological distress, anxiety or confusion. The sexual freedom experienced by the adolescent Samoans, is strongly restricted and vehemently prohibited among adolescents in Ghana by parents, adults and authorities. The anxiety and confusion most Ghanaian adolescents experience as a result of this restrictions, turn to rebel against parents and authorities by engaging in unhealthy sexual behaviours and practices of which the end effect is well known. On the other hand, in order to encourage smooth transition among adolescents in Western world, the practice of the Samoans can be adapted by parents and authorities to expose and educate early adolescents about sex and the use of contraceptives. This practice can reduce the conflict and stress between parents and adolescents.

**Social Learning Theory (SLT) – Albert Bandura**

The main focus of social learning theory is learning that occurs within a social context. It posits that through concepts such as observational learning,

imitation, and modelling, people learn from one another. Among others Albert Bandura is considered the leading proponent of this theory. Earlier learning theories emphasised how individuals behave in response to environmental stimuli, such as physical rewards or punishment (Johnson, 2017). On the contrary, social learning theory emphasises the reciprocal relationship among social characteristics of the environment, how they are perceived by individuals, and how motivated and able an individual is to reproduce behaviours they see happening around them. Individuals both influence and are influenced by the world around them (Johnson, 2017).

Social learning theory has become conceivably the most influential theory of learning and development (Nabavi, 2012). The principles of social learning theory according to Bandura (1977) are assumed to operate in the same way throughout life. Observational learning may take place at any age. As long as exposure to new influential, powerful models who control resources may occur at life stage, new learning through the modelling process is always possible. (Newman & Newman, 2007). Bandura (1965), mentioned that based on these general principles, learning can occur without a change in behaviour. In other words, behaviourists believe that learning has to be represented by a permanent change in behaviour; while in contrast social learning theorists argue that because individuals can learn through observation alone, their learning may not necessarily be shown in their performance (Bandura, 1965). Learning may or may not result in a behaviour change (Bandura, 2006b). Bandura (1965) stated that, individuals learn from one another in the social context, through: Observation; Imitation; and Modelling.

In 1961 Bandura conducted an experiment known as the Bobo doll experiment, to study patterns of behaviour, by social learning theory, and that similar behaviour s were learned by individuals shaping their own behaviour after the actions of models. Bandura's results from the Bobo Doll Experiment changed the course of modern psychology, and was widely credited for helping shift the focus in academic psychology from pure behaviour ism to cognitive. The experiment is among the most lauded and celebrated of psychological experiments (Newman & Newman, 2007). The study was significant because it departed from behaviour ism's insistence that all behaviour is directed by reinforcement or rewards. The children received no encouragement or incentives to beat up the doll; they were simply imitating the behaviour they had observed. Bandura (1977), termed this phenomena observational learning and characterized the elements of effective observational learning as attention, retention, reciprocation and motivation. He demonstrated that children learn and imitate behaviour s which they have observed in other people.

Individuals that are observed are referred to as models. Children in the society are surrounded by many influential models, such as parents within the family, characters on children's TV, friends within their peer group and teachers at school. These models provide examples of behaviour to observe and imitate. Children pay attention to some of these individuals (models) and encode their behaviour. At a later time they may imitate (i.e., copy) the behaviour they have observed. They may do this regardless of whether the behaviour is 'gender appropriate' or not.

Bandura mentions four necessary conditions which are needed in modelling process. By considering these steps, an individual can successfully

make the behaviour model of someone else. These steps are attention, retention, reproduction and motivation. Attention is the extent to which an individual is exposed to /notice the behaviour (McLeod, 2016). For a behaviour is imitated, it has to grab the observer's attention. The person must first pay attention to the model. The more striking or different something is the more likely it is to gain attention (Nabavi, 2012). Likewise observers take more notice, of something or someone that is regarded as prestigious, attractive or resemblance (Nabavi, 2012).

Retention is how well the behaviour is remembered (McLeod, 2016). The behaviour may be noticed but is it not always remembered which obviously prevents imitation (McLeod, 2016). The observer must be able to remember the behaviour that has been observed. One way of increasing this is using the rehearsal technique (Nabavi, 2012). The third condition is the ability to replicate the behaviour that the model has just demonstrated (Nabavi, 2012). This indicates that the observer has to be able to replicate the action, which could be a problem with a learner who is not ready developmentally to replicate the action (Nabavi, 2012). It is not always possible to reproduce behaviour we see on a daily basis. We are limited by our physical ability and for that reason, even if we wish to reproduce the behaviour, we cannot (McLeod, 2016). This influences observer's decisions whether to try and imitate it or not. For instance, imagine a toddler who struggles to walk watching his or her brother play football. The toddler may appreciate that the skill is a desirable one, but will not be able to imitate it because he or she is physically not ready (McLeod, 2016).

Motivation is the will to perform the behaviour (McLeod, 2016). The final necessary step for modelling to occur is motivation, learners must want to

demonstrate what they have learned (Nabavi, 2012). It is worth to note that, since these four conditions vary among individuals, different people will reproduce the same behaviour differently. Reinforcement and punishment play an important role in motivation (Nabavi, 2012). If the perceived rewards outweigh the perceived costs (if there are any), then the behaviour will be more likely imitated by the observer (McLeod, 2016). If the vicarious reinforcement is not seen to be important enough to the observer, then the likelihood the behaviour will not be imitated (McLeod, 2016).

The social learning theory takes thought processes into account and acknowledges the role it play in deciding if a behaviour is likely to be imitated or not. As such, SLT provides a more comprehensive explanation of human learning by recognizing the role of mediational processes.

**Social Learning Theory and Perception of Contraceptive Use**

The principles of social learning theory can be applied to almost any social and behaviour change that aims to influence social behaviour s, particularly behaviour s that are complex or involve interactions with other people (Health Communication Capacity Collaborative, 2014). It may be especially useful when a particular behaviour like the sexual behaviour of adolescents is difficult to describe, but can be explained through demonstration or modelling. Also, when adopting or practicing a particular behaviour, for instance perception in contraceptive use which requires overcoming barriers or challenges, social learning principles can be used to demonstrate how a person can overcome those challenges and succeed (Health Communication Capacity Collaborative, 2014). Finally, because people tend to adopt and practice behaviour s they see others doing, social learning principles can be used to

change perceptions of the social environment (example; perception in contraceptive use among adolescents), making behaviour s seem more common and providing social support to people who are considering a behaviour change (Health Communication Capacity Collaborative, 2014).

For instance, in the year 2010, there was high rise of HIV infection in South Africa, a South African entertainment-education television applied observational learning by producing a TV series about sex, love, and relationships, and how secrets within those relationships can place individuals at risk for HIV infection (Health Communication Capacity Collaborative, 2014). In 2011, the Centre for AIDS Development, Research and Evaluation (CADRE) in South Africa, conducted an evaluation of the impact of the TV series on viewer's lives and health outcomes. Findings from the evaluation showed that, 23,000 to 4 million viewers of the series reported taking concrete steps to change or modify their behaviour in line with what they had seen characters do on the show, particularly when it came to consistent contraceptives usage and undergoing HIV testing and counselling (Health Communication Capacity Collaborative, 2014). Therefore in dealing with the perception of contraceptive use and its impact on the sexual behaviours of adolescents, adopting the principles of social learning theory can be adopted to address the issue.

## Conceptual Review

### History of Contraceptives

The earliest insight into fertility regulation at the personal level dates back to the 13th century. Contraceptives are the methods of the family planning framework which allows programme persons and couples to define the number

of children, when and at what interval to have them (Intra Health, 2010). 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 in 1500. The guide suggests that a fibre tampon moistened with 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.

The concept of contraceptives and family planning, as earlier stated, is an old one. It rose out of a universal need for people to enjoy sex and not be saddled with a pregnancy after the act; that is, being able to space or limit births (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006). Methods such as celibacy, sexual taboos, abstinence, withdrawal (coitus interruptus), and induced abortion were commonly used by many ancient societies (Frejka, 2008; Woods, Hensel, & Fortenberry, 2009).

The layman's definition of contraception is about protection and prevention of human related sexual problems. Contraception is noted to be a

control method, to and represents a general term for the use of devices or acts that prevent sexual-related problems during intercourse (Vocabulary.com).

The term is formed by blending together the Latin word “contra”, meaning “against” and a shortened form of French word “concepcion”, meaning “conception” (against conception). The term is believed to be propounded in the 19th century, when the science of birth control was beginning to be seriously considered. Contraceptives such as birth control devices that had been around then in unrefined forms, began to be produced in larger quantities and were eventually socially accepted by people (Vocabulary.com). With this at the time, it can be concluded that contraception was not all that effective because it was in the early years.

According to Hanson, Burke and Anne (2010), contraception has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century for people to plan their marital and sexual relationship lives. According to Daniels, Daugherty and Mosher (2015) there are a number of contraception types ranging from medical, hormonebased and physical-based. The medical-based contraception is about caesarian methods in preventing and controlling sexual-related problems on people (vasectomy, tubal ligation, intrauterine devices (IUDs) and implantable controls). The hormone-based is about introducing chemicals into the body of people to protect and prevent them from contracting sexual-related problems (oral pills, patches, vaginal rings, and injections). The physical-based is known as barrier method and is about physically applying preventive and protective tools to avoid sexual-related problems (Contraceptives, diaphragms, control sponges and awareness creation).

According to Daniels, Daugherty and Mosher (2015) among the numerous types of contraception, it is touted that the medical-based are the most effective protective and preventive measure as it is characterised by permanence using. It is permanent and for one to get back normality is impossible, however, the person will still look healthy but cannot forth bring offspring.

The least effective methods are spermicides and withdrawal by the male before ejaculation (Daniels, Daugherty & Mosher, 2015) Sterilization, while highly effective, is not usually reversible; all other methods are reversible, most immediately upon stopping them. According to Taliaferro, Sieving, Brady and Bearinger (2011), safe sex practices methods such as with the use of male or female Contraceptives as contraceptive can also help prevent sexually transmitted infections while the others cannot. Chin et al., (2012) reported that not all contraceptives work for prevention of contractible sexual-related problems, but Contraceptives do.

**Concept of Contraceptives**

The layman's definition of Contraceptives can be termed as obstruction or barricade to sexual-related problems. According to Hatcher and Nelson (2007), a contraceptives is a sheath-shaped barrier device used during sexual intercourse to reduce the probability of pregnancy or a sexually transmitted infection (STIs). According to Daniels, Daugherty & Mosher (2015), contraceptives are of different categories, thus, male and female Contraceptives. Records show that with proper use and use at every act of sexual intercourse, women whose partners use male contraceptives experience a 2% per-year pregnancy rate (Hatcher & Nelson, 2007). Hatcher and Nelson (2007) indicated that the use of contraceptives greatly decreases sexually transmitted infections

and the risk of gonorrhea, chlamydia, trichomoniasis, hepatitis B, and HIV/AIDS, protect against genital herpes, human papillomavirus (HPV), and syphilis.

According to Speroff and Darny (2012), the use of contraceptives is precautionary and its use by males should be trolled onto a rigid or an erected penis before intercourse and works by blocking semen from entering the body of a sexual partner. Male condoms are typically made from latex and less commonly from polyurethane or lamb intestine and these contraceptives have the advantages of ease of use, easy to access, and few side effects (Hatcher & nelson, 2007). According to Hatcher and Nelson (2007), contraceptives as a method of preventing STIs have been used since at least 1564. Rubber contraceptives became available in 1855 followed by latex contraceptives in the 1920s (Allen, 2011). They are on the World Health Organisation's List of Essential Medicines, the most effective and safe medicines needed in a health system and the wholesale cost in the developing world is about 0.03 to 0.08 USD each (WHO, 2015). In the United States, contraceptives usually cost less than 1.00 USD (Shoupe, 2011).

Chen, Amor and Segal (2012) were of the view that, globally, less than 10% of those using birth control are using the contraceptives and the rates of contraceptives use are higher in the developed world. In United Kingdom the contraceptives is the second most common method of birth control (22%) while in the United States it is the third most common with 15% (Herring, 2014) and remarkably around 6-9 billion are sold a year (Hermann, 2016). These empirics show that contraceptives are no mean smaller contraceptive because it is the

cheapest and most easily accessed control method when it comes to human sexual relationship or intercourse.

According to Frost, Henshaw and Sonfield (2010) contraceptives are generally commended for the avoidance of sexually transmitted infections (STIs) as they have been revealed to be operative in decreasing infection rates in both men and women. While not perfect, the contraceptives is effective at reducing the transmission of organisms that cause AIDS, genital herpes, cervical cancer, genital warts, syphilis, chlamydia, gonorrhea, and other diseases. According to a 2000 statement by the Natinonal Institute of Health ( Ford, Sohn, & Lepkowski 2001), the constant use of latex contraceptives moderates the risk of HIV/AIDS transmission approximately by 85% relative to risk when unguarded, putting the seroconversion rate (infection rate) at 0.9 per 100 person-years with contraceptives, down from 6.7 per 100 personyears. The review settled that contraceptives use considerably decreases the risk of gonorrhea for men.

In a related study, it was reported that proper contraceptives use decreases the risk of transmission of human papillomavirus (HPV) to women by approximately 70% (Winer et al., 2006) and another study found that the constant Contraceptives use was effective at reducing transmission of herpes simplex virus-2 also known as genital herpes, in both men and women (Wald et al., 2005).

Despite the touts about contraceptives, it is possible that one uses it and still contract sexual transmitted infections or diseases. According to Villhauer (2005), although contraceptives use is effective in restrictive exposure, some disease transmission may occur even with a contraceptives. Infectious areas of

the genitals, especially when symptoms are present, may not be covered by a contraceptives, and as a result, some diseases like HPV and herpes may be transmitted by direct contact. Contraceptives may also be useful in treating potentially precancerous cervical changes. Exposure to human papillomavirus, even in individuals already infected with the virus, appears to increase the risk of precancerous changes. The use of contraceptives helps promote reversion of these changes (Hogewoning et. al., 2003).

**Contraceptives Usage**

Ideally Contraceptives are used to protect from unplanned pregnancies and sexually transmitted diseases. Male Contraceptives for instance are usually parceled inside a plastic wrapper, in a folded form and are applied to the tip of an erected penis and then unfolded over. It is always advisable that some space be left in the tip of the Contraceptives so that sperm from the man can be collect to avoid the force out of the base of the device. After use, it is recommended the Contraceptives be enclosed in a disposal material and then disposed in a recommended way. According to Häggström-Nordin (2005), contraceptives are regularly used in sex education programs for adolescents because they have the capability to reduce the chances of pregnancy and the spread of some sexually transmitted diseases when used correctly. In the United States, teaching about contraceptives in public schools is opposed by some religious organizations (Rector, Pardue & Martin, 2004). Advocates of family planning and sex education, argues that no studies have shown abstinence-only programme to result in delayed intercourse, and cites surveys showing that 76% of American parents want their children to receive comprehensive sexuality education including contraceptives use (Frost, Henshaw & Sonfield, 2010).

Sexual behaviour is about how people show or express their feelings or erotic emotions. According to Schacter, Gilbert and Wegner (2010), human sexual behaviour is the manner in which humans experience and express their sexuality. It is noted that people engage in a variety of sexual acts, ranging from individualistic (masturbation) to pairs or multiples (sexual intercourse, non-penetrative sex, oral sex) in varying patterns of frequency, for a wide variety of reasons (Schacter, Gilbert & Wegner, 2010). According to Rosenthal (2012) sexual behaviour commonly results in sexual arousal and bodily changes in the aroused person, some of which are noticeable while others are unnoticeable. Sexual behaviour may include conduct and activities which are intended to arouse the sexual interest of another or enhance the sex life of another person, such as strategies to find or attract partners or personal interactions between individuals.

Weiner and Craighead (2010) opined that sexual behaviour may follow sexual arousal and is characterised by sociological, cognitive, emotional, behavioural and biological aspects that include personal closeness, sharing emotions and the physiology of the reproductive system, sex drive, sexual intercourse and sexual behaviour in all forms. Sexual behaviour can be risky when precautions are not taken. It could be that a partner may be having sexual-related infection that can be transmitted when he or she is not protected or the use of other things that are not appropriate in sexual encounters. According to Dimbuene, Emina, and Sankoh (2014), risky sexual behaviour is the description of the activity that will increase the probability that a person engaging in sexual activity with another person infected with a sexually transmitted infection will be infected or become pregnant, or make a partner pregnant. To Hall (2004),

risky sexual behaviour can be understood in two related ways, as in the behaviour itself, the description of the partner's behaviour. This behaviour could be unprotected vaginal, oral, or anal intercourse. The partner could be a nonexclusive partner, HIV-positive, or an intravenous drug user.

Sexual behaviours do not occur for nothing. It is based on multiple of reasons ranging from procreation, joy and monetary purposes. Meston and Buss (2007) indicated that in as much as the prime evolutionary purpose of sexual behaviour is reproduction, however research on college students suggested that people have sex for four general reasons; physical attraction, as a means to an end, to increase emotional connection, and to alleviate insecurity. They further reported that people engage in sexual activity because of pleasure they derive from the arousal of their sexuality, especially if they can achieve orgasm.

Fortenberry (2013) was of the view that most commonly, people engage in sexual behaviours because of the sexual desire generated by a person to whom they feel sexual attraction and may engage in sexual activity for the physical satisfaction they achieve in the absence of attraction for another, as in the case of casual or social sex. He further indicated that a person may engage in sexual activity for purely monetary considerations, or to obtain some advantage from either the partner or the activity. Some people engage in hate sex, which occurs between two people who strongly dislike or annoy each other. It is related to the idea that opposition between two people can heighten sexual tension, attraction and interest (Fortenberry, 2013).

The sexual behaviours people engage in are understood to possess some psychological underpinnings. This means that sexual behaviours are linked to mental aspects of those who depict them. From personal experience, sexual

activity can lower human pressure and overall stress levels in people who engage in it. It releases tension, elevates mood, and may create an insightful sense of relaxation, especially within the ejaculation period.

According to Brunell and Webster (2013), in their study, revealed that people who engaged in sexual activities had more positive psychological wellbeing because as they engage in sexual activity they had a higher need for satisfaction. The study also revealed that females had higher satisfaction and relationship quality than males did from the sexual activities. It was therefore concluded that psychological well-being, sexual motivation, and sexual satisfaction were all determinants of sexual behaviour (Brunell & Webster, 2013). This can be best expatiated that sex in itself is psychologically medicinal, if only practiced at the age-appropriate time. The age of sexual behaviours is believed to be varied based on jurisdictional differences. Laws of people are not universal when it comes to sexual behaviours. Different continents, countries and culture have their own laws that govern what is termed age-appropriate sexual behaviour, and such laws are strictly applied in those places. The jurisdiction and the culture determines the age-appropriate for signs of sexual behaviour for people of different places around the world.

In as much as age is known to be a determinant of sexual behaviour, so goes to the gender of people. According to Suar and Gochhayat (2016), social gender roles can influence sexual behaviour as well as the reaction of individuals and communities to certain incidents especially where there is the belief that male sexual entitlement are strong.

Suar and Gochhayat (2016), indicated that Human sexuality and gender relations are closely interrelated and together affect the ability of men and

women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when imparted during the developmental years, improve and stimulate respectful and pleasant relationships between men and women.

**Type of contraceptives**

According to www.Zavamed.com/uk, the following are some types of contraceptives

**Male condom**

A male condom is a covering worn over the penis to stop sperm getting into the womb. Condoms are most commonly made of latex but other types are available. The condom is the most common form of male contraceptive. With perfect use, male condoms are 98% effective at preventing pregnancy, but with typical use this drops to 82%. A condom is the only form of contraceptive that also helps to avoid getting STIs.

**Female condom**

A female condom is worn inside the vagina and stops sperm getting into the womb. Like male condoms, they are most commonly made of latex. The female condom is 95% effective with perfect use and 79% effective with typical use. As with the male condom, a female condom will help to avoid getting STIs.

**Diaphragm**

A diaphragm is placed inside the vagina to cover the lowest part of the womb (the cervix) to stop sperm getting in. It's made of a soft silicone and is shaped like a shallow cup. It must be used with spermicide (commonly a gel or cream) which slows down the movement of sperm. It is inserted before having sexual intercourse and should left in for at least 6 hours afterwards. Depending on the material and type of the diaphragm, it can be reused many times. With perfect use, the diaphragm is 94% effective. With typical use, it is 88% effective. Despite being a barrier method, the diaphragm does not protect against STIs.

**Cervical cap – FemCap**

The cervical cap (sold as FemCap) is a silicone cup, similar to a diaphragm but smaller. It also needs to be used with a spermicide. The cervical cap must remain in the vagina for at least 6 hours after sex and should be taken out within 48 hours. The cervical cap is 92 to 96% effective with perfect use and 71 to 88% effective with typical use. Cervical caps do not protect against STIs.

**Contraceptive coil**

The contraceptive coil is a long-acting reversible method of contraception. It is a plastic, T-shaped device fitted in the vagina by a doctor or nurse. There are two types of coil: the intrauterine device (IUD) and the intrauterine system (IUS). The IUD releases copper into the womb and is also known as the copper coil. The IUS releases lab-made progesterone and is also called the hormonal coil. Once it's fitted, the IUS can stay in place for 3 or 5 years (depending on the brand) and the IUD for 5 or 10 years. Both coils can be removed at any time by a doctor or nurse. The effectiveness rate for both is

above 99%. IUDs can also be a form of emergency contraception if the device is inserted within 5 days after unprotected sex. Coils offer no protection from STIs.

**Contraceptive implant**

This is another long-acting reversible method of contraception. The implant is a matchstick-sized piece of plastic, inserted under the skin on your upper arm. It can be safely left in place for 3 years but can be taken out at any time. The implant must be fitted and removed by a doctor or nurse. The implant works like the mini pill by releasing lab-made progesterone. It's 99.95% effective and does not protect against STIs.

**Contraceptive injection**

The contraceptive injection is a shot of lab-made progesterone, the hormone that's in the mini pill. The injection lasts for 12 weeks and once given it cannot be reversed, so the user is effectively infertile for the next 3 months. The contraceptive injection must be given by a doctor or nurse who will discuss whether it is suitable for the adolescent. Injectable contraceptives are more than 99% effective with perfect use, 94% with typical use. The main thing that makes perfect use more difficult is remembering to get a new injection every 3 months. Like other hormonal methods of contraception, injections do not protect from STIs.

**Vaginal ring**

The vaginal ring is a piece of circular plastic that is placed in the vagina. The ring works in the same way as the combined pill, releasing progesterone and oestrogen. The vaginal ring is more than 99% effective with perfect use,

and 91% effective with typical use. You need a doctor's prescription to get the ring. It does not protect from STIs.

**Contraceptive patch**

The contraceptive patch is the same thing as the contraceptive pill but in the form of a plaster-like patch worn on the skin. It provides the same protection against pregnancy. The patch can be worn on different places around the body. It is changed once a week. You then start again with a new patch. You need a doctor's prescription to get the patch. The patch is over 99% effective with perfect use and 91% with typical use. It does not protect from STIs.

**Emergency contraception**

Emergency contraception is used to prevent pregnancy after one had unprotected sex. It's not recommended as a regular method of contraception. The morning after pill is the most common form of emergency contraception. It's a single pill containing synthetic hormones which stop or slow down the release of an egg (ovulation). An IUD can also be used as emergency contraception. Emergency contraception needs to be used within 3 or 5 days of unprotected sex (depending on the method and brand used

**Sterilisation**

Sterilisation is an operation by a doctor which permanently protects against pregnancy. It's available to both men and women. In men, the procedure is called a vasectomy. The tubes that carry sperm are cut or sealed. In women, the fallopian tubes are clipped or tied so eggs cannot move into the womb. Women can also have non-surgical sterilisation. This is when an implant is placed in each fallopian tube to create scars that eventually block each tube. The scars may take up to 3 months to completely block the tubes, so one needs to

use another method of contraception in the meantime. Sterilisation offers more than 99% protection against pregnancy. In rare cases blocked tubes grow back and reconnect, or tubes are not effectively blocked.

Sterilisation does not provide any protection against STIs

**Empirical Review**

**Age Difference in Contraceptive Use**

Researches have typically generalised contraceptive use among all women with age as a covariate, more recent studies have highlighted the need to differentiate by age when studying factors affecting contraception use (Tavrow, Withers & McMullen, 2012). These studies provide evidence that adolescents in particular need special attention in order to control contraceptive prevalence, recognizing that improving availability, affordability, and youth-friendliness may not fully address the psychosocial barriers to contraceptive use among adolescents (Ngome & Odimegw, 2014).

A study conducted by Decker and Constantine (2011), indicated age differences as a necessary variable in studying the use of contraceptives. They identified age to be associated with contraceptive use, with particularly low level of contraceptive use among adolescents, concluding that young women needed special attention with regards to family services in Angola (Decker & Constantine, 2011). Prata et al., (2016) in their study reported that, contraceptive use was prevalence among women between the ages of 25-49 years than women between the ages of 15-24 years. Akotli (2010), in her study identified a significant difference between age categories and contraceptive use. Findings from a study conducted in Kenya by Okech, Wawire, and Mburu (2011) revealed that contraceptive use was highest among women aged between 20

years and 39 years compared to those below 20 years and above 39 years. They reported that, 49 percent of the women that were using contraceptives were aged 20- 29 years, 41 percent were aged between 30 - 39 years, while 4 percent of the women who were using contraceptives were less than 20 years.

Adolescence conceptually is categorised into three (3) stages because it is believed that the period is not uniform for human generation. The differentiation with respect to age in adolescence has the possibility to bring about differences among adolescents with respect to knowledge and this is not limited to sexual behaviours and knowledge contraceptives use. A study in Angola among adolescent students revealed that, males in all adolescence agegroups were more likely than females to be consistent users of contraceptives with 19% against 13% (Prata, Vahidnia & Fraser, 2005).

**Gender Difference in Contraceptive Use**

Several studies conducted have focused on adolescents' perception about contraceptive use. Some of these studies revealed gender difference in the use of contraceptives. A study conducted by Almeida, Aquino, Gaffikin and Magnani (2003) revealed gender difference in contraceptive use among adolescents in Brazil. The study revealed that, female adolescents used contraceptives more than their male counterparts. They indicated that, the factors positively linked to the regular use of contraceptive methods among male students included; a) postponing their first experience of sexual intercourse and interaction with a stable partner, b) the family as a potential provider of contraceptive methods, and c) access to health services. Among female students on the other hand, the factors positively associated with the consistent use of contraceptive methods included; a) recent sexual initiation, and b) having a

father as their source of information regarding sexuality, contraception and STD/Aids prevention (Almeida, Aquino, Gaffikin & Magnani, 2003).

Manlove, Ryan and Franzetta (2003), in their study reported that, both male and female adolescents used contraceptives. They mentioned that, teenagers who had waited a longer time between the start of a relationship and first sex with that partner, discussed contraception before first having sex or applied dual contraceptive methods which had significantly increased probabilities of ever or always using contraceptives (Manlove, Ryan and Franzetta, 2003).

Similarly, Yilmaz, Kavlak and Atan (2010), reported that, male Turkish students had started sexual relations at a younger age but had less often unprotected first sex than female students. They revealed that, of the surveyed students, 50.3% reported having engaged in sexual intercourse; the mean age at first sexual intercourse was 18.4 years for girls and 16.9 years for boys. They found that 44.5% of female and 30.6% of male students failed to use contraception at their first sexual intercourse, whereas 2.2% of female and 13.7% of male students failed to do so at their most recent intercourse. The rate of contraceptives usage for students' first sexual encounter was 50.1% and was 67.8% at their most recent intercourse (Yilmaz, Kavlak & Atan, 2010).

A study conducted by Kareem and Samba (2016) on contraceptive use among female adolescents in Korle-Gonno revealed that, the mean age at first sexual intercourse was 15.9 years and 55.5% of female adolescents were sexually active. Contraceptive use prevalence among sexually active female adolescents was 38.0%. The commonest method used was the male Contraceptives (73.9%). They further added that, the main reasons for the

choice of this method were easy access and safety of method, and also dual protection specifically for the male contraceptives. Most adolescents due to little or no knowledge about protection at time of sexual intercourse had no specific reason for not using contraception (Kareem & Samba, 2016). Boamah (2013) who conducted a study at Kintampo Ghana, asserted that, 67% of sexually active adolescents had ever used contraceptives. He also revealed that, 22.9% used contraceptives consistently while 44.1% used contraceptives sometimes. He gathered that, most of contraceptives used by these active adolescents were male and female condoms and the pills. Thirty-five percent of adolescents had ever used any contraceptives to prevent pregnancy or STIs. In as much as adolescents can differ in gender, there is the likelihood that sexual behaviours as well as knowledge about contraceptives usage by adolescents may differ.

Leland and Barth (1992) in their study asserted that females were more likely than males to have discussed sexuality topics with parents, to have engaged in sexual intercourse more frequently, to have experienced a pregnancy scare, to have used contraceptives during their last sexual encounter. To perceive that a larger proportion of their peers were engaging in sex and using birth control, to obtain birth control from health facilities, and to report intentions to abstain or use protection in hypothetical situations placing them at risk for unprotected sex. In that same study, it was reported that adolescent males were more likely to have always used birth control, to have used birth control during their first sexual encounter, and to have used a Contraceptives during their last sexual encounter. Furthermore, males were more likely to obtain birth control from a store or a friend and males knew more about using

Contraceptives correctly and their role in preventing sexually transmitted diseases (Leland & Barth, 1992).

A study by Prata, Vahidnia and Fraser (2005) in Angola revealed that a larger proportion of males than of females indicated that they had much knowledge about contraceptives and used some of them with all of their partners in the three months preceding the survey 17% against 12%. This synopsis above puts the male adolescents in pole position against female adolescents when it comes to Contraceptives usage in sexual behaviours.

**Impacts of Contraceptive Use on the Sexual Behaviour of Adolescents**

Adolescence is a period of experimentation for most developing teenagers. Adolescents' exuberance is not by accident but naturally-motivated urge to try and explore new things as they keep growing. In the quest of supplying the biological demands (erotic feelings) of this stage of development, adolescents engage in a lot of sexual behaviours that do not exclude Contraceptives usage. These behaviours at this period of development are culturally illegal depending on the geographical jurisdiction. Taken Ghana for instance, sexual behaviours as in intercourse at adolescence is culturally frowned upon because Ghanaians are inclined that the stage is for learning to become an adult but not to engage in adult sexual behaviours before one marries. This means sexual intercourse is a reserve for the adults and not for adolescents. This is traditionally observed, but quit the opposite is seen because many adolescents can be seen carrying babies at their backs after defying these culturally-oriented norms.

For the fear of being ridiculed in society for being pregnant or making someone pregnant, adolescents in recent times resort to the use of

Contraceptives as they engage themselves in amoral sexual behaviours. To some, it may be for preventive measures towards contracting sexual transmitted diseases and consequently preventing unplanned pregnancies. According to Eaton (2012), the Condom remains the most popularly used contraceptive method among teenagers. An increased proportion of sexually active adolescents report using a Contraceptives at last intercourse, according to Anderson, Santelli, and Morrow (2006). In the Youth Risk Behaviour Survey in the United States, Condom use was reported to have increased from 46.2% in 1991 to 60.2% in 2011. The prevalence of Contraceptives use was higher among male with 68.6% than female with 53.9% students and higher among white 63.3% and African American with 62.4% than Hispanic students with 54.9% (Eaton, 2012).

Contraceptive demand and prevalence is generally higher for sexually active unmarried adolescent than for those married (Sanchez-Paez & Ortega, 2018). Research conducted have reported the effect of contraceptive use on the sexual behaviour of adolescents. Sanchez-Paez and Ortega (2018), found in their study that, the use of contraceptive was prevalent among adolescents and had reduced adolescent fertility by 6.8% in Latin-America and 4.1%insubSaharan Africa. They concluded that, meeting the total demand for contraceptives of unmarried adolescents would lead to an additional decrease in fertility of 8.9% and 17.4% respectively (Sanchez-Paez & Ortega, 2018).

More so, Kiragu and Zabin, (1995) in their study on contraceptive use among high school students in Kenya show that 69% of the males and 27% of the females were sexually experienced. Among the sexually experienced students, 49% of the males and 42% of the females had ever used a

contraceptive. Only 25% of the males and 28% of the females had used a method the first time they had sex, and similar percentages had done so the last time they had sex (31% and 29%, respectively). The Condom was the method most frequently used at last intercourse (55% males, 43% females), followed by the "safe period" (29% males, 43% females) and the pill (6% males, 10% females) (Kiragu & Zabin, 1995).

Amazigo, Silva, Kaufman and Obikeze, (1997) also reported in their study that, young women had intercourse more frequently and were less likely to restrict intercourse to the safe period of their cycle when they were involved with older partners than when they had boyfriends who were of their own age, only 17% of sexually active students had ever used a contraceptive method other than abstinence (Amazigo, Silva, Kaufman & Obikeze, 1997). In the same vein, Champiti, (2015) in his study revealed that, 30.8% of adolescents have had sex without the fear of pregnancy or HIV because of Contraceptives use. Majority (62.1%) had knowledge of at least three methods of contraceptives. Majority of the adolescents recommended Contraceptives as the method to be used by young people. His findings also showed that 19% of the students in the study used contraceptives (Champiti, 2015).

In the National Survey of Family Growth by Martinez, Capen and Abma (2011), Contraceptives use at last intercourse increased among females from 31% in 1988 to 52% in 2006-2010 and males from 53% to 75%. Rates of actual Contraceptives use in both surveys may also be lower than thought because of the uncertain/questionable validity of self-report of this and other sexual behaviours that are prone to bias. According to Rose, Diclemente and Wingood (2009), as an explanation to these findings, Contraceptives may have been used

inconsistently or incorrectly, or youth might have provided socially desirable answers.

According to Eaton et al. (2012), the Centre for Disease Control through survey reported sexual risk behaviour s in a nationally representative sample of adolescent students surveyed biannually. Boulet et al. (2016) revealed that 47.4% of the adolescent students reported that they had ever had sexual intercourse with Contraceptives, 33.7% reported that they were currently sexually active, and 15.3% had had sexual intercourse with four or more partners in their lifetime. Among sexually active students, 60.2% reported contraceptives use during their last sexual encounter. It would not be a mistake for one to say that contraceptives use among adolescents has become rampant or a norm in this 21st Century. According to Brown (2008), the motivation for adolescents to have sex include the pursuit of fulfilling sexual experience in addition to other impetuses such as intimacy, procreation, or in response to peer or partner pressure. For Ghana, this may be as a result of adolescents' desire to satisfy their sexual urges that are common within that period of development without becoming pregnant or contracting any sexualrelated diseases or infections.

The use of contraceptives among adolescents by adolescents is believed to be caused by many factors that are not limited to adolescent individual personality, family, socio-demographic, attitude, education, relationship and partner-related factors and influence contraceptives use (Manlove, Ikramullah & Terry-Humen, 2008).

A study conducted in Rwanda by Dominique and Megan (2001) among adolescents with a sample of 3013 revealed that overall, 42% of female

adolescent students and 30% of male adolescent students report that they have ever used a Contraceptives. In that same study, female adolescent students' percentage on the use of Contraceptives was expressively higher for with 55%. Among the male adolescent students, the percentage that report having used Condom increased with age, from 20% for early adolescence to late adolescence Comparing geographical location and use of Contraceptives among adolescents, it was revealed that the use of Condom is substantially higher among males in the urban with 35% than those in semi-urban with 21% or rural ones with 20% (Dominique & Megan, 2001).

Dominque and Megan (2001) in making a reasonable case on the consistency in the use of Contraceptives among adolescents reported that the levels of Contraceptives use in the last sex act with partners was amazingly high and the percentage of adolescents who reported Contraceptives use in last sex with a regular partner is higher than the percentage adolescents' who ever used Contraceptives because many youths who have tried Contraceptives are no longer sexually active. It was reported further that female adolescents report much higher levels of Contraceptives use with 71% in their last sex act with a regular partner than male adolescents with 46%.

**Knowledge Level of Adolescents about Contraceptive use**

Adolescents by nature are curious about events in their lives as that stage touted to be a moment that presents both positive and negative consequences on adolescents depending on how they handle and manage their lives. In the face of adolescent sexual maturity and sexual behaviour, there is the possibility that adolescents may be privy to sexual contraceptives like condoms and their usage

as they may be pressured to get involved in amoral sexual relationships with others.

Speroff and Fritz (as cited in Akpan, Ekott & Udo, 2014), reported that since 1900, knowledge and application of contraceptives have been encouraged and promoted and in 1960s, contraception teaching and practice became part of the programme in academic medicine.

Silassie (2016) was of the view that Condoms are an integral part of sexually transmitted diseases; unwanted pregnancy and human immune deficiency virus (HIV) acquiring immune deficiency syndrome (AIDS) prevention and their use has increased significantly over the past decade. Correct use of Contraceptives reduces the risk of HIV transmission by almost 100 percent. According to Tarkang and Bain (2015), Sub-Saharan Africa (SSA) remains the region hardest hit by the HIV/AIDS pandemic than any other in the world, largely due to high risk behaviour and neglect of potential preventive measures. This has led to most adolescents resorting to the use of Contraceptives to prevent the HIV/AIDS canker in their lives. Unwanted pregnancy, sexually transmitted diseases (STDs) and their adverse health consequences among adolescents are widespread public health problems worldwide that has called for the knowledge of Contraceptives (Public Health Progress Review, 2005). An estimated 19 million new STDs occur each year in the United States of America of which 50% are among persons between the ages of 15 and 24 (CDC, 2013).

Hearst and Chen (as cited in Tarkang & Bain, 2015) indicated that the correct or right knowledge and consistent Contraceptives use whether male or female, has been acknowledged to be effective towards successful prevention

of sexually transmissible infections (STIs), including HIV/AIDS that come as a result of adolescents sexual behaviours.

In a study conducted by Tarkang and Bain (2015) in Cameroon among adolescents revealed that majority of the adolescents were having appreciable knowledge about Contraceptives and their usage with 75.6%. However, these adolescents were having negative attitudes towards the use of Contraceptives as they exhibit sexual behaviours. This may be dangerous to them because they may be exposed to the HIV/AIDS if the adolescents do not change their attitudes.

In a related study among adolescents in Nigeria conducted by Akpan, Ekott and Udo (2014) revealed that currently, there was increased awareness and knowledge about Contraceptives as a means of contraception and prevention of STDs/HIV among adolescent students in Nigeria. This is evident by the fact that 100% of the respondents in this study reported knowing about Contraceptives and its usage. They attributed the revelation to adolescents belonging to one of the most educated segments of Nigerian societies. The revelation was encouraging as adolescents may be safe from contracting any sexual-related disease provided they correctly use the Contraceptives.

It is possible to believe that most adolescents become sexually active early and the need to Contraceptives use knowledge is vital as they may be protected from unplanned sexual-related problems that might result from their pressing sexual behaviours. Mucugu, Joash & Mwania (2013) in their study among adolescents in Kenyan Secondary Schools revealed that majority of the students were sexually active and they also actively use Contraceptives so their knowledge was above average. In the study, males using Contraceptives or

while some adolescents have adopted measures to reduce their risks of sexually transmitted infection and unwanted pregnancy others reported high risk sexual behaviour. The results of the research indicate that it is common knowledge that students are sexually active and engage in sexual activities with Contraceptives.

In a related study by Silassie et al. (2016), it was revealed that adolescents had adequate knowledge about Contraceptives use with majority 290 (75.1%) of the respondents while 24.9% were not knowledgeable about Contraceptives and their usage. Almost all 309 (89%) adolescent students knew that Contraceptives will prevent HIV/AIDS transmission. Most participants 259 (74.6%) knew that Contraceptives uses can prevent both pregnancy; STIs and HIV/ AIDS; hepatitis-b virus and equally had positive attitude towards Contraceptives use with 290 (83.6%) against 57 (16.4%) adolescent students who had negative attitude towards Contraceptives use.

There may be circumstances where the knowledge of Contraceptives use would be delusional by adolescents and may come up with unsubstantiated tags. According to Ochieng, Kakai, and Abok (2011), misconceptions about HIV/AIDS and the protective role of Contraceptives in preventing its spread are potentially dangerous since they may lead young people to avoid Contraceptives during sexual intercourse.

In their study, Ochieng, Kakai, and Abok (2011) indicated that misconceptions about Contraceptives also existed as more male than female students believed that Contraceptives reduce sexual pleasure. Even though Contraceptives play a protective role in the fight against HIV/AIDS their use among the respondents was low and inconsistent, reflecting the fact that for

adolescents, Contraceptives use may not be an effective tool in protecting them against HIV/AIDS.

According to Masoda and Govender (2013) in their study among adolescent students in DR Congo, 137 (99%) of respondents knew what Contraceptives were. Ninety-two of the respondents (67%) knew that generally, Contraceptives are made of latex. Sixty-five per cent of participants from other studies also understood what Contraceptives were and what they comprised. They stressed the reason that adolescent students' knowledge about Contraceptives was high could be as a result of the intensive efforts of the DRC government and non-governmental organisations (NGOs) to educate students about HIV and Contraceptives use. In this study, most participants (76%) knew that Contraceptives prevented HIV, STIs and unwanted pregnancies, and that it was important to use a Contraceptives every time that they had sexual intercourse.

**Sources of Information on Contraceptives and their usage**

Boamah (2013) in a study in Kintampo revealed that 79.5 percent of adolescents got information about contraceptives usage from friends. So in this, peers or friends became one of their sources and is not surprising because adolescents always learn from age groups to whom they may feel somehow safe with when interacting on issues relating about sexuality.

In similar vein, a study by Benzaken, Palep and Gill (2011) in

Mumbai, India revealed that, adolescents' source of information about Contraceptives use were peers. A national survey in the United States, conducted between 2001-2002 revealed that, about 76% of the sampled adolescents reported citing friends as their source of information about

contraception (Rideout, 2003). In a study in Ghana, it was revealed that 47% of adolescents reported that they obtained information about contraceptives from friends (Esantsi et al., 2015).

The 21st Century media serve a lot of purposes including presenting information on both positive and negative sexual behaviours to adolescents. Adolescents are curious and as such, they explore every avenue available to them for any information they consider to be important and interesting. Advocates for Youth in the U. S, in their policy document indicated that 21th Century media is considered to be proofs of life for the new cohort. In adolescence young people are exposed to resources on sex behaviours such contraceptive use from several media sources (Rideout, 2001). Sutton, Brown, Wilson and Klein (2002) indicated when interacting with adolescents about sources of Contraceptives use and contraceptives in most occasions, adolescents often mention media as the major source of information. Adolescent students blessed with technology where at their liberty can browse the internet for any information they intend searching or looking out for, watch television for similar information, read books and graphics for information about similar sexual related phenomena. Rideout (2004), in collaboration with the American Academy of Paediatrics (2001) revealed in their study that adolescents spent commonly some hours on the media daily and specifically about 65% of the adolescents reported they got information about contraceptives and their usage during advertisements. In that same study, 58% of the sampled adolescents reported they got access to Contraceptives usage from the print media like sex education magazines and about 39% of the adolescents confirmed they got information about contraceptives from the internet. Among the various media

platforms, the adolescents ranked the audio media and entertainment media as the most sourced platforms. According to Foehr and Roberts; and Strasburger (as cited in Mahama, 2017) American adolescents devote about seven hours per day on media and the media are flooded with sexual messages and images where preventive measures were equally offered.

Medical doctors and nurses are usually provide sex education information including contraceptive use to adolescents anytime they visit the health centres for issues pertaining human sexuality. Boamah (2013) in his study in Kintampo among adolescents reported that, information on contraceptives at health care facilities had been captured with 4.3%. Rideout (2003) in a national survey revealed that about 51% of the sampled adolescents reported to have received information about Contraceptives use and sex education from health care providers or centres through the health professionals like doctors and nurses. Benzaken, Palep and Gill (2011) revealed that 18.3% of the adolescent respondents indicated medical doctors as their source of information about Contraceptives use. According to Enuameh et al. (2017) this shows that health professionals contribute a great deal on adolescents' acquisition of knowledge about sex education and this aspect cannot be overlooked when it comes to human sexuality related issues.

It is common knowledge that pharmacy shops and other drug stores are avenues for contraceptives. Most chemical shops are private-owned and are profit-oriented, so sub-letting and educating adolescents about Contraceptives and their usage may look simple because that alone can increase patronage from adolescent. A study among adolescents in Kintampo, Ghana by Boamah et al. (2013) revealed that majority of the respondents 62.1% (131/211) reported that

they got information on contraceptives from the pharmacy and the chemical sellers' shops. The findings were not surprising as indicated because pharmacy shops are less restrictive and less threatening to adolescents and besides they are readily available in most parts of Ghana with contraceptives stalked for patronage of the adolescents and the grown-ups.

**Impacts of Contraceptives use on Sexual Behaviour of Adolescent Students**

In as much as adolescents become abreast or the otherwise of Contraceptives and their use, it may invariably have effects on the behaviours they depict with regards to sexuality. According to Sellers, McGrow and McKinlay (1994), the proponents of contraception education and Contraceptives availability programmes argue that teenagers are sexually active and must be provided with the means to protect themselves against pregnancy and sexually transmitted diseases. This brings to bear that Contraceptives usage has empirical potential to curb sexual-related problems that come as result of adolescents sexual behaviour based on figures from 1988, which indicated that about 50% of female adolescents and 60% of male adolescents between 15 to 19 years of age have had sexual intercourse, more than 1 in 10 teenage girls became pregnant and 1 in 6 of sexually active adolescents had been infected with sexually transmitted disease (CDC, 1990).

Others were of the view that Contraceptives use among adolescents approves and promotes sexual activity at a time that may not be appropriate. It is believed that this stance was initiated by Surgeon General of the United States, Senator Dan Coates in 1993 as he was addressing some group professionals. He expressed concern that just promoting Contraceptives as a solution to the problem can promote promiscuity. A more extreme position was

voiced by Phyllis Schlafly during the debate over the distribution of Contraceptives in the New York City public schools. She stated that Contraceptives distribution programmes produce an increase in teenage sexual activity (Schlafly, 1994).

Cates and Stone (as cited in American Academy of Paediatrics, 2001) reported that Contraceptives use decreases the rate of acquisition of HIV by those who engage in high-risk sexual activity or whose partners are seropositive for HIV, with relative risk ratios generally in the range of 60% to 96% protective. A study revealed that consistent Contraceptives use decreased the rate of HIV conversion by the negative partner to 1%, compared with 7% in those who did not use Contraceptives among adolescents (Cates & Stones, 1992). Although Contraceptives use known to decrease sexual transmitted infections, however, it is generally accepted that Contraceptives use is less protective against transmission of STDs and HIV than it is for pregnancy when used correctly and consistently and in real life use (Davis & Weller, 1992).

According to Blake (2003) in her study among 4,000 adolescents in high school, making Contraceptives available and allowing their use in high schools does not increase adolescent sexual activity, but it protects those who are already sexually active from some sexually transmitted diseases. Blake (2003) noted that Contraceptives availability was not associated with greater sexual activity among adolescents but was associated with greater Contraceptives use among those who were already sexually active, a highly positive result.

From the foregoing, it is evident to support the fact that the merits of Contraceptives use among adolescents far outweigh that of non-usage because it can help adolescents maintain their healthy lifestyles as they continue to grow.

**Ways in Improving/Enhancing Sexual Behaviours of Adolescent Students**

Nothing can be hidden from adolescents in this 21st Century environment that is bombarded with a lot of sexual information that are least restricted. Having this in mind, there is no doubt that adolescents sexual behaviours may change in conjunction with the growing trend of human sexuality. To avoid doubt and the quest not to compound issues with adolescent development, there is the need that well-thought strategies, wellinformed modalities are put in place to improve and enhance adolescent students' sexual behaviours as they keep growing to become adults and future stakeholders in various platforms and societies. Motivation at School

Motivations at school are programmes and activities that are of great importance to nurturing adolescents against risk-taking sexual behaviours and rather enhance the way they handle themselves against sexual pressures. According to Kirby (2002), social scientists and educators have proffered a wide variety of explanations for how schools reduce sexual risk-taking behaviours. Some of their explanations have empirical research supporting them, while others are plausible, but lack supporting research.

To Kirby (2002), educators concerned with adolescent sexual behaviour have suggested that schools structure adolescent students' time and limit the amount of time that students can be alone and engage in sex. Schools increase interaction with and attachment to adults who discourage risk-taking behaviour of any kind (substance use, sexual risk-taking, or accident- producing behaviour). More generally, schools create an environment which discourages risk-taking as they affect selection of friends and larger peer groups that are important to them. Schools can increase belief in the future and help youth plan

for higher education and careers. Such planning may increase the motivation to avoid early childbearing.

As noted above, multiple studies demonstrate that educational and career aspirations are related to use of contraception, pregnancy, and childbearing. Schools are believed to have the potential to increase adolescent students' self-esteem, sense of competence, and communication and refusal skills and these skills may help students avoid unprotected sex (Kirby, 2002).

**Introduction of School-Based Sex Education Programmes**

Sex education is well-thought educative programme that is designed to educate the growing populace of the world to understand everything about human sexuality so that they can be guided against any sexual-related misfortunes and help them improve upon their sexual behaviours to prevent risk-taking sexual behaviours.

According to Bennell, Hyde and Swainson (2002), school-based sex education is an encouraging platform for getting many adolescents with vital health information and life skills that can avert accidental conditions and sexually transmitted infections (STIs) including HIV/AIDS. Shrestha et al. (2013) indicated that although sex education looks important to improving adolescents' sexual behaviours, yet it is challenged in many jurisdictions, particularly in developing countries like as it is severely controlled by social and cultural taboos on discussing issues related to sex whether in school or home. According to Shrestha et al. (2013), in as much as school-based sex education can influence students' knowledge, beliefs, and intentions regarding sexual health, it is important to fully explicate and address the social and cultural challenges of school-based sex education.

The importance of school-based education is expatiated in a research work by Enuameh et al. (2017) among adolescent high school students in the Wa Municipality in Ghana. The study revealed that 85.1% of 390 adolescent students surveyed agreed that sex education will have a positive effect on their social lives while 14.9% of the respondents' sex education will have negative effects on them. This revelation was sounding as these adolescents were not taught holistically on anything on sex education, yet they foresaw its significance on their sexual behaviours, hence their suggestion. The adolescent students with 92.6% further suggested that sex education should be part of academic / school curriculum and 93.8% of the respondents agreed that sex education should be taught by qualified teachers (Enuameh et al., 2017).

**Parents-Adolescents' Relationship Programmes**

Adolescence is challenged with a lot of factors including parenting. Adolescents usually would want to exert their boisterous stage of development in terms of their sexual behaviours and this is met with opposition from parents. It there leads to the breeding of hostility between children and their parents and children are likely not to discuss anything with regards to their sexual behaviours with parents but do it in the blind side of parental eyes. The perceived hostility that become eminent between parents and their adolescents can be tackled if parents understand the period of adolescence and tackle any unsavoury sexual behaviour holistically in amicable way for their growing adolescents.

Manlove, Fish and Moore (2015) in their study among American high school students revealed that parent-youth relationship programmes are particularly effective at influencing the sexual behaviours and reproductive

health outcomes among adolescents'. The study revealed that, more than three-quarters (9 out of 11) evaluated parent-adolescent relationship programmes were effective for at least one outcome or population. In addition, several other effective programs incorporated parent-involvement components. According to Miller, Benson and Galbraith (2001) the important role that parent-adolescent relationships provide include parental monitoring and parent-adolescent communication as they help influence adolescents sexual and reproductive health behaviours.

It is noted that parents-adolescents with relation to communication is inevitable and is believed to possess the impetus to improve adolescents' sexual behaviours. According to Widman, Choukas-Bradley, Noar, Nesi, and Garrett (2016), parent-adolescent sexual communication has received considerable attention as one factor that could positively impact youth safer sex behaviour, including adolescents' use of contraception and Contraceptives. It is understood that this communication relationship between parents and adolescents is characterized with real-world and hypothetical motives why parenting may be proxies of sexual socialization for adolescents as parents may realistically convey sexual information and may exercise significant influence on adolescents' sexual attitudes, values, and risk-related beliefs (DiIorio, Pluhar, & Belcher, 2003).

Hutchinson and Montgomery (2007) asserted that parental communication about sex has appeared to be an essential component in the field of adolescent sexual behaviour with suggestions for prevention programming. Hutchinson, Jemmot, Jemmot, Braverman, and Fong (2003) in their longitudinal study among adolescents suggested that higher levels of mother-

daughter sexual risk communication correlated with a lower incidence of sexual intercourse and more consistent contraceptive use. This assertion corroborates with the results of a study conducted by (Enuameh et al., 2017)

The study among adolescents' high school students in the Wa Municipality in Ghana, where 95.1% of them suggested that their parents should be involved discussing sexual behaviours and sex education so that they can learn to protect themselves against risky sexual behaviours.

According to Ajidahun (2013), parental monitoring during preadolescence affects the age at which adolescents start and begin sexual activity. He was of the view that adolescents who are knowledgeable about sex are more likely to use contraceptives consistently. They are also more likely to postpone sexual intimacy the most effective means of preventing sexual problems. Sex counselling can be regarded as a process of making an individual develop a positive and wholesome attitude towards sex. Sex counselling is a way of providing adolescents with valuable knowledge about sex so as to avert risks associated with sex such as teenage pregnancy, sexual diseases and emotional problems.

**Adoption of Health-Based Adolescent Programmes**

Information dissemination agencies are limitless provided they are accessible to the teeming global population of adolescents. In managing adolescents' sexual behaviours, health-based programmes can be adopted so that pertinent and valuable information can be imparted on adolescents to guard against unforeseeable risky sexual behaviours.

**Counselling**

Counselling as way of guiding and giving sound offers for distraught people to choose from in managing their lives cannot be overlooked. In curbing potential setbacks that might come adolescents' way as they behave sexually can espouse or embrace the value of counselling. According to Ventura, Mathew and Curtin (as cited in Ajidahun, 2013) touted that adolescents who get sexual behaviour counselling from school or community programme have a better chance of avoiding pregnancy and other risks connected with sexual behaviours or activity.

To Ajidahun (2013), sexual behaviour counselling need to be shared responsibility and should not be left in the hands of parents alone. Teachers, professional counsellors and more importantly the society should be involved. Sexual behaviour counselling is supposed to be the reproductive rite that gives one knowledge about one's body and value so that it cannot be abused. Despite the possible different views on sexual behaviour counselling, it may be a necessary end in the development of adolescents. It should be seen as part of the formal education that every child needs to survive in the society. To prevent young adult from ignorance, they need to be told about issues surrounding their growth and developments. This will in turn reduce the number of embarrassments they will receive when they begin to experience developmental changes. Apart from this, the knowledge of sexual behaviour counselling will help young adults to differentiate myths from truths (Ajidahun, 2013).

**Youth-Based Development Programmes**

Engaging the growing adolescents in developing and executing adolescents-related programmes that target sexual behaviour is enormous as the

good far outweigh the bad. Adolescents being involved can serve as turning point for positive things towards healthy growth and development.

According to International Women's Health Coalition (2015), young people have a fundamental human right to participate in matters that affect their lives. Meaningful participation is defined as seeking information, expressing ideas, taking an active role in different steps of a process, being informed or consulted on decisions concerning public interest, analysing situations, and making personal choices. Several factors, including age, gender, social and economic class, ethnicity, race, sexual orientation, and HIV status, are key determinants of what role young people see for themselves in society and the ways in which they participate in programs and policies. Giving decision-making power to young people and integrating them into all aspects of program development are vital components of ensuring meaningful participation. Simply having a youth program within an organization does not necessarily guarantee meaningful youth participation. Although there is relatively little evidence on the impact of youth participation, according to the International Women's Health Coalition (IWHC) (2015) more meaningful participation will result in better-developed interventions to promote adolescent sexual behaviours and reproductive health and rights.

Adolescents' participation can be in a form of youth leadership in sexual behaviour promotion and peer education. According to IWHC (2015), many organizations have established youth programs that staff young people or include youth representatives in steering committees or youth councils. These organizations have been very successful in advocating for adolescent and youth sexual and reproductive health and rights at the UN level.

To IWHC (2015), the most solid evidence on youth participation relates to the peer education model, but the results are not promising for SRHR programmes. While peer educators can help create a safe, youthoriented environment, adolescents are more likely to turn to adults for information on sexual and reproductive health. Several studies have shown that the selection of appropriate peer educators may be a challenge: peer educators may not be seen as legitimate, they may have competing demands, or there may be a feeling of competitiveness between educators and other young people. However, many components of peer educator programmes including youth needs assessments, youth- focused recruitment strategies, and better training and mentoring for young people can be used to more effectively engage young people. This dichotomy demonstrates a need to clearly set roles, responsibilities, and effective partnerships between young people and adults when implementing SRHR programmes.

**Clinical-Based Programmes**

Development of clinical-based sexual behaviour programmes may go a long way to reduce risky sexual behaviours adolescents get themselves engaged. There is no denying fact that health professionals coming into contact adolescents as and they visit clinics offer them a lot information that they can draw on as adolescents in managing their natural turbulent situations. According to Maria, Guilamos-Ramos, Jemmott, Derouin and Villarruel (2017), health professionals' care for adolescents in a variety of settings, including communities, schools, and public health and acute care clinics, which affords them many opportunities to improve adolescents' sexual behaviours and reproductive health and reduce sexual-related problems such as unplanned

pregnancy and sexually transmitted infections. To ensure that adolescents have access to sexual and reproductive health care (which includes both preventive counselling and treatment) in all nursing practice sites, health professionals need to gain the knowledge and improve the skills required to deliver evidence-based sexual-clinical services to adolescents and parents. Collectively, they can use their unique combination of knowledge and skills to make a positive impact on adolescent sexual and reproductive outcomes because they have the capacity and opportunity to disseminate information about sexual and reproductive health to adolescents and their parents in communities, schools, public health clinics, and acute care settings (Maria, Guilamos-Ramos, Jemmott, Derouin & Villarruel, 2017).

**Perceptions of contraceptives use among adolescent students**

Studies conducted have reported on the perception of adolescent students regarding the use of contraceptives and how these perceptions influences their usage of contraceptives.

A study conducted by Agyemang, Newton, Nkrumah, TsokaGwegweni and Cumbe (2019) on contraceptive use among sexually active female adolescents in Ashanti Region-Ghana indicated that the perceived side effects of contraceptives among female adolescents was found to be the main reason for about 53.66% of them not using the contraceptives. Hagan and Buxton (2012) in a study on contraceptive knowledge, perceptions and use among adolescents in the Central Region of Ghana revealed that, adolescents in Senior high Schools perceived contraceptives are meant for only married adults hence do not see the need to use contraceptives themselves. Similarly, Nana and Esinam (2012) found that, most adolescents did not use contraceptives because

of their perceived side-effects of contraceptives. In the same study, Nana and Esinam (2012) reported that, the use of contraceptive by the adolescent students was a reserve for the married adults. Kareem and Samba (2016) also reported that, misconceptions and misinformation of adolescent girls in Korle-Gonno, Accra, Ghana on contraceptives discouraged them from using contraceptives. Komey (2016) indicated in a study on perceptions of contraceptive use among second cycle institutions in the Adentan Municipality that, adolescents' misperceptions about contraceptives tended to cloud the judgment towards contraceptives, thus serving as a barrier to the use of contraceptives. Mohammed, Abdulai, and Iddrisu (2019) revealed in their study that, most adolescents perceived contraceptives use as not morally right and tends to promote promiscuity among adolescents in Northern Ghana. Ekstrand (2008) in a study on perceptions of contraceptive use, abortion, and sexually transmitted infections among adolescent in Sweden mentioned that, main barriers to contraceptives especially condom use were interference with spontaneity, pleasure reduction, loss of erection, and embarrassment or distrust. Many of the young men generally preferred coitus interruptus to condom use. An investigation into contraceptive use, knowledge, attitude, perceptions and sexual behaviour among female University students in Uganda by Nsubuga, Sekandi, Sempeera and Makumbi (2015) indicated that, students perceived contraceptives use are only for females. Etenikang, Uji, Obinna and Ife (2017) interestingly revealed that, religious adherence and myths about the side effects of modern contraceptives accounted for low prevalence of modern contraceptive use among literate adolescents in Calabar, Nigeria. In the same vein, Okanlawon, Reeves and Agbaje (2010) reported that most adolescents in

Nigeria had little correct information about contraceptives, with 42.9% having misperceptions about its safety, believing that contraceptives are dangerous and that chemicals in contraceptives can damage their reproductive system.

# CHAPTER THREE

# RESEARCH METHODS

## Introduction

It is generally accepted that, the quality of any research project hinges on gathering relevant information that would be used to solve a stated problem. The quality of these processes determines the validity and reliability of data collection and the results obtained (Willington, 2000). This chapter outlines the methods used in the research work. The research methods and procedures used in the study are described under the following sub-heading: research design, population, sample and sampling procedure, instrument, and data collection procedure and data analysis.

## Research Design

A research design can be viewed as a plan, structure and strategy of a research to find the tools to solve the problems and to minimize the variance (Creswell & Creswell, 2017). Its function, therefore, is to ensure that the evidence obtained ensures that the initial question is answered as unambiguously as possible. A research design is a plan of a study (McMillan & Schumacher, 2001). This means a research design is a programme that guides the researcher to collect, analyse and interpret data. According to Ary, Jacob, and Raavieh (2002), research studies are designed to obtain information concerning the current status of a phenomenon. Descriptive survey research was used for this study. Seidu (2006) described descriptive survey design as the study of existing condition, prevailing view points, attitudes, ongoing processes

and developing trends in order to obtain information that can be analysed and interpreted to come up with a report of the present status of the subject or phenomenon under study. This design was found suitable for this study because it gave an in-depth description of the phenomenon under study and also, it was economical in collecting data from a large sample with high data turn over (Kothari, 2004).

The study investigated the perception of contraceptives use and its impact on the sexual behaviour of adolescence in Senior High Schools in the Krachi East District. This invariably involves finding out the opinions of students on how the perception of contraceptives use impacts their sexual behaviour. Against this background, the descriptive survey was the research design used for the study. Again, the descriptive survey design was used because it has the advantage of producing good responses from a wide range of people. It also provided a picture of a situation as it naturally occurs or happens (Burns & Grove, 2003). At the same time, it provides a meaningful picture of events and explains people's opinions and behaviour on the basis of the data gathered at a point in time (Best & Khan, 1986). Again, descriptive survey research was deemed most appropriate because it involved the collection of data in order to answer questions concerning current status of the subject matter under study.

**Population**

Based on data collected from the District Education office, the target population for Senior High Students in the District is 6030 with an accessible population of 2063 second year students. Form two (2) students were chosen because, they are quite exposed to sexual behaviours and the use of

contraceptives. The third years were not chosen because, they were preparing for their April-May West African Senior Certificate Examination (WASCE).

**Sample and Sampling Procedures**

The quality of any research not only stands or falls by the appropriateness of methodology and instrumentation but also by the suitability of the sampling strategy that is adopted (Cohen, Manion & Marrison, 2011).

Polit (2001) defined a sample as a proportion or a subset of the accessible population that serves as true representation of the accessible population. The sample size was 317. In arriving at this sample size, the sample size determination table of Krejcie and Morgan (1970) was used as a guide. But for attrition purpose, the sample size was increased to 340. There are seven (7) SHS in the District which consists of four (4) public schools and three (3) private school. Four (4) out of seven (7) Senior High Schools in the Krachi - East District in the Volta Region of Ghana were simple randomly sampled. These include two (2) private schools and two (2) public schools were simple randomly sampled. This enabled the researcher to compare the perceptions of contraceptives use and its impact on sexual behaviour since these schools belong to different categories. Table 1 represents the various schools and their sample proportions:

Table 1-*Sample Size Proportions for the selected schools in the Krachi - East District*

| School | N | % | n | Male | Female | Category |
|---|---|---|---|---|---|---|
| Dambai SHS | 95 | 5 | 17 | 9 | 8 | Private |
| Mist SHS | 571 | 30 | 104 | 56 | 48 | Private |
| Oti SHS | 1022 | 55 | 185 | 100 | 85 | Public |
| Asukawkaw SHS | 184 | 10 | 34 | 18 | 16 | Public |
| Total | 1872 | 100 | 340 | 183 | 157 | |

Where; N denotes the accessible population; n denotes the Sampled Size

The study employed the multistage sampling procedure where the following were considered: Simple Random sampling method was used to sample the various schools based on the categories. This procedure was employed because both private and public schools have an equal chance of being selected and on their specific categories they belong to. Also both private and public schools have similar characteristics of elements for the research.

Purposive sampling: The purposive sampling procedure was used in the selection of the class thus: all second year students in these schools for the study. This is due to the fact that, the third years who were more exposed to the use of Contraceptives were preparing for their West African Examination Certificate were exempted to give them the chance to study. The stratified method was used to group male and female students.

**Data Collection Instruments**

A Perception and Contraceptives Uses on Sexual Behaviour Questionnaire (PCSBQ) designed by the researcher was used to collect data for the study. The questionnaire was considered most appropriate because it could reach a large number of respondents more easily. Also, the questionnaires could be filled at the respondents' own convenience and it's less expensive. The questionnaire comprised six (6) sections with fifty-one (51) items. Section A contained the demographic information of the respondents with three (3) items. The section B solicited information on adolescents' perception of contraceptives use with ten (10) items. The section C solicited information on the perceived contraceptives use influence on adolescents' sexual behaviour with ten (10) items. The section D was about the effect of perceived contraceptives use on adolescent students' sexual behaviour with ten (10) items. The section E was

about the improvement of sexual behaviour of adolescents concerning Contraceptives use with seven (7) items. The last section was the types of contraceptives used by the adolescents with eleven (11) different types of items. The questionnaires were administered to the sampled population within a period of four (4) working days with the help of two (2) well trained colleagues after which the questionnaires were collected for sorting.

**Validation of the instrument**

Validity is the exactness and precision of deductions based on the findings from the research (Mugenda & Mugenda, 2003). The validation of the instrument was carried out to check correctness of the data collection instrument during the pilot study.

In order to enhance the validity of the study, the questionnaire was given to the researcher's supervisors and some lecturers in the Department of Education and Psychology in the Faculty of Education and Foundation for expert assessment as their vast knowledge in research studies seemed enormous. This ensured both face and content related evidence to the items in examining whether the items would relate to the research questions and also comprehensively cover the details of the study.

**Reliability of the Instrument**

Leedy and Ormrod (2005) explained reliability as the consistency with which a measuring instrument yields certain result when the entity being measured has not changed. Consistency of the instrument was achieved through a number of initiatives. Reliability reveals that when procedures of the study are repeated, the exact same result are expected (Mugenda & Mugenda, 2003). A reliability test was carried out with the purpose of testing the consistency of the

instrument. The questionnaire was pre-tested in Yabram Senior High School which is a public school and Action Senior High School a private school to test for its reliability. The choice of these schools was based on the fact that, they are all located in the Krachi East District where the participants share similar characteristics. The obtained reliability for Section B (Perceptions of adolescents about contraceptives use) was (r) = **.728** (See appendix B). Section C (Sources of information on Contraceptives) was gotten to be (r) =**.824** (See appendix C). In addition, section D (Perceived effects of Contraceptives use on sexual behaviour of adolescents) also had a reliability of (r) =**.791** (See appendix D) and section E (Perceived ways in which Contraceptives use education can enhance sexual behaviours of adolescent students) also saw a reliability co-efficient of **(**r) =**.672** (See appendix E). The overall obtained reliability co-efficient for all the sections was **.764** indicating that, the questionnaire was reliable.

**Ethical Considerations**

Ethical consideration is a matter of necessity due to the nature of this research. In conducting research, there are ethical principles that must be considered, some of these are informed consent, assuring anonymity and confidentiality. Informed consent is the major ethical issue in conducting research. The consent of participants were first sought through a consent letter, stating the purpose of the research.

The participants were constantly assured of anonymity by asking them not to write their names or anything that could reveal their identity and the information they provided was kept confidential. That is keeping private information by the researcher in order to protect the respondents' identity since

this research is a highly sensitive one and that the ethical clearance form was taken from the University of Cape Coast to ascertain the confidentiality of the study.

**Data Collection Procedure**

Permission was sought from authorities of the various schools, after being cleared by the Department of Education and Psychology and the Institutional Review Board to carry out this study. A preliminary visit to these was organized by the researcher to familiarize himself with these schools. Meetings were later organized to meet these research participants where the purpose and significance of the research were clearly explained to the participants and the various school authorities. Participants were made aware that their participation was voluntary and that they would have the opportunity to withdraw freely from the research along the study period. The participants were assured of confidentiality of the study with regards to the information they provided and were equally given directions with regards to answering the questionnaire. The researcher then issued the PCSB questionnaires to the participants to answer all questions on it by the help of the researcher and his assistants.

The researcher used four (4) days to collect data with the help of two (2) research assistants who have much knowledge in research. The assistants were academic friends who have much knowledge in research so their understanding of the questionnaire administration process was of importance.

**Data Processing and Analysis**

The completed questionnaire by the respondents were serially numbered and coded. The analysis involved coding, organizing, describing, interpreting,

cross tabulation and drawing conclusion. The analysis was done in two stages. Data for research questions 1-4 were analysed by using means and standard deviation. With respect to the hypotheses, hypothesis 1 was tested using the independent samples t-test because the researcher tested for differences between male and female adolescent students about contraceptive use for which males and females are natural dichotomies. Hypothesis 2 was tested using independent samples t-test because the researcher wanted to find the effects of contraceptive use on the adolescent students. Hypothesis 3 was tested using one way analysis of variance (ANOVA) to test the statistical significance difference in the perception of contraceptive use among the ages of the students. The one- way analysis of variance (ANOVA) was used to determine whether there were any statistical significance between the means of three or more independent (unrelated) groups (ages ranges).

# CHAPTER FOUR

# RESULTS AND DISCUSSION

## Introduction

This chapter presented result analysis and the data collected from the field. This is followed by the interpretation of the results and discussion of findings. The purpose of the study was to investigate impact of contraceptive use on the sexual behaviours of adolescents in the Krachi-East District. The analyses and interpretation of data were done based on the data of the research and question set for the study. The analysis was based on the 100% return rate data obtained from 340 respondents used in the study. The first part of this chapter designates the demographic characteristics of the selected Senior High School students in the Krachi-East District which was analysed using frequencies and percentages. In the second part, the research results were presented based on the research question and hypotheses framed for the study.

## Respondents' Demographic Information

This section relates to the background information of the selected Senior High School students in the Krachi-East District who responded to the questionnaire. Demographic variables that were measured included the students' age, gender and school type. The demographic data were analysed using frequencies and percentages. Table 2 presents the results:

Table 2-*Demographic Characteristics of the Selected Students*

| Demographic Variables | Subscale | Freq. | Percent |
|---|---|---|---|
| Gender | Male | 183 | 53.8 |
| | Female | 157 | 46.2 |
| Age Range | 12-15 | 25 | 7.3 |
| | 16-19 | 256 | 75.3 |
| | 20-23 | 59 | 17.4 |
| Category of school | Public | 219 | 64.4 |
| | Private | 119 | 35.6 |

Source: Field Data, (2018) (n=340)

From Table 2, it is evident that the male students (53.8%) were more than female students (46.2%) in the Krachi-East District. The responses of the respondents concerning their age revealed that those within 16-19 were the majority (75.3%), this was followed by those within 20-23 (17.4%). Those within the ages of 12-15 were the least (7.4%). Lastly on their school category, those selected from the public schools were the largest (64.4%) while students who were selected from the private schools were the least (35.6%).

**Analysis of Main Data**

To realize the purpose of the formulated research questions, descriptive statistics (means and standard deviations) were used to analyse the obtained data on perceptions of contraceptives use and its impact on adolescents' sexual behaviour in the Krachi-East District. In the analysis, means provides the summary of the responses from the selected students from the Krachi-East District and the standard deviation indicates whether their responses were clustered to the mean score or dispersed. Standard deviation ranges from 0 to 1.70. Therefore, where the standard deviation is relatively small (within 0), the

respondents were homogeneous. On the other hand, where the standard deviation is relatively large (around 1.02), the responses were heterogeneous. The test value of 2.50 was used to determine the degree of the impact on adolescents' students from the Krachi-East District responses**.** By implication, a mean of 2.50 and above indicates agreement of students in the Krachi-East District concerning contraceptives use while a mean of 2.49 and below indicates disagreement towards contraceptives use. The findings are presented as below.

**Research Question One: What is the knowledge level of adolescent students about contraceptives use?**

The purpose of this research question was to assess the perceived knowledge level of adolescent students about contraceptives use. To achieve this, means and standard deviations were used to assess the adolescents' knowledge level. The results are presented in Table 3.

Table 3-*Results on the Perceived Knowledge Level of Adolescent Students about Contraceptives Use*

| | Test value=2.50 | |
|---|---|---|
| | Mean | Std. D |
| Condom is a form of contraceptive that is available for both males and females | 2.96 | .948 |
| Contraceptives use prevents the contraction of sexually transmitted diseases | 2.90 | .943 |
| Contraceptives use prevents any unplanned pregnancy related issue in relationships | 2.86 | .993 |
| Contraceptives use reduces the sexual pleasures that one is supposed to have during sexual intercourse. | 2.83 | .933 |
| Contraceptives can disappear inside a female's vagina when it strips from the male's penis | 2.51 | .970 |
| One Contraceptives can be used more than once | 2.18 | 1.02 |
| Contraceptives use means that one does not trust the partner | 2.14 | .965 |
| Contraceptives use indicates that one is spoilt or leads an immoral life | 2.01 | .961 |
| Mean of means/ Std.D N=340 | 3.07 | 1.17 |

Statements

Source: Field Survey (2018). Where N is the sampled size

As represented in Table 3, the results show that generally, adolescents in the Krachi-East District have perceived knowledge about contraceptives use. This was quite evident after the responses from the respondents scored a mean greater than the test value (2.50). Dwelling on the individual items, the results indicated that some of the items were rated higher than the others. This implies that each of the students had different understanding about contraceptives use.

For example, it was evident that most of the adolescents in the KrachiEast District know that condom is a form of contraceptive that is available for both males and females *(M=2.96, SD=.948)*. In other evidence, it was revealed that adolescents in the Krachi-East District are aware that contraceptives use prevents the contraction of sexually transmitted diseases *(M=2.90, SD=.943)*.

The results from most of the adolescents in the Krachi-East District indicated that they know that contraceptives use prevents any unplanned pregnancy related issue in relationships *(M=2.86, SD=.993)*. In another related results, the adolescents specified that Contraceptives use reduces the sexual pleasures that one is supposed to have during sexual intercourse *(M=2.83, SD=.933)*. The adolescents in the Krachi-East District further demonstrated their knowledge level that contraceptives can disappear inside a female's vagina when it strips from the male's penis *(M=2.51, SD=.970)*.

Few of the items scored a mean less than the test value of 2.50 indicating that adolescents in the Krachi-East District do not have much knowledge in that aspect of contraceptives use. For example, they disagreed that one Contraceptives can be used more than once *(M=2.18, SD=1.02)*. Also they disagreed that contraceptives use means that one does not trust the partner

*(M=2.14, SD=* .965*)* and finally they disconfirmed that contraceptives use indicates that one is spoilt or leads an immoral life *(M=2.01, SD=.961)*.

From the foregoing, it can be concluded that adolescent senior high school students in the Krachi-East District knowledge level about contraceptives use was adequate as their observed grand mean 3.07 was above the criterion grand mean of 2.50.

**Research Question Two: What are the sources of information on the usage of contraceptives among adolescents?**

To provide more evidence to the study, the researcher went ahead to determine the sources of information on Contraceptives use among adolescents in the Krachi-East District. To measure this**,** means and standard deviations were used for the analysis. Table 4 offers the results.

Table 4-*Results on the Sources of Information on Contraceptives Use*

| Statements | Test Value=2.50 | |
|---|---|---|
| | Mean | Std. D |
| I got to know the use of contraceptives at the hospital, clinic, health centres etc. from the doctors and the nurses | 2.79 | 1.067 |
| I got to know the use of contraceptives through my sexual partner | 2.67 | 1.027 |
| I got to know the use of contraceptives through my friends | 2.61 | 2.377 |
| I got to know the use of contraceptives through watching television and other social media platforms | 2.60 | 1.016 |
| I got to know about contraceptives use through the internet by browsing with my phone | 2.59 | 1.092 |
| I got to know about the use of contraceptives at the chemical shop | 2.39 | 1.068 |
| I got to know the use of contraceptives through the association I joined (Clubs) | 2.35 | 1.038 |
| I got to know the use of contraceptives through my teachers in school | 2.33 | 1.055 |
| I got to know the use of contraceptives through my siblings | 2.01 | 1.116 |
| I got to know the use of contraceptives through my parents (mother and father) | 1.99 | 1.254 |
| I got to know about contraceptives usage in my church/mosque (pastors, imams etc.) | 1.81 | 1.065 |
| Mean of means/ Std. Deviation | 3.07 | 1.171 |

N=340
Where N is the sampled size
Source: Field Survey (2018)

Table 4 presented the results on the sources of information on contraceptives and their usage. The means and standard deviations results from the study suggest that most of the adolescents in the Krachi-East District know the sources of information on contraceptives use and other contraceptives.

For example, the students postulated that they got to know the use of Contraceptives at the hospital, clinic, health centres etc. from the doctors and the nurses *(M=2.79, SD=1.067)*. The respondents further stated that that they got to know the use of contraceptives through their sexual partners *(M=2.67, SD=1.027)*.

In furtherance, it was further stated by the respondents in the Krachi East District that most of them got to know the use of contraceptives through their friends *(M=2.61, SD=2.377)*. In other evidence, they further confirmed that they got to know the use of Contraceptives through watching television and other social media platforms *(M=2.60, SD=1.016)*. Most the adolescents in the Krachi-East District were of the view that they got to know about contraceptives use through the internet by browsing with their phones *(M=2.59, SD=1.092)*.

Nevertheless, most of the adolescents were ignorant about other sources of information for Contraceptives use. For example, they demonstrated that they did not get to know about the use of Contraceptives at the chemical shop *(M=2.39, SD=1.068)*. In similar results they indicated they did not get to know the use of Contraceptives through the association I joined (Clubs) *(M=2.35, SD=1.038)*.

The adolescents agreed that they did not get to know the use of contraceptives through their teachers in school *(M=2.33, SD=1.055)*. They again indicated that they did not get to know the use of contraceptives through

their siblings *(M=2.01, SD=1.116)*. The source of information about the use of contraceptives was not attributed to the adolescents' parents (mother and father) *(M=1.99, SD=1.254)*. Finally, the source of information about use of Contraceptives was not ascribed church/mosque (pastors, imams etc.) *(M=1.81, SD=1.065)*.

From the foregoing, it is indicative that the sources where adolescents got to know about Contraceptives and it usage were many. However, those sources through which they got the information included hospitals, peers, sexual partners, internet and watching televisions.

**Research Question Three: What are the effects of the perception of contraceptives use on the sexual behaviour of adolescent students?**

To establish more comprehensive results for the study, the researcher further investigated the effects of the perception of contraceptives use on the sexual behaviour of adolescent in the Krachi-East District. The mean and standard deviations were used for the analysis. Table 5 illustrated the results.

Table 5-*Perception of contraceptives Use on the sexual behaviour of adolescent students*

| Statements | Test Value=2.50 | |
|---|---|---|
| | Mean | Std. D |
| Contraceptives use decreases the contraction of sexually transmitted infections | 2.74 | .987 |
| Contraceptives use helps minimize issues about unintended pregnancies among adolescents | 2.69 | 1.013 |
| Contraceptives use increases the rate at which people engage in sexual intercourse | 2.44 | .987 |

Table 5: Continued

| | | |
|---|---|---|
| Contraceptives use exposes adolescents more than necessary to infidelity even after maturity | 2.41 | .999 |
| Contraceptives use allows for multiple sexual partners among adolescents | 2.39 | 1.023 |
| Contraceptives use is panacea to less sexual gratification or unsatisfied sexual-intercourse | 2.26 | 1.052 |
| Contraceptives use leads adolescents to act in similar ways sexually like adults and this would not be good | 2.24 | .991 |
| Contraceptives use brings about early initiation of sexual intercourse among adolescents | 2.20 | .970 |
| Contraceptives use pressures intercourse among adolescents | 2.17 | .991 |
| Contraceptives use makes one unreligious among adolescents | 2.13 | .964 |
| Mean of means/ Std.Deviation | 2.36 | 0.99 |

Source: Field Survey, (2018)
N=340
Where N is the sampled size

Table 5 presents results on the effects of the perception of contraceptives use on the sexual behaviour of adolescents in the Senior High Schools in the Krachi-East District. The results show that generally, there is less effects of the perception of Contraceptives use on the sexual behaviour of adolescent in the Krachi-East District. This was clearly evident after most of responses from the adolescents scored a mean less than the test value (2.50).

Only few of the items were agreed to have greater effect on the perception of contraceptives use on the sexual behaviour of adolescent in the Krachi-East District. For instance, they agreed that Contraceptives use decreases the contraction of sexually transmitted infections *(M=2.74,*

*SD=.987)*. Similar results were found after they pointed out that contraceptives use helps minimize issues about unintended pregnancies among adolescents *(M=2.69, SD=1.013)*.

In addition, adolescents in the Krachi-East District were of the view that contraceptives use did not increase the rate at which people engage in sexual intercourse *(M=2.44, SD= .987)*. Similar results was found when the adolescents indicated that contraceptives use did not expose adolescents more than necessary to infidelity even after maturity *(M=2.39, SD= 1.023)*.

In furtherance to the above, adolescents pointed out that contraceptives use was not a panacea to less sexual gratification or unsatisfied sexualintercourse *(M=2.26, SD= 1.052)*. The adolescents in the Krachi-East District further pointed out that, contraceptives use did not lead adolescents to act in similar ways sexually as adults *(M=2.24, SD= .991)*.

The results further show that according to adolescents, the

Contraceptives use do not brings about early initiation of sexual intercourse among adolescents *(M=2.20, SD= .970)*. Again, the adolescents asserted that Contraceptives use do not pressures intercourse among adolescents *(M=2.17, SD= .991)*. Finally, they were of the view that contraceptives use did not make one unreligious among adolescents *(M=2.13, SD= .964)*.

On basis of the findings, it could be seen that majority of the respondents disagreed that knowledge on contraceptives and their usage would lead to teenage pregnancy and the contraction of sexually transmitted diseases.

**Research Question Four: How can the perception of contraceptives Use improve the sexual behaviour of adolescent students?**

Lastly on the research questions, the researcher examined how the perception of contraceptives use improve the sexual behaviour of adolescent students. Means and standard deviations were deemed appropriate for the analysis. Table 6 presents the results.

Table 6-*Results on the how Adolescent Students' Perception of Contraceptives use Improve their Sexual Behaviour*

| Statements | Test Value=2.50 Mean | Std. D |
|---|---|---|
| Adolescents' sexual behaviours can be improved through the use of clinical-based programs that are championed by nurses and other health professionals | 2.90 | 1.009 |
| Adolescents' sexual behaviours can be improved by taking them through sex education | 2.85 | 1.014 |
| Adolescents' sexual behaviours can be improved by encouraging and motivating them to avoid amoral sexual activities and think of school and academics | 2.78 | 1.002 |
| Adolescents' sexual behaviours can be improved by adopting health-based programmes to educate them on the best practices | 2.76 | .954 |
| Adolescents' sexual behaviours can be improved by counselling them on the values of remaining pious and sexual intercourse free at their age | 2.71 | .989 |
| Adolescents' sexual behaviours can be improved by using adolescent role models in championing their course so that they can learn from such role models | 2.63 | 1.023 |
| Adolescents' sexual behaviours can be improved through programmes that are parent-oriented where parents can engage their adolescents on the consequences of teenage sexual relationships | 2.60 | 1.058 |
| Mean of means/ Std.D | 2.747 | 1.00 |

N=340
Where N is the sampled size

Source: Field Survey, (2018)

As illustrated in Table 6, the results give indication that some measures can be used to improve the use of contraceptives on sexual behaviour of

adolescent students in the Krachi-East District. The results however show that some of the measures can be more effective and more conducive to the adolescent students than others.

For instance, the adolescent students agreed that adolescents' sexual behaviours could be improved through the use of clinical-based programs that were championed by nurses and other health professionals *(M=2.90, SD= 1.009)*. They further suggested that adolescents' sexual behaviours can be improved by taking them through sex education *(M=2.85, SD= 1.014)*.

The result above showed that, adolescents' sexual behaviours can be improved by encouraging and motivating them to avoid amoral sexual activities and to think of school and academics *(M=2.78, SD= 1.002)*. The adolescent students were also of the idea that adolescents' sexual behaviours can be improved by adopting health-based programmes to educate them on the best practices *(M=2.76, SD= .954)*.

The respondents pointed out that adolescents' sexual behaviours could be improved by counselling them on the values of remaining pious and sexual intercourse free at their age *(M=2.71, SD= .989)*. Measure like adolescents' sexual behaviours can be improved by using adolescent role models in championing their course so that they can learn from such role models was not left out *(M=2.63, SD= 1.023)*. Lastly, the measure by which adolescents' sexual behaviours could be improved was through programmes that were parent-oriented where parents could engage their adolescents on the consequences of teenage amoral sexual relationships was least approved by the adolescents *(M=2.60, SD= 1.058)*.

In general, adolescent students' knowledge about contraceptives and their usage can go a long way to improve upon their sexual behaviours as they continue to grow in societies that allow interaction among adolescents of both sexes.

**Research Question Five: What contraceptives are well known to the adolescent students?**

The main aim of this research question was to assess the types of contraceptives that are well known by the adolescents. The results are presented in Table 7.

Table 7-*Results on the contraceptives well known by the adolescents*

| Types of Contraceptives | Freq. (no) | Percentage (%) |
|---|---|---|
| Male Condoms | 202 | 59.4 |
| Female Condoms | 110 | 32.4 |
| Diaphragm | 9 | 3.0 |
| Cervical cap-fem cap | 5 | 1.5 |
| Contraceptive coil | 4 | 1.2 |
| Contraceptive patch | 3 | 0.9 |
| Contraceptive implant | 2 | 0.6 |
| Vaginal Ring | 2 | 0.6 |
| Contraceptive injection | 1 | 0.3 |
| Emergency Contraceptive | 1 | 0.3 |
| Sterilizer | 1 | 0.3 |

Source: Field Survey, (2018) n=340

Table 7 presents results on the contraceptives that are well known by the adolescents. From the results, it is clear that Male Contraceptives was well

known by the adolescents (n=202, 59.4%). Female Contraceptives followed (n=110, 32.4%). The rest of the contraceptives were not very common among the adolescents in the Krachi-East District.

**Factor Analysis Results**

Factor analysis is a statistic procedure or analysis which allows the researcher to condense a large set of variables or scale items down to a smaller, more manageable number of dimensions or factors. It does this by summarizing the underlying patterns of correlation and looking for groups of closely related items. In this study, exploratory factor analysis using principal components analysis (PCA) has been employed. In PCA, the original variables are transformed into a smaller set of linear combinations, with all of the variance in the variables being used. It is admitted a preference for PCA and gives a number of reasons for this. He recommends that it is psychometrically sound, simpler mathematically and it avoids some of the potential problems with factor indeterminacy associated with factor analysis.

The purpose of the study was to find out the perceptions of contraceptives use and its impact on adolescents' sexual behaviour in the Krachi-East District. In obtaining this, all the factors (perceived knowledge level of adolescent students about contraceptives use, sources of information on Contraceptives and their usage, effects of the perception of contraceptives use on the sexual behaviour of adolescent students and how the perception of contraceptives Use improve the sexual behaviour of adolescent students) measuring perceptions of contraceptives were analyzed confirmatory factor analysis. Table 8 presents the KMO and Bartlett's Test Result.

Table 8-*KMO and Bartlett's Test Result*

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .821 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 783.085 |
| | df | 66 |
| | Sig. | .000 |

Source: Field Survey, (2018) Significant @ 0.05 n=340

The adequacy of the sample is measured by KMO in SPSS. The sampling is adequate or sufficient if the value of Kaiser Meyer Olkin (KMO) is larger than 0.5 Field (2000), according to Pallant (2013) the value of KMO is 0.6 and above. Kaiser (1974) recommends a bare minimum of 0.5 and the value between 0.5 and 0.7 are mediocre, value between 0.7 and 0.8 are good, value between 0.8 and 0.9 are great and value between 0.9 and above are superb (Hutcheson & Sofroniou, 1999). From Table 8, the results show the Kaiser-Meyer-Olkin Measure of Sampling (KMO=.821) was adequate and good.

Again, the strength of the relationship in SPSS can be measured by a Bartlett Test of Sphericity. It is actually a measure of a multivariate normality of set of distribution. This test also checks the null hypothesis that the original correlation matrix is an identity matrix. The significant value less than 0.05 indicates that these data do not produce an identity matrix and are thus approximately multivariate normal and acceptable for further analysis (Pallant, 2013; Field, 2000). From Table 8, the Bartlett Test of Sphericity result (sig=.000) was less than .05 indicates that these data do not produce an identity matrix and are thus approximately multivariate normal and acceptable for further analysis.

Table 9-*Results of the Exploratory Factor Analysis*

| Factors | Variables included in the factor | Loadings | Eigenvalues | % of Variance explained | Cronbach's Alpha |
|---|---|---|---|---|---|
| **Perceived Knowledge (I)** | Contraceptives use prevents any unplanned pregnancy related issue in relationships | 0.650 | | | |
| | Condom is a form of contraceptive that is available for both males and females | 0.618 | 4.679 | 29.526 | .847 |
| | Contraceptives use reduces the sexual pleasures that one is supposed to have during sexual intercourse | 0.533 | | | |
| | Contraceptives can disappear inside a female's vagina when it strips from the male's penis | | | | |
| **Sources of Information (II)** | I got to know the use of contraceptives at the hospital, clinic, health centers etc. from the doctors and the nurses | 0.506 | | | |
| | I got to know the use of contraceptives through my sexual partner | 0.736 | 3.255 | 21.459 | .785 |
| | I got to know the use of contraceptives through my friends | 0.662 | | | |
| | I got to know about contraceptives use through the internet by browsing with my phone | | | | |
| **Effect Factors (III)** | Contraceptives use decreases the contraction of sexually transmitted infections | 0.746 | 2.069 | 17.671 | .129 |

Table 1: Continued

| | | | | | |
|---|---|---|---|---|---|
| | Contraceptives use helps minimize issues about unintended pregnancies among adolescents | 0.666 | | | |
| **Use of Contraceptives to improve Sexual Behaviour (IV)** | Adolescents' sexual behaviours can be improved through the use of clinical-based programs that are championed by nurses and other health professionals | | | | |
| | Adolescents' sexual behaviours can be improved by taking them through sex education | .773 | 1.133 | 9.867 | .525 |
| | Adolescents' sexual behaviours can be improved by encouraging and motivating them to avoid amoral sexual activities and think of school and academics | .804 | | | |
| | Adolescents' sexual behaviours can be improved by adopting health-based programmes to educate them on the best practices | | | | |
| Total variance | | | | 78.523 | |

Source: Field Survey, (2018)
Bartlett's Test of Sphericity=783.085, Significance=0.000
Kaiser-Meyer-Olkin Measure of Sampling Adequacy=0.821

As shown in Table 9 total variance of 78.523% is achieved for four factors using perceived knowledge level of adolescent students about contraceptives use. The first Eigen value is equal to 4.679 and explained 29.526% of the variance in the original data. The second factor (Sources of Information) Eigen value is equal to 3.255 and explains 21.459% of the variance, the third component (Effect Factors) Eigen value is equal to 2.069 and explains 17.671% of the variance. The last factor (Use of Contraceptives to improve Sexual Behaviour) Eigen value is equal to 1.133 and explains 9.867% of the variance.

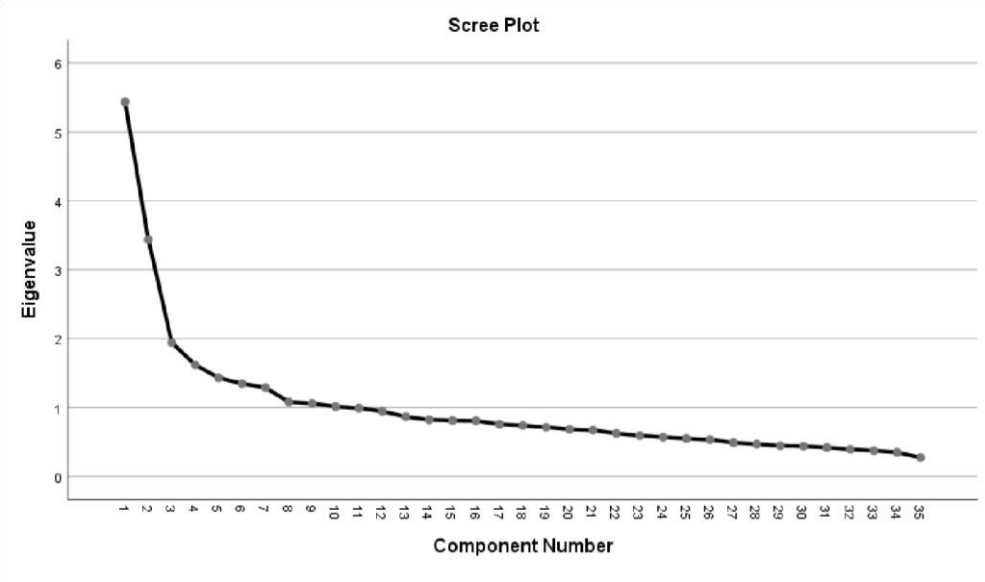


*Figure 1*-Scree Plot

The scree plot show that not all the factors were loading to predict the construct

**Factor Rotation**

It can be hard to name the components after extraction based on their factor loadings because PCA criteria is that the first factor / component account for the maximum part of the variance. This understanding of the factors might be hard. Therefore to interpret them, the rotation of factors assists in this process, for this reason the factors are rotated. Accordingly,

factor rotation changes the pattern of the unrotated factors (as shown in component matrix) and increases the understanding of each factor, by presenting the pattern of loadings in a manner that is easier to interpret and understand.

Table 10-*Rotated Component Matrix*

| | | Rotated Component Matrix and Internal Consistencies<br>Principal Component Loadings | | |
|---|---|---|---|---|
| | | Varimax | Variance | Cronbach's |
| Items | Variables | | Explained | Alphas |
| Factor 1 (PK) | PKF1 | .800 | .86596 | .960 |
| | PKF2 | .743 | | |
| | PKF3 | .615 | | |
| Factor 2 (SI) | SIF1 | .663 | .65294 | .855 |
| | SIF2 | .833 | | |
| | SIF3 | .856 | | |
| | SIF4 | .786 | | |
| Factor 3 (EF) | EF1 | | .76569 | |
| | EF2 | .844 | | |
| | EF3 | .866 | | |
| | EF4 | .807 | | |
| Factor 4 (ISBF) | ISBF1 | .575 | .58694 | .833 |
| | ISBF2 | .818 | | |
| | ISBF3 | .678 | | |
| | ISBF4 | .785 | | |

Source: Field Survey, (2018) Significant @ 0.05 n=340

In order to increase the interpretability of the extracted factors, rotation is necessary to maximize the loadings of some of the items. Later, these items can be used to identify the meaning of a factor. It is noteworthy to mention that rotation does not change the underlying solution, rather, it presents the pattern of loadings in a manner that is easier to interpret. From the analysis, the items in Table 10 are factored in familiar component as for perceptions of contraceptives use and its impact on adolescents' sexual behaviour in the Krachi-East District item 1, item 2, item 3 and item 4, are consistently moving together and are in one group.

**Analysis of Research Hypotheses**

**Research Hypothesis One: There will be no statistically significant difference between male and female students' perception on the use of contraceptives**.

One of the objectives of the study was to determine the differences between male and female students' perception on the use of contraceptives in the Krachi-East District. To achieve this, independent sample t-test was deemed appropriate for the analysis. The results are presented in Table 8.

Table 8-*Results of t-test Comparing Gender Difference on the Perception of the Use of Contraceptives*

| Gender | N | Mean | SD | t-value | Df | Sig-Value |
|---|---|---|---|---|---|---|
| Male | 183 | 19.394 | 3.384 | | | |
| Female | 157 | 19.306 | 3.502 | .236 | .338 | .814 |

Source: Field Data, (2018) *Significant difference exists at P<0.05, (n=340)

Results on the male and female students' perception on the use of contraceptives are presented in Table 8. As depicted in the Table, the means

and standard deviation gives slight indication that male students (mean= 19.394, Std.D=3.384) have high perception on the use of contraceptives than female students in the Krachi-East District (mean=19.306, SD=3.502). However, a critical look at the *t* and *p*-value show that, there was no statistically significant difference between male and female students' perception on the use of contraceptives (t (df =338) =.236, p = .814, p>0.05, n=340, 2-tailed). Hence, the null hypothesis that; "*There is no statistically significant difference between male and female students' perception on the use of contraceptives*" was upheld.

**Research Hypothesis Two**: **There will be no statistically significant difference in the perception of contraceptives use between students in private and public Senior High Schools.**

This hypothesis set out to determine the differences in the perception of contraceptives use between students in private and public schools. To achieve this, independent samples t-test was deemed appropriate for the analysis. Table 9 offers the results on the differences on the perception of contraceptives use between students in private and public schools in the Krachi-East District.

Table 9-*Results of t-test Comparing Type of School on the Perception of the Use of Contraceptives*

| Type of school | N | Mean | SD | t-value | Df | Sig-Value |
|---|---|---|---|---|---|---|
| Public | 219 | 19.4220 | 3.12502 | | | |
| Private | 121 | 19.2295 | 3.94128 | .464 | .844 | .643 |

Source: Field Data (2018)

The Table showed the results on the private and public schools' perception on the use of contraceptives. As described in the Table, the means and standard deviation gives small differences in the mean scores of the private and public schools. In comparing the means scores, the results show that public schools (mean= 19.422, Std.d=3.125) have different perception on the use of contraceptives than private schools in the Krachi-East District (mean=19.2295, SD=3.94128, n=122). However, the *t* and *p*-value showed that, there was no statistically significant difference between private and public schools' perception on the use of contraceptives (t (df=.844)t =.464, p = .643, p>0.05,). Therefore, the null hypothesis which stated that; "*There is no statistically significant difference in the perception of Contraceptives use between students in private and public schools"* was upheld.

**Research Hypothesis Three: There will be no statistically significant difference in the perception of contraceptive use among the ages of the students**

This enabled the researcher to test the hypothesis and find out whether ages of the students could have different perception on contraceptives use among adolescent students in the Krachi-East District. To achieve this, oneway between-groups analysis of variance (ANOVA) was used for the analysis.

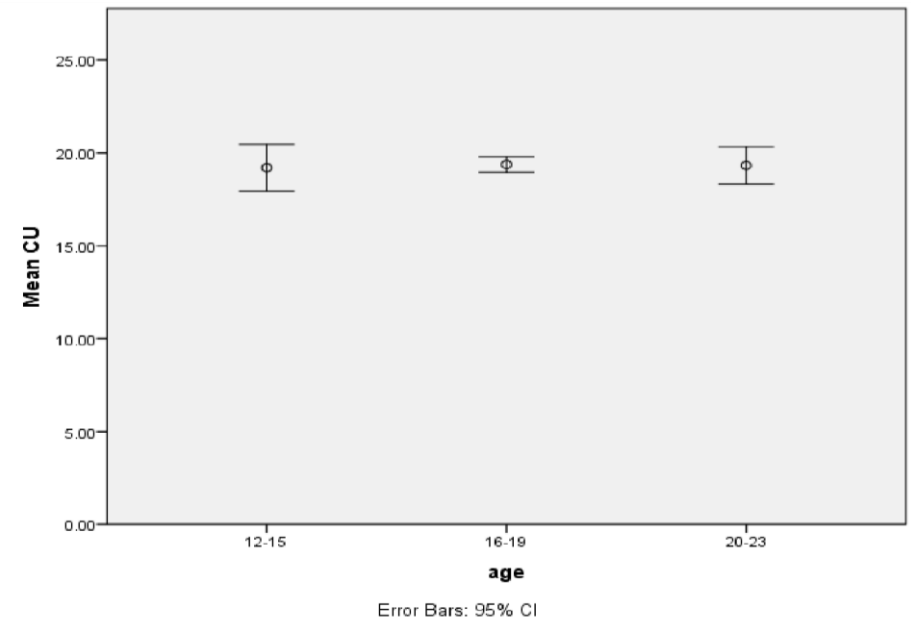


*Figure 1*-Mean Plots on ages of the Students by their Perception of Contraceptives Use

Figure 1 presents a graphical way to compare the means scores of the ages of the students by the perception of Contraceptives use. The results from the Means Plots Figure show there were no differences in the scores among the ages of the students. To gain more statistical evidence, one-way betweengroups analysis of variance (ANOVA) was conducted to gain more statistical confirmation.

Table 10-*Summary of One-way Analysis of Variance (ANOVA) Results*

| Sources | Sum of Squares | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | .766 | 2 | .383 | .032 | .968**(ns)** |
| Within Groups | 4000.881 | 337 | 11.872 | | |
| Total | 4001.647 | 339 | | | |

Source: Field Data, (2018)

A one-way between-groups analysis of variance (ANOVA) was conducted to compare mean scores of the ages of the students with respect to their perception of Contraceptives use. From Table 9, the results show that there was no a statistically significant difference ages of the students with respect to their perception of Contraceptives use. This was evident after the between-groups analysis of variance (ANOVA) produced an F-ratio results of $F$ (2, 337) = .032, p<.05, n=340, Sig. = .968, 2-tailed). Henceforth, null Hypothesis two which states that "*There is no statistically significant difference in the perception of Contraceptives use among the ages of the students"* was upheld.

Based on the result, it can be affirmed that, there is no statistical significant difference among the ages of adolescent students about their knowledge level concerning contraceptives usage.

**Discussion**

**Perceived knowledge level of adolescent students about contraceptive use**

The objective was to find out the knowledge level of adolescent students about contraceptives use and the study revealed that adolescent senior high school students in the Krachi-East District knowledge level about contraceptives use was adequate as their observed grand mean 3.07 was above the criterion grand mean of 2.50. Based on this, adolescents would be able to protect themselves from sexual transmitted infections due to their knowledge on contraceptives and their usage. The result therefore agreed to the study findings of Tarkang and Bain, (2015), who indicated that the correct or right knowledge and consistent contraceptives use whether male or female, has been acknowledged to be effective towards successful prevention of sexually

transmissible infections (STIs), including HIV/AIDS that come as a result of adolescents sexual behaviours. The findings further confirmed that of Masoda and Govender (2013) in their study that, adolescent students in DR Congo, 137 (99%) of respondents knew what condoms as a form contraceptives. Ninety-two of the respondents (67%) knew that generally, Contraceptives are made of latex. Sixty-five per cent of participants from the same study also understood what contraceptives were and what they comprised. They stressed the reason that adolescent students' knowledge about Contraceptives was high could be as a result of the intensive efforts of the DRC government and nongovernmental organisations (NGOs) to educate students about HIV and Contraceptives use. In the same study, most participants (76%) knew that some contraceptives prevented HIV, STIs and unwanted pregnancies, and that it was important to use a contraceptives every time that they had sexual intercourse.

**Sources of Information on contraceptive and contraceptive use**

The objective of the question was to identify sources of information to contraceptives use by adolescents and it was indicative that the sources where adolescents got to know about contraceptives and it usage were many.

However, those sources through which they get the information included hospitals, peers, sexual partners, internet and watching televisions. The study findings agreed with Boamah (2013) on adolescents in Kintampo, Ghana revealed that a lot of participants indicated they got information about contraceptives and other contraceptives usage from friends. On that same note, the findings corroborate the findings of Sutton, Brown, Wilson and Klein (2002) who indicated when interacting with adolescents about sources to condom use and other contraceptives in most occasions, adolescents often

mentioned media as the major source of information and such media include television and internet. The study finding was in conformity with findings by Rideot, Foehr and Roberts; and Strasburger (as cited in Mahama, 2017) which reported that American adolescents devoted about seven hours per day on media and the media are flooded with sexual messages and images.

On the issue of health care providers being an information source to adolescents in Krachi-East District concerning sex education, it agreed with the assertion of Mahama (2017) in his study that, health care providers are essential as every responsible avenue where adolescents learn about their bodily changes and understand what these changes entailed.

**Impact of the perception of contraceptive use on the sexual behaviour of adolescent students**

The aim of the objective was to find out the effects of knowledge on contraceptives use among adolescents. This revealed that adolescents agreed that knowledge on contraceptives and its usage could help prevent sexually transmitted infections and unintended pregnancies among the adolescents which was consistent with the findings of Cates and Stone (as cited in American Academy of Paediatrics, 2001) that condoms use decreased the rate of acquisition of HIV by those who engaged in high-risk sexual activity or whose partners were seropositive for HIV, with relative risk ratios generally in the range of 60% to 96% protective. The findings further agreed with that of Blake (2003) who studied 4,000 adolescents in high schools and posited that making contraceptives available and allowing their use in high schools did not increase adolescent sexual activity, but it protects those who are already sexually active from some sexually transmitted diseases. Blake (2003) noted

that contraceptives availability was not associated with greater sexual activity among adolescents but was associated with greater contraceptives use among those who were already sexually active, a highly positive result.

**How perception of contraceptive use improved the sexual behaviour of adolescent students?**

The aim was to accentuate adolescent sexual behaviours can be improved based their knowledge on Contraceptives use and all respondents agreed to the statement as adolescent students' knowledge about Contraceptives and their usage can go a long way to improve upon their sexual behaviours as they continue to grow in societies that allow interaction among adolescents of both sexes. Programmes can be initiated including school-based ones. According to Mahama (2017) study among adolescent high school students in the Wa Municipality in Ghana. The study revealed that 85.1% of 390 adolescent students surveyed agreed that sex education will have a positive effect on their social lives while 14.9% of the respondents' sex education will have negative effects on them. It is important to note that issues about Contraceptives and its usage is part of sex education and as such a probable way getting adolescents sexual behaviours improved.

Again, communication between parents and adolescents being espoused was in line to improve adolescent students' sexual behaviours and this touted that parents-adolescents with relation to communication is inevitable and is believed to possess the impetus to improve adolescents' sexual behaviours. According to Widman, Choukas-Bradley, Noar, Nesi, and Garrett (2016), parent-adolescent sexual communication has received considerable attention as one factor that could positively impact youth safer

sex behaviour, including adolescents' use of contraception and Contraceptives. It is understood that this communication relationship between parents and adolescents is characterized with real-world and hypothetical motives why parenting may be proxies of sexual socialization for adolescents as parents may realistically convey sexual information and may exercise significant influence on adolescents' sexual attitudes, values, and risk-related beliefs (DiIorio, Pluhar, & Belcher, 2003).

**Discussion on Hypothesis One**

The study revealed that there was no statistically significant difference between male and female adolescent students about their perceptual level concerning contraceptives usage. In this regard, the findings disagreed with that of Leland and Barth (1992) which revealed that females were more likely than males to have discussed sexuality topics with parents to have engaged in sexual intercourse more frequently, to have experienced a pregnancy scare, to have used contraceptives during their last sexual encounter. In addition to perceive that, most of their peers were engaging in sex and using birth control, to obtain birth control from health facilities, and to report intentions to abstain or use protection in hypothetical situations placing them at risk for unprotected sex. In that same study, it was reported that adolescent males were more likely to have always used birth control, to have used birth control during their first sexual encounter, and to have used a contraceptives during their last sexual encounter. Furthermore, males were more likely to obtain birth control from a store or a friend and males knew more about using Contraceptives correctly and their role in preventing sexually transmitted diseases (Leland & Barth, 1992). The findings equally refute Prata, Vahidnia and Fraser (2005) study

findings which revealed that a larger proportion of males than of females indicated that they had always used Contraceptives with all of their partners in the three months preceding the survey 17% against 12%. This synopsis above puts the male adolescents in position against female adolescents when it comes to contraceptives usage in sexual behaviours.

**Discussion on Hypothesis Two**

The study revealed that there was no statistically significant difference between public and private schools' adolescent students about their knowledge level concerning contraceptives and their usage. The findings of this study were incoherent with existing empirically-based literature as a study in Angola among adolescent students revealed otherwise that males in all adolescence age-groups were more likely than females to be consistent users of contraceptives (Prata, Vahidnia & Fraser, 2005)

**Discussion on Hypothesis Three**

The study revealed there was no statistically significant difference among the ages of adolescent students about their knowledge level concerning contraceptives usage. The results were in line with a study in Angola. The findings of the study indicated that no differences existed among males in all adolescent age groups were more likely than females to be users of contraceptives with 19% against 13% (Prata, Vahidnia &Fraser, 2005)

# CHAPTER FIVE

# SUMMARY, CONCLUSION AND RECOMMENDATIONS

## Introduction

This chapter presents a summary of the research findings, discussion of the research findings, the conclusion and the recommendations. The study sought to investigate the impact of Contraceptives use on sexual behaviours among adolescent senior high school students in the Krachi-East District in the Volta Region of Ghana. The study espoused a descriptive survey research method with the quantitative paradigm. A sample of 340 from 2063 adolescent senior high school students were used for the study. The participants were selected using the simple random and purposive sampling procedures. A close-ended type questionnaire developed by the researcher was used and it comprised five (6) sections (A-F) containing 51 items. Section "A" solicited demographic information of respondents. Section "B" sought information from the respondents on their knowledge of contraceptives usage. Section "C" dealt with the sources of information on contraceptives and their usage. Section "D" gathered information on the effects of contraceptives usage on adolescents' sexual behaviour. Section "E" sought information about how sexual behaviours could be enhanced through the knowledge of contraceptives and their usage. Section 'F' gathered information on the types of contraceptives known to adolescent students.

**Summary of Findings**

Adolescent students in the Krachi-East District knowledge level on contraceptives especially condoms use was adequate and was above average. Research question two indicated that, hospitals, peers, sexual partners, internet and watching televisions were the major sources about contraceptives and their usage. Adolescents agreed that contraceptives knowledge and its usage would help prevent sexually transmitted infections and unintended pregnancies among adolescents. Adolescent students' knowledge about contraceptives and their usage could go a long way to improve upon their sexual behaviours as they continue to grow in societies that allow interaction among adolescents of both sexes.

There was no statistically significant difference between male and female adolescent students about their perceptual level concerning contraceptives and their usage. Which means that, both male female adolescent students were aware of contraceptives and how they are used. There was no statistically significant difference between public schools' and private schools' adolescent students about their perception on contraceptives and their usage. This finding means that, students in both private and public schools were highly aware of contraceptives and their usage. Finally, there was no statistical significant difference among the ages of adolescent students about their knowledge level concerning contraceptives usage. This also means that all the adolescent age group were aware of contraceptives and their usage.

## Conclusion

Based on the findings of the study, it was concluded that, adolescent students in the Krachi-East District were knowledgeable on contraceptives use with observed mean of 3.07 above the criterion mean of 2.50. It was also concluded that hospitals, peers, sexual partners, and internet and watching televisions are the main sources adolescents get information about contraceptives and it usage.

It was again concluded that, adolescent students were affected positively through contraceptives knowledge and its usage since they were protected from sexually transmitted infections and unintended pregnancies among the adolescents.

## Recommendations

In light of conclusions drawn from the findings of the study, the following recommendations are offered:

The researcher recommends that, adolescent students be guided by teachers on their information sources, especially the media. It is possible that information presented by these electronic media might be beyond the reality of contraceptives usage and could bring about emotional destabilisation in the lives of the adolescents. In this, parents, peer-educator groups and teachers can be implored to sway adolescents from some unwholesome sexual information presented by these uncensored media outlet (internet and television). Finally, there is an urgent need for Ghana Education Service to undertake programmes that would empower adolescents, especially females, to become assertive in negotiating contraceptive use every time they want to have sex or engage in unprotected sex. Continued advocacy by NGOs and GES should be available

to adolescents who are not abstaining from sex, so they can continually use contraceptives as a way of protecting themselves from unwanted pregnancies or contracting sexually transmitted disease.

All these interventions, if put in place will go a long way to improve and sustain contraceptive use among adolescents in the Krachi-East District.

**Suggestions for Further Research**

The researcher suggests for further studies on factors the influence modern contraceptive practices among adolescents in rural areas in the Krachi-East District of Ghana.

## RFEERENCES

Agyemang, J., Newton, S., Nkrumah, I., Tsoka-Gwegweni, J. M., & Cumber, S. N. (2019). Contraceptive use and associated factors among sexually active female adolescents in Atwima Kwanwoma District, Ashanti region-Ghana. *Pan African Medical Journal*, *32*(182).

Ajidahun, B. O. (2013). Sex counselling and its impacts on adolescents' moral behaviour. *American International Journal of Social Sciences*, *2*(4), 17

Akpan, U. B., Ekott, M. I., & Udo, A. E. (2014). Male condom: Knowledge and practice among undergraduates of a tertiary institution in Nigeria. *International Journal of Obstetrics and Gynaecology*, *2*(1), 032-039.

Allen, M. J. (2011). *The anthem anthology of Victorian sonnets*. Anthem Press.

Almeida, C., Maria, E., Aquino, L. De, Gaffikin, L., & Robert, J. (2003). *Contraceptive use among adolescents at public schools in Brazil,* Retrieved from https://.org/5de1/58dfb782f6bea661adc47.pdf

Almeida, M. D. C., Estela, M. L. A., Lynne, G., & Robert, J. M. (2003). *Use of contraceptives among adolescents.* Escolas Publications: Na Bahia, Revista, Brazil**.**

Amazigo, U., Silva, N., Kaufman, J., & Obikeze, D. S. (1997). Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria. *International Family Planning Perspectives*, *23*(1). Retrieved from https://www.guttmacher.org/sites/default/files/pdf /2302897.pdf American Academy of Paediatrics (2001). Contraceptives use by adolescents. *Paediatrics, 107*(6), 14-38.

American Academy of Pediatrics (1995). Committee on Adolescence: Contraceptives availability for youth. *Pediatrics*, *95*, 281-285.

American Academy of Pediatrics (1998). Committee on Adolescence: Adolescent pregnancy-current trends and issues. *Pediatrics, 103*, 516520.

Anderson, J. E., Santelli, J. S., & Morrow, B. (2006). Trends in adolescent contraceptive use, unprotected and poorly protected sex, 1991–2003. *Journal of Adolescent Health, 38*(6), 734-739.

Aras, S., Orcin, E., Ozan, S., & Semin, S. (2007). Sexual behaviours and contraception among university students in Turkey. *Journal of Biosocial Science, 39*(1), 121-135.

Arnett, J. J. (2007). The myth of peer influence in adolescent smoking initiation. *Health Education & Behaviour, 34(*4), 594-607.

Ary, D., Jacobs, L. C., & Razavieh, A. (2002). *Introduction to Research in Education (6th ed.).* Belmont: Wadsworth.

Babcock, B. (1999). Introduction: Subject to Writing: The Victor Turner Prize and the Anthropological Text. *Anthropology and Humanism, 24*(2), 91-94.

Bailey, G. (2003). *NASW standards for the Practice of Social Work with Adolescents*. NA o. S. Workers (Ed.). Washington DC: National Association of Social Workers.

Bandura, A. (1963). *Social learning and personality development*. New York: Holt, Rinehart, and Winston.

Bandura, A. (1965). Influence of models' reinforcement contingencies on the acquisition of imitative responses. *Journal of Personality and Social Psychology*, *1*(6), 589

Bandura, A. (1971). *Social learning theory*. General Learning Corporation.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review, 84*(2), 191-291.

Bandura, A. (1977). *Social learning theory.* New York: General Learning Press.

Bandura, A. (1986). *Social foundations of thought and action.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology, 52*(1-26).

Bandura, A. (2006b). Toward a psychology of human agency. *Perspectives on Psychological Science, 1(*2), 164-172.

Bennell, P., Hyde, K., & Swainson, N. (2002). *The impact of the HIV/AIDS epidemic on the education sectors in Sub-Saharan Africa. A synthesis of the findings and recommendations of three country studies. England: Centre for International Education, University of Sus*sex Institute of Education.

Benzaken, T., Palep, A. H., & Gill, P. S. (2011). Exposure to and opinions towards sex education among adolescent students in Mumbai: A crosssectional survey. *BMC Public Health, 11*(1), 805.

Best, J. W., & Kahn, J. V. (1993). *Research in education*. (7th ed.). Toronto: Allyn and Bacon.

Bingenheimer, J. B., Asante, E., & Ahiadeke, C. (2015). Peer influences on sexual activity among adolescents in Ghana. *Studies in Family Planning, 46*(1), 1-19.

Blake, S. M. (2003). *School Contraceptives availability does not increase sexual activity.* Retrieved from https://www.eurekalert.org/pub_releases/2003-05/cftasca052103.php.

Boamah, E. A., Asante, K. P., Mahama, E., Manu, G., Ayipah, E. K., Adeniji, E., & Owusu-Agyei, S. (2014). Use of contraceptives among adolescents in Kintampo, Ghana: a cross-sectional study. *Open Access Journal of Contraception, 5*, 7-15.

Boulet, S. L., D'Angelo, D. V., Morrow, B., Zapata, L., Berry-Bibee, E., Rivera, M., & Williams, T. (2016). Contraceptive use among nonpregnant and postpartum women at risk for unintended pregnancy, and female high school students, in the context of Zika preparedness United States, 2011-2013 and 2015. Retrieved from https://stacks.cdc.gov/view/cdc/40618/cdc_40618_DS1.pd

Brown, L. K. (2008). Contraceptives use among high-risk adolescents: anticipation of partner disapproval and less pleasure associated with not using Contraceptives. *Public Health Report, 123*(5), 601-607.

Brunell, A. B., & Webster, G. D. (2013). Self-determination and sexual experience in dating relationships. *Personality and Social Psychology Bulletin, 39*(7), 970-987.

Bullock, A., & Trombley, S. (1999). *The new Fontana dictionary of modern thought*. Harper Collins: London.

Burns, N., & Grove, S. K. (2003). *Understanding nursing research (3rd ed.).* Philadelphia: W.B. Saunders Company.

Cates, W., & Stone, K. M. (1992). Family planning, sexually transmitted diseases and contraceptive choice: A literature update Part I. *Family Planning Perspective*, *24*, 75-84.

Centres for Disease Control. (1992). *Sexual behaviour among high school students.* United States, Hearings before the Senate Labor and Human Resources Committee, 103rd Cong, 1st Sess (1993).

Centres for Disease Control and Prevention (2013) *Contraceptives and STDs: Fact sheet for public health personnel.* Atlanta USA.

Champiti, A. M. (2015). *Sexual behaviour and contraceptive knowledge and use among female adolescents in senior high school in Manhyia Submetro, Kumasi. Thesis.* Kwame Nkrumah University of Science and Technology. Retrieved from http://ir.knust.edu. /123456789/ %20MLEPH%20CHAMPITI.pdf

Chein, J., Albert, D., O'Brien, L., Uckert, K., & Steinberg, L. (2011). Peers increase adolescent risk taking by enhancing activity in the brain's reward circuitry. *Developmental Science, 14*(2), F1-F10.

Chen, L. C., Amor, J. S. & Segal, S. J. (2012). *AIDS and women's reproductive health. Springer Science & Business Media*.

Chin, H. B., et al. (2012). The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: Two systematic reviews for the Guide to Community Preventive Services. *American Journal of Preventive Medicine, 42*(3), 272-294.

Cohen, L., Manion, L., & Morrison, K. (2011). *Planning educational research. Research methods in education*. New York: Routledge Editors.

Connolly, J., Craig, W., Goldberg, A., & Pepler, D. (2004). Mixed-gender groups, dating, and romantic relationships in early adolescence. *Journal of Research on Adolescence, 14*(2), 185-207.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Daniels, K., Daugherty, J. D., & Mosher, W. D. (2015). *Current contraceptive use and variation by selected characteristics among women aged 1544*: United States, 2011-2013.

Davis, K. R, & Weller, S. C. (1999). The effectiveness of Contraceptives in reducing heterosexual transmission of HIV. *Fam*ily *Plann*ing Perspective, *31*, 272-279.

Decker M., & Constantine, N. A. (2011). Factors associated with contraceptive use in Angola. *African Journal Reproductive Health. 15*(4):68–77.

Deri, M. (2016). *Contraceptive Use among Women of Reproductive Age in Jirapa District*. (Doctoral dissertation, University of Ghana).

Diamond, L. M., & Savin-Williams, R. C. (2009). Adolescent sexuality. *Handbook of Adolescent Psychology, 1*, 479-523.

DiIorio, C., Pluhar, E., Belcher, L. (2003). Parent-child communication about sexuality. *Journal of HIV/AIDS Prevention Educating Adolescent Child, 5*, 7-32.

Dimbuene, Z. T., Emina, J. B. O., & Sankoh, O. (2014). UNAIDS multiple sexual partners core indicator: promoting sexual networks to reduce potential biases. *Global Health Action, 7*(1), 231-233.

Doku, D. (2012). Substance use and risky sexual behaviours among sexually experienced Ghanaian youth. *BMC Public Health, 12*(1), 571.

Dominique, M., & Megan, K. (2001). *Patterns of sexual behaviour and Contraceptives use among high school and university students in Butare and Gitarama province, Rwanda.* Population Service International Research Division Working Paper No. 48.

Eaton, D. K., et al. (2012). Centers for Disease Control and Prevention (CDC). Youth risk behaviour surveillance, *United States, 2011. MMWR Surveill Summary*, *61*(4 SS-4), 1-162.

Ekstrand, M. (2008). *Sexual Risk Taking:–Perceptions of Contraceptive Use, Abortion, and Sexually Transmitted Infections among Adolescents in Sweden* (Doctoral dissertation, Acta Universitatis Upsaliensis). Encarta (2006). *Birth control*, Redmond, WA: Macrosoft

Enuameh, Y., Tawiah, C., Nettey, E., Mahama, E., Adjei, K., Asante, K. P., & Owusu-Agyei, S. (2017). Designing culturally sensitive and contextually appropriate sexual and reproductive health messages for adolescents: stakeholder perspectives from Ghana.

Esantsi, S. F., Onyango, F., Asare, G. Q., Kuffour, E., Tapsoba, P., Birungi, H., & Askew, I. (2015). Are parents talking to adolescents about sexuality? Evidence from four slums in Ghana.

Etenikang, A. S., Uji, A. B., Obinna, N. C., & Ife, E. C. (2017). Knowledge, practice and perception of contraception by literate adolescents in Calabar, Nigeria. European Journal of *Biology and Medical Science Research*, *5*(6), 1-6.

Felder, D. G. (2003). *A Century of women: The most influential events in 20th Century women's history*. Citadel Press.

Field, D. (2000). *The essentials of factor analysis*. (3rd ed.). New York, NY: Continuum International Publishing Group

Fields, E. L., Bogart, L. M., Smith, K. C., Malebranche, D. J., Ellen, J., & Schuster, M. A. (2012). HIV risk and perceptions of masculinity among young black men who have sex with men. *Journal of Adolescent Health, 50*(3), 296-303.

Ford, K., Sohn, W., & Lepkowski, J. (2001). Characteristics of adolescents' sexual partners and their association with use of condoms and other contraceptive methods. *Family Planning perspectives*, 100-132.

Fortenberry, J. D. (2013). Puberty and adolescent sexuality. *Hormones and behaviour, 64*(2), 280–287. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3761219/

Freeman, D. (1983). *The fateful hoaxing of Margaret Mead: A historical analysis of her Samoan research*. Oxford: Westview Press.

Freud, S. (1856–1939). *Encyclopaedia of German Literature*. Routledge: London.

Freud, S. (1905). *Three essays on the theory of sexuality*. Se, 7. Renzetti, Claire; Curran.

Frost, J. J., Henshaw, S. K., & Sonfield, A. (2010). Contraceptive needs and services: National and state data, 2008 update. Retrieved from https://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and reproductive health: a matter of life and death. *The Lancet, 368*(9547), 1595-1607.

Hagan, J. E., & Buxton, C. (2012). Contraceptive knowledge, perceptions and use among adolescents in selected senior high schools in the central region of Ghana. *J Sociol Res, 3*(2), 170-180.

Häggström-Nordin, E. (2005). *Worlds apart? sexual behaviour, contraceptive use, and pornography consumption among young women and men* (Doctoral Dissertation, Acta Universitatis Upsaliensis).

Hall, P. A. (2004). Risky adolescent sexual behaviour: A psychological perspective for primary care clinicians. *Topics in Advanced Practice Nursing e-Journal*, *6*(3), 23-30.

Hanson, S. J., & Burke, A. E. (2010). *Fertility control: Contraception, sterilization, and abortion*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Hatcher, R. A., & Nelson, M. D. A. L. (2007). *Contraceptive technology*. Ardent Health Service/Health Iowa.

Health Communication Capacity Collaborative. (2014). *Social Learning Theory: An HC3 Research Primer*. Retrieved from https://www.lsrhs.net/sites/kleina/files/2012/11/SocialLearningTheory.pdf

Heimans, F. (1987). Margaret Mead and Samoa. *Event occurs, 41*, 20.

Hermann, H. R. (2016). *Dominance and aggression in humans and other animals: The great game of life*. Academic Press.

Herring, J. (2014). *Medical law and ethics*. Oxford: Oxford University Press.

Hilliard, M. E., Powell, P. W., & Anderson, B. J. (2016). Evidence-based behaviour al interventions to promote diabetes management in children, adolescents, and families. *American Psychologist, 71*(7), 590.

Hogewoning, C. J., Bleeker, M. C., van den Bruler, A. J., Voorhorst, F. J., & Snijders, H. D. (1972). *The masks of hate: The problem of false solutions in the culture of an acquisitive society*. Pergamon Press.

Hutchinson, M. K., & Montgomery, A. J. (2007). Parent communication and sexual risk among African Americans. *Western Journal of Nursing Research, 29*(6), 691-707.

Hutchinson, M. K., Jemmot, J. B., Jemmot L. S., Braverman, P., & Fong, G. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviour s among urban adolescent females: A prospective study. *Journal of Adolescent Health, 33*, 98-107.

Hutcheson, G. & Sofroniou, H. B. (1992). *A first course in factor analysis*. Hillsdale, NJ: Lawrence Erlbaum.

International Women's Health Coalition (2015). *Ensuring youth participation in sexual and reproductive health policies and programmes: What we know*. Retrieved from

Johnson, J. (2017). Social learning theory as a framework for recreational therapy intervention in children with neurodevelopmental disorders. *Illuminare, 15*.

Kar, S. K., Choudhury, A., & Singh, A. P. (2015). Understanding normal development of adolescent sexuality: A bumpy ride. *Journal of Human Reproductive Science, 8*(2), 70-74.

Kareem, M., & Samba, A. (2016). Contraceptive use among female adolescents in Korle-Gonno, Accra, Ghana. *Gynecology & Obstetrics, 6*(12).

Kareem, M., & Samba, A. (2016). Contraceptive use among female adolescents in Korle-Gonno, Accra, Ghana. *Gynecol Obstet (Sunnyvale), 6*(414), 2161-0932.

Kiragu, K., & Zabin, L. S. (1995). Contraceptive use among high school students in Kenya. *International Family Planning Perspectives. 21*(3).

Kirby, D. (2002). The impact of schools and school programs upon adolescent sexual behaviour. *The Journal of Sex Research, 39*(1), 27-33.

Komey, L. Y. N. N. (2016). *Knowledge, Attitude and Perceptions of Contraceptive Use among Second Cycle Institutions in the Adentan Municipality* (Doctoral dissertation, University of Ghana).

Kothari, C. R. (2004). *Research methodology*: Methods and techniques. New Age International.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. *Educational and psychological measurement, 30*(3), 607610.

Larson, R., & Wilson, S. (2004). Adolescence across place and time. Globalization and the changing pathways to adulthood. In R. M. Lerner, L. Steinberg (Editors). *Handbook of Adolescent Psychology*, 299-330.

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research*. Pearson Custom.

Leland, N. L., & Barth, R. P. (1992). Gender differences in knowledge, intentions, and behaviour s concerning pregnancy and sexually transmitted disease prevention among adolescents. *Journal of Adolescence Health, 13*(7), 589-599.

Lewin-Bizan, S., Bowers, E. P., & Lerner, R. M. (2010). One good thing leads to another: Cascades of positive youth development among A*merican adolescents. Development and Psychopathology, 22*(4), 759-770.

Mahama, I. (2017). *Adolescent students' perception of sex education and its effect on their social lives in the Wa Municipality.* Master's Thesis submitted to Department of Education and Psychology, University of Cape Coast, Ghana.

Manlove, J., Fish, H., & Moore, K. A. (2015). Programmes to improve adolescent sexual and reproductive health in the US: A review of the evidence. *Adolescent Health, Medicine and Therapeutics,* 1-45.

Manlove, J., Ikramullah, E., & Terry-Humen, E. (2008). Contraceptives use and consistency among male adolescents in the United States. *Journal of Adolescence Health, 43*(4), 325-333.

Manlove, J., Ryan, S., & Franzetta, K. (2003). Patterns of contraceptive use within teenagers' first sexual relationships. *Perspectives on Sexual and Reproductive Health, 35*(6), 246–255. Retrieved from https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/3524603.pdf

Maria, D. S., Guilamos-Ramos, V., Jemmott, L. S., Derouin, A., & Villarruel, A. (2017). Nurses on the front lines: Improving adolescent sexual and reproductive health across health care settings: An evidence-based guide to delivering counseling and services to adolescents and parents. *American Journal of Nursing, 117*(1), 42-51.

Martinez, G., Capen, C. E., & Abma, J. C. (2011). Teenagers in the United States: Sexual activity, contraceptive use and childbearing, 2006. National Survey of Family Growth. National Center for Health Statistics. *Vital Health Statistics, 23*(31), 81-98.

Masoda, M., & Govender, I. (2013). Knowledge and attitudes about and practices of Contraceptives use for reducing HIV infection among Goma University students in the Democratic Republic of Congo. *South* African *Journal of Epidemiology Infections, 28*(1), 61-68.

McLeod, S. A. (2008). *Psychosexual stages.* Retrieved from www.simplypsychology.org/psychosexual.html

McLeod, S. A. (2016). *Bandura - social learning theory.* Retrieved from www.simplypsychology.org/bandura.html

McMillan, J. H., & Schumacher, S. (2001). *Research in Education. A Conceptual Introduction* (5th ed.). New York: Longman.

Mead, M. (1928). *Coming of age in Samoa*. William Morrow Paperbacks.

Meston, C. M., & Buss, D. M. (2007). Why humans have sex. *Archives of sexual behaviour, 36*(4), 477-507.

Miller, B., Benson, B., & Galbraith, K. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Development Rev*ised, *21*(1), 1-38.

Mohammed, S., Abdulai, A. M., & Iddrisu, O. A. (2019). Pre-service knowledge, perception, and use of emergency contraception among future healthcare providers in northern Ghana. *Contraception and Reproductive Medicine, 4*(1), 1.

Mucugu, P., Joash, M., & Mwania, J. (2013). Contraceptives use, awareness and perceptions among secondary school students in Kenya. *International Journal of Asian Social Science*, ***3***(8), 1658-1677.

Mugenda, O. M., & Mugenda, A. G. (2003). *Qualitative and quantitative approaches.* Research Methods Africa Center for Technology Studies (Acts) Press. Nairobi Kenya.

Muuss, R. E. (1975). *Lawrence Kohlberg's cognitive development approach to adolescent morality.* Theories of adolescence (3rd ed) New York: Random House, 210-216.

Myre, S. (1974). *Guide to psychiatry* (3rd ed.). Churchill Livingstone: Edinburgh and London. Stanford: CA.

Nabavi, R.T. (2012). *Bandura's social learning theory & social cognitive learning theory.* Retrieved From https://www.researchgate.net/profile/Razieh_Tadayon_Nabavi/publication/267750204_Bandura's_Social_Learning_Theory_Social_Cognitive_Learning_Theory/links/545914d90cf26d5090ad007b/Banduras-Social-Learning-Theory-Social-Cognitive-Learning-Theory.pdf

Nana, N. A., & Esinam, A. K. (2012). Students' Perceptions of Contraceptives in University of Ghana. *Journal of Family and Reproductive Health*, *7*(1), 3-4.

Newman, B. M., & Newman, P. R. (2007). *Theories of human development.* Lawrence Erlbaum.

Ngome, E., & Odimegwu, C. (2014). The social context of adolescent women's use of modern contraceptives in Zimbabwe: A multilevel analysis. *Reproductive Health*, 11-64.

Nsubuga, H., Sekandi, J. N., Sempeera, H., & Makumbi, F. E. (2015). Contraceptive use, knowledge, attitude, perceptions and sexual behaviour among female University students in Uganda: a crosssectional survey. *BMC women's health, 16*(1), 6.

Ochieng, M. A., Kakai, R., & Abok, K. (2011). Knowledge, Attitude and Practice of Contraceptives use among Secondary School Students in Kisumu District, Nyanza Province. *Asian Journal of Medical Sciences***,** *3***(1),** 32-36.

Okanlawon, K., Reeves, M., & Agbaje, O. F. (2010). Contraceptive use: Knowledge, perceptions and attitudes of refugee youths in Oru Refugee Camp, Nigeria. *African journal of reproductive health, 14*(4).

Okech, T.C., Wawire, N., & Mburu, T. (2011). Contraceptive use among women of reproductive age in Kenya's city slums. *International Journal of Business and Social Science. 2*(1).

Ott, M. A. (2010). Examining the development and sexual behaviour of adolescent males. *Journal of Adolescents Health, 46*(4), 3-11.

Pallant, R. K. (2013). An analysis of friendship networks, social connectedness, homesickness, and satisfaction levels of international students. *International Journal of Intercultural Relations, 35*, 281-295.

Parahoo, K. (1997). *Nursing research: principles, process and issues.* Basingstoke: Macmillan.

Pauline, M., Migosi, J., & Mwania, J. (2013). Condom Use, Awareness and Perceptions among Secondary School Students in Kenya. *International Journal of Asian Social Science, 3*(8), 1658-1677.

Pauline, M., Migosi, J., & Mwania, J. (2013). Contraceptives use, awareness and perceptions among secondary school students in Kenya. *International Journal of Asian Social Science*, *3*(8), 1658-1677.

Polit, D. E. (2001). *Essentials of qualitative research* (3rd ed.). New York. Eippincott, Williams and Wilkins.

Prata, N., et al. (2016). Varying family planning strategies across age categories: differences in factors associated with current modern contraceptive use among youth and adult women in Luanda, Angola. *Open Access Journal of Contraception*, *7*, 1-9.

Prata, N., Vahidnia, F., & Fraser, A. (2005). Gender and Relationship Differences in Contraceptives Use among 15–24-Year-Olds in Angola. *International Family Planning Perspective, 31*(4), 192-199.

Rector, R. E., Pardue, M. G., Martin, S. (2004). *What do parents want taught in sex education programs?* The Heritage Foundation.

Rideout, V. (2003). *Reaching the MTV generation: recent research on the impact of the Kaiser Family Foundation/MTV public education campaign on sexual health*.

Roberts, D. F., & Foehr, U. G. (2004). *Kids and media in America*. Cambridge University Press.

Roker, D., Player, K., & Coleman, J. (1998). Challenging the image: The involvement of young people with disabilities in volunteering and campaigning. *Disability & Society*, *13*(5), 725-741.

Rose, E. et al. (2009). The validity of teens' and young adults' self- reported Contraceptives use. *Archives Pediatric Adolescence Medicine*, *163*(1), 61-64.

Rosenthal, M. (2012). *Human sexuality: From cells to society*. Cengage Learning.

Sanchez, D.A., & Ortega, J.O. (2018). Adolescent contraceptive use and its effects on fertility. *Journal of Population Sciences. 38*(45), 1359–1388.

Schacter, D., Gilbert, D., Wegner, D., & Hood, B. M. (2011). *Psychology: European Edition*. Macmillan International Higher Education.

Schlafly, P. (1994). Leading students into early sex? *The Washington Times.*

Seidu, A. (2006). *Modern approaches to research in educational administration for research students.*

Sellers, D. E., McGrow, S. A., & McKinlay, J. B. (1994). Does the promotion and distribution of Contraceptives increase teen sexual activity? Evidence from an HIV prevention Programme for Latino youth. *American Journal of Public Health, 84*(12), 1-10.

Shoupe, D. (2011). *Contraception*. New York: John Wiley and Sons.

Shrestha, R. M., Otsuka, K., Poudel, K. C., Yasuoka, J., Lamichhane, M., & Jimba, M. (2013). Better learning in schools to improve attitudes toward abstinence and intentions for safer sex among adolescents in urban Nepal. *BMC, Public Health, 13*(244), 1-10.

Silassie, A. G., et al. (2016). Knowledge, attitude and practice of Contraceptives utilization among Axum preparatory school students. *Journal of AIDS and Clinical Research, 7*(4), 1-6.

Sonenstein, F. L. Pleck, J. H., & Ku, L. C. (1989). Sexual activity, Contraceptives use and AIDS awareness among adolescent males. *Family Planning Perspective*, 21, 152-158.

Sonenstein, F. L., Ku, L. C., & Lindberg, L. D., Turner, C. F., & Pleck, J. H. (1998). Changes in sexual behaviour and Contraceptives use among teenage males: 1988 to 1995. *American Journal of Public Health, 88*, 956-959.

Speroff, L., & Darney, P. D. (2011). *A clinical guide for contraception*. Lippincott Williams and Wilkins.

Suar, D., & Gochhayat, J. (2016). Influence of biological sex and gender roles on ethicality. *Journal of Business Ethics, 134*(2), 199-208.

Sutton, M. J., Brown, J. D., Wilson, K. M., & Klein, J. D. (2002). 'Shaking the Tree of Knowledge for Forbidden Fruit. Sexual teens, sexual media: *Investigating media's influence on adolescent sexuality*, 25-55.

Taliaferro, L. A., Sieving, R., Brady, S. S., & Bearinger, L. H. (2011). We have the evidence to enhance adolescent sexual and reproductive health. Do we have the will? *Adolescent medicine: State of the Art Reviews 22*(3), 521-543.

Tarkang, E. E., & Bain, L. E. (2015). Knowledge, attitudes and utilisation of the female Contraceptives among high school female students in Kumba, Cameroon. *British Journal of Education, Society & Behavioural Science 5*(2), 169-180.

Tavrow, P., Withers, M., & McMullen, K. (2012). Age matters: Differential impact of service quality on contraceptive uptake among post-abortion clients in Kenya. *Cult Health Sex. 14*(8), 849–862

Villhauer, T. (2005). *Contraceptives preventing HPV? University of Iowa Students.* Retrieved from https://www.vocabulary.com/dictionary/contraception

Wald, A., et al. (2012). The effectiveness of group-based comprehensive riskreduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections. *American Journal of Preventive Medicine, 42*(3), 272-294.

Weiner, I. B., & Craighead, W. E. (2010). *The Corsini encyclopedia of psychology* (Vol. 4). New York: John Wiley & Sons.

Widman, L., Choukas-Bradley, S. M. A., Noar, S. M., Nesi, J. M. A., & Garrett, K. M. A. (2016). Parent-adolescent sexual communication and adolescent safer sex behaviour: A meta-analysis. *JAMA Pediatrics, 170*(1), 52-61.

Winer, R., et al. (2003). Contraceptives use promotes the regression of cervical intraepithelial neoplasia and clearance of HPV: Randomized clinical trial. *International Journal of Cancer, 107*(5), 811-816.

Yilmaz, H. B., Kavlak, O., & Atan, S. O. (2010). Sexual activity, knowledge and contraceptive usage by gender among university students in Turkey. *The European Journal of Contraception and Reproductive* Health *Care*. Retrieved from https://doi.org/10.3109/13625187.2010.515045

Zimbard, P. G. & Weber, A. L. (1999). *Psychology*. New York, N.Y.: Harper Collins College Publishers.

# APPENDICES

## APPENDIX A

**UNIVERSITY OF CAPE COAST**

**COLLEGE OF EDUCATION STUDIES**

**FACULTY OF EDUCATIONAL FOUNDATIONS**

**DEPARTMENT OF EDUCATION AND PSYCHOLOGY**

**QUESTIONNAIRE**

**Dear Respondent,**

I am embarking on a study that seeks to find out "**Perception of Contraceptives use and its impact on the sexual behaviours of adolescents in senior high school in the Krachi – East District.** I would be grateful if you could answer the questions below. There is no right or wrong answer. I am interested in your personal experience and opinion. The confidentiality of your information is guaranteed.

**Instruction:** For each item, please choose the answer which best describes your experiences by ticking [√]

**SECTION A**

**Demographic Data**

1. **Gender/Sex:** Male **[ ]** Female **[ ]**

2. **Age Range:** 12-15 [ ], 16-19 [ ], 20-23 [ ]

3. **Type of School:** Public [ ] Private [ ]

**Instruction:** In the tables below for each statement mark how much you agree with a tick **[√]** in the box to the right of each statement. The responses are on the scale **1-4**, where **1 =** Strongly Disagree **[SD], 2 =** Disagree **[D], 3 =** Agree **[A]** and **4 =** Strongly Agree **[SA].** You are kindly required to tick only one response in each case.

SECTION B

**Perceptions of adolescents about Contraceptives use**

| SN | Statements | SD | D | A | SA |
|---|---|---|---|---|---|
| 1 | Condom is a form of contraceptive that is available for both males and females | | | | |
| 2 | Contraceptives use prevents the contraction of sexually transmitted diseases | | | | |
| 3 | Contraceptives use prevents any unplanned pregnancy related issue in relationships | | | | |
| 4 | Contraceptives use reduces the sexual pleasures that one is supposed to have during sexual intercourse. | | | | |
| 5 | Contraceptives can disappear inside a female's vagina when it strips from the male's penis | | | | |
| 6 | One Contraceptives can be used more than once | | | | |
| 7 | Contraceptives use means that one does not trust the partner | | | | |
| 8 | Contraceptives use indicates that one is spoilt or leads an immoral life | | | | |
| 9 | Contraceptives are very painful when used | | | | |
| 10 | Contraceptives are same in structure and size for male and females | | | | |

**SECTION C**

**Sources of information on Contraceptives and other contraceptives**

| SN | Statements | SD | D | A | SA |
|---|---|---|---|---|---|
| 1 | I got to know the use of Contraceptives through my friends | | | | |
| 2 | I got to know the use of Contraceptives through watching television and other social media platforms | | | | |
| 3 | I got to know the use of Contraceptives at the hospital, clinic, health centers etc. from the doctors and the nurses | | | | |
| 4 | I got to know about the use of Contraceptives at the chemical shop | | | | |
| 4 | I got to know the use of Contraceptives through my sexual partner | | | | |
| 5 | I got to know the use of Contraceptives through my parents (mother and father) | | | | |
| 6 | I got to know the use of Contraceptives through my siblings | | | | |
| 7 | I got to know the use of Contraceptives through my teachers in school | | | | |
| 8 | I got to know about Contraceptives usage in my church/mosque (pastors, imams etc.) | | | | |
| 9 | I got to know the use of Contraceptives through the association I joined (Clubs) | | | | |
| 10 | I got to know about Contraceptives use through the internet by browsing with my phone | | | | |

**SECTION D**

**Perceived effects of Contraceptives use on sexual behaviour of adolescent students**

| SN | Statements | SD | D | A | SA |
|---|---|---|---|---|---|
| 1 | Contraceptives use increases the rate at which people engage in sexual intercourse | | | | |
| 2 | Contraceptives use decreases the contraction of sexually transmitted infections | | | | |
| 3 | Contraceptives use allows for multiple sexual partners among adolescents | | | | |
| 4 | Contraceptives use helps minimize issues about unintended pregnancies among adolescents | | | | |
| 5 | Contraceptives use makes one unreligious among adolescents | | | | |
| 6 | Contraceptives use brings about early initiation of sexual intercourse among adolescents | | | | |
| 7 | Contraceptives use pressures intercourse among adolescents | | | | |
| 8 | Contraceptives use leads adolescents to act in similar ways sexually like adults and this would not be good | | | | |
| 9 | Contraceptives use is panacea to less sexual gratification or unsatisfied sexual-intercourse | | | | |
| 10 | Contraceptives use exposes adolescents more than necessary to infidelity even after maturity | | | | |

**SECTION E**

**Perceived ways in which contraceptives use education can enhance sexual behaviours of adolescent students**

| SN | Statements | SD | D | A | SA |
|---|---|---|---|---|---|
| 1 | Adolescents' sexual behaviours can be improved by taking them through sex education | | | | |
| 2 | Adolescents' sexual behaviours can be improved by encouraging and motivating them to avoid amoral sexual activities and think of school and academics | | | | |
| 3 | Adolescents' sexual behaviours can be improved through programmes that are parent-oriented where parents can engage their adolescents on the consequences of teenage amoral sexual relationships | | | | |
| 4 | Adolescents' sexual behaviours can be improved by counselling them on the values of remaining pious and sexual intercourse free at their age | | | | |
| 5 | Adolescents' sexual behaviours can be improved by adopting health-based programmes to educate them on the best practices | | | | |
| 6 | Adolescents' sexual behaviours can be improved by using adolescent role models in championi ng their course so that they can learn from such role models | | | | |
| 7 | Adolescents' sexual behaviours can be improved through the use of clinical-based programs that are championed by nurses and other health professionals | | | | |

**SECTION F**

**Types of Contraceptives known by adolescent students**

| Types of Contraceptives | YES | NO |
|---|---|---|
| Male Condoms | | |
| Female Condoms | | |
| Diaphragm | | |
| Cervical cap-fem cap | | |
| Contraceptive coil | | |
| Contraceptive patch | | |
| Contraceptive implant | | |
| Vaginal Ring | | |
| Contraceptive injection | | |
| Emergency Contraceptive | | |
| Sterilizer | | |

## APPENDIX B

## RELIABILITY TEST RESULTS OF THE INSTRUMENT

## PERCEPTIONS

**Case Processing Summary**

| | | N | % |
|---|---|---|---|
| Cases | Valid | 30 | 100.0 |
| | Excluded[a] | 0 | .0 |
| | Total | 30 | 100.0 |

a. Listwise deletion based on all variables in the procedure.

| Reliability Statistics | | |
|---|---|---|
| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
| .728 | .408 | 10 |

## APPENDIX C

## SOURCES OF INFORMATION

### Case Processing Summary

| | | N | % |
|---|---|---|---|
| Cases | Valid | 30 | 100.0 |
| | Excluded[a] | 0 | .0 |
| | Total | 30 | 100.0 |

a. Listwise deletion based on all variables in the procedure.

| Reliability Statistics | | |
|---|---|---|
| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
| .824 | .778 | 10 |

## APPENDIX D

## PERCEIVED EFFECTS

### Case Processing Summary

| | | N | % |
|---|---|---|---|
| Cases | Valid | 30 | 100.0 |
| | Excluded[a] | 0 | .0 |
| | Total | 30 | 100.0 |

a. List wise deletion based on all variables in the procedure.

| Reliability Statistics | | |
|---|---|---|
| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
| .791 | .793 | 10 |

## APPENDIX E

## PERCEIVED WAYS

### Case Processing Summary

| | | N | % |
|---|---|---|---|
| Cases | Valid | 30 | 100.0 |
| | Excluded[a] | 0 | .0 |
| | Total | 30 | 100.0 |

a. List wise deletion based on all variables in the procedure.

**Reliability Statistics**

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|
| .672 | .672 | 7 |

## APPENDIX F

## INTRODUCTORY LETTER


**UNIVERSITY OF CAPE COAST**
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
***DEPARTMENT OF EDUCATION AND PSYCHOLOGY***

Telephone: 233-3321-32440/4 & 32480/3
Direct: 033 20 91697
Fax: 03321-30184
Telex: 2552, UCC, GH.
Telegram & Cables: University, Cape Coast
Email: edufound@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA


Our Ref:

Your Ref: **TO WHOM IT MAY CONCERN**

Dear Sir/Madam,

**THESIS WORK**
**LETTER OF INTRODUCTION**
**MR. ROWLAND DEY KWAMI**

We introduce to you Mr. Dey, a Master's student from the University of Cape Coast. Department of Education and Psychology. He is pursuing Master of Philosophy degree in Educational Psychology and is currently at the thesis stage.

Mr. Dey is researching on the topic:

> ***"Perception of Contraceptive use and its Impact on the Sexual Behaviours of Adolescents Students in Senior High Schools in the Krachi-East District".***

He has opted to collect/gather data at your institution/establishment for the Thesis work. We would be most grateful if you could provide him the opportunity for the study. Any information provided would be treated as strictly confidential.

Thank you.

Yours faithfully,

Theophilus Amuzu Fiadzomor

*Principal Administrative Assistant*

For:

(Dr. Irene Vanderpuye)

**Head**

# APPENDIX G

# ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
*ETHICAL REVIEW BOARD*

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-ERB/ucc.edu/43/19-43 Date: August 22, 2019

Your Ref: .....

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

The bearer, Rowland Dey Kwami Reg. No. ED/APE/16/0092 is an M.Phil. / ~~Ph.D~~ student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Perceptions of contraceptive use and its impact on the sexual behaviours of adolescents in Senior High Schools in the Krachi-East District

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed his/~~her~~ proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

In view of the above, the researcher has been cleared and given approval to commence his/~~her~~ study. The ERB would be grateful if you would give him/~~her~~ the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

*Chairman, CES-ERB*
Prof. J. A. Omotosho
jomotosho@ucc.edu.gh
0243784739

*Vice-Chairman, CES-ERB*
Prof. K. Edjah
kedjah@ucc.edu.gh
0244742357

*Secretary, CES-ERB*
Prof. Linda Dzama Forde
lforde@ucc.edu.gh
0244786080