

**SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA**

**ATTITUDE OF PARENTS AND ADOLESCENTS TOWARDS  
CONTRACEPTIVE USE BY ADOLESCENTS IN ALAJO,  
AYAWASO CENTRAL SUBMETRO OF ACCRA**

BY  
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# DECLARATION

I hereby declare that with the exception of references cited to other people's work which has been duly acknowledged, this work is the result of my own original research work done under supervision. It has neither in part nor in whole been presented elsewhere for another degree.

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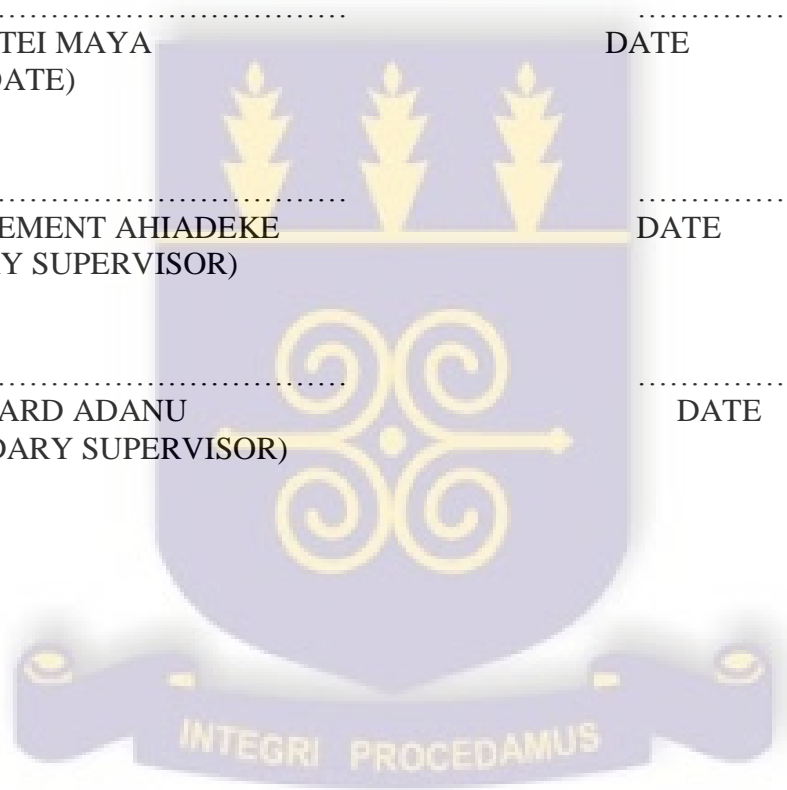
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## DEDICATION

I dedicate this work to my wife Theresa and our children Frederick and Salome for their support and understanding during this course.



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## **ABSTRACT**

### **Introduction**

Despite high knowledge about contraceptives among adolescents its use is low. Parental attitude towards adolescent contraceptive can adversely affect contraceptive use by adolescents.

### **Objectives:**

1. To describe the general knowledge of parents and adolescents on contraceptives
2. To determine the proportion of parents and adolescents who are in favour of contraceptive use among adolescents
3. To determine the proportion of parents and adolescents who discuss contraception
4. To describe how selected sociodemographic factors affect the attitude of parents and adolescents towards contraceptive use among adolescents.

### **Methods**

A cross-sectional survey was done employing both quantitative and qualitative methods. A face-to-face interview using a structured questionnaire was conducted with a simple randomly selected sample of adolescents and parents. Focus group discussions were held with some parents. The quantitative data was analysed using SPSS 16.0. The qualitative data was analysed in themes according to study objectives.

## **Results**

Two hundred and seventy seven adolescents and 264 parents were interviewed. More than 99% knew about modern contraceptives. Over 95% of them knew sexually transmitted infections can be prevented by using condoms. About 60% approve of contraceptive use by adolescents. However, only about 12 - 18% of parents who agreed to adolescent contraceptive use will encourage this when faced with the reality. Less than 10% of the adolescents had on their own initiated a discussion that involved contraception with their parents. About 30 – 40% of parents indicated that they have on their own discussed contraception with adolescents but the qualitative study indicated that such discussions were rare. Both parents and adolescents had misconceptions about contraceptive use among adolescents. For the adolescents, being sexually active, and for the parents, belief that contraceptive use has advantages for adolescent users and their own prior contraceptive use were significantly associated with agreeing that sexually active adolescents should use contraceptives.

## **Conclusion and recommendations**

Both parents and adolescents have high knowledge about modern contraceptive use in preventing both sexually transmitted infections and pregnancy. However, misconceptions and fear of side effects is preventing parents from discussing contraception with adolescents. Parents do not have the will to also encourage adolescents to use contraceptives. There is the need to educate both parents and adolescents to dispel the misconceptions about contraceptives. Contraceptive use among adults should be encouraged as adults on contraceptives are more likely to encourage adolescent contraceptive use.

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## **LIST OF BBREVIATIONS**

AMA	Accra Metropolitan Authority
Fig	Figure
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
IUCD	Intra uterine contraceptive device
MOH	Ministry of Health
NPC	National Population Council
SD	Standard deviation
SPSS 16	Statistical Package for the Social Sciences Version 16
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UG	University of Ghana
vs	Versus
WHO	World Health Organization

## DEFINITION OF TERMS

**Contraception:** the use of medication, device, or other methods to prevent pregnancy from occurring.

**Contraceptive:** Devices/agents or techniques that are used to prevent conception/ pregnancy from occurring

**Injectables:** These are injections containing either progestin only such as Depo-Provera or contains both progestin and oestrogen

**Implant:** These are small rods containing progestins which are inserted under the skin into the upper inner arm e.g. Norplant and Jadelle

**Intrauterine contraceptive Devices (IUCD):** Most are made of molded plastic that are inserted by a healthcare provider through the vagina and into the uterus

**Natural family planning/ fertility awareness-based methods:** These methods involves identifying the fertile days of the menstrual cycle by assessing cycle length or observable signs and avoiding intercourse or using barrier methods on those days

**Oral Contraceptive pills** May contain either oestrogen and progestin or only progestin; the combined pill contains both oestrogen and progestin the Minipill has only progestin only

**Parent** As used in this study refers to both biological parents and guardians

**Withdrawal:** requires the man to withdraw his penis from the vagina before ejaculation

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 Background

The reproductive health needs of adolescents are now attracting special attention because of the peculiar situation in which they find themselves. Adolescence is defined as the age group between 10 – 19 years (WHO, 1986). They are neither children nor adults. They experience new and exciting things and whatever happens during this period whether good or bad shapes how they live their lives as adults (Mensch et al., 1998). This period of transition between childhood and adulthood presents adolescents with the task of bringing together familial and culturally acceptable behaviour and emerging feeling for the opposite sex (Weiss et al., 2000).

A number of normal physiological and psychological changes take place in adolescents that make them wish for sexual intercourse (Mulugeta, 2003) albeit lack of knowledge on secondary sexual characteristics, contraception and sexually transmitted infections (STIs) (Rob et al., 2002).

Adolescents constitute 20% of the world's population with over 80% living in developing countries (Weiss et al., 2000). In Ghana they constitute 21.7% of the total population (GSS, 2005). A study done at Dodowa, in the Greater-Accra region of Ghana revealed that 54% of the never married adolescent male students and 32% of their female counterparts reported having had sexual intercourse before (Afenyadu et al., 2003).

Adolescent premarital sexual encounters are generally unplanned, infrequent, and sporadic and these predispose them to unintended pregnancies (Oindo, 2002) which often end up as illegal unsafe abortions (Mulugeta, 2003). Glover et al. (2003) reported that about a third of the sexually active females they surveyed in some Ghanaian towns reported having ever been pregnant with 70% of them attempting or having an abortion.

Adolescents generally look for contraception counselling about a year after initiating sexual intercourse by which time many would have become pregnant or have contracted sexually transmitted infections. Up to 61% of unintended pregnancies will occur prior to receiving counselling (Strickland et al., 2005). About 2.5 million (14%) of all unsafe abortions in developing countries are in adolescents and in Africa 15 – 19 year olds account for 25% of all unsafe abortions on the continent (Sedgh et al., 2007).

Much as pregnancy can result from contraceptive failure, the problem of adolescent pregnancy is due to the fact that most of the sexually active ones are not on contraception. Even those who are on contraception are not using it consistently (Afenyadu et al., 2003; GDHS, 2003).

Abstinence is the most effective way of preventing pregnancy. But for a sexually active fecund adolescent, it is effective contraception that is needed to prevent an unwanted pregnancy. Adolescent abstinence education usually concentrates only on waiting until marriage or adulthood before starting sexual intercourse. Many however are not able to observe the abstinence and have sex (Klein et al., 2007).

Contraception is a far cheaper way of preventing unintended births and this holds even for countries where abortion can be secured just on demand (Sedgh, Henshaw et al., 2007). Contraceptive use however does not depend solely on knowledge about contraceptives. Other factors that can affect contraceptive use are significant attitudinal barriers such as shyness about purchasing contraceptives, lack of communication between adolescents and their parents, fear of parental reactions, the feeling that using contraceptives will be equated to promiscuity and fears of side effects most of which are based on misconceptions (Hamani et al., 2007, Glover et al., 2003, Briggs 1998).

It is expected that adolescents will be sexually experienced with the necessary skills and confidence to make the appropriate decisions about their reproductive lives as adults. Such skills and knowledge however are not attained naturally and must be learned. The support of their parents among others is needed during this period (Senanayake et al., 2003).

The fast rate of urbanization and its associated high growth of poor city residents pose new challenges for health care in Ghana. Alajo can be described as one of the deprived communities within the Accra metropolis.

The reproductive health needs of residents in deprived urban communities have been neglected. This unfortunate scenario has come about because of the assumption that educational and health facilities and other social amenities are available in the urban areas. As such attention has been turned unto the rural communities to the disadvantage

of those in deprived urban communities. Residents in deprived urban communities however are a vulnerable group due to poverty and poor infrastructure. Adolescents in these areas are known to start sexual intercourse early, have multiple sexual partners and are less likely to protect themselves as compared to their counterparts in non deprived areas (Zulu et al., 2002).

Even though traditional values are being relegated to the back in most modern communities, parents still have a lot of influence on their children (Briggs, 1998). They play pivotal roles in the upbringing of their children. If they are able to do that effectively with regards to contraceptive use, it will go a long way to encourage their sexually active children to protect themselves (Odimegwu et al., 2002).

Taking cognisance of the problems associated with adolescent sexuality and pregnancies in Ghana, provision has been made to provide information and counselling on family planning to adolescents. It is also considered that provision of contraceptives to sexually active adolescents is in the right direction (GHS, 2003).

## **1.2 Statement of the Problem**

Adolescent premarital sex and pregnancy, abortion and lack of parental care are among the major public problems facing adolescents in Ghana (Awusabo-Asare et al., 2008; UG/GHS 2000). Adolescents aged 15 – 19 years have consistently contributed 10% of the over all fertility in Ghana, but unlike the time past, most of the deliveries nowadays are outside marriage (NPC, 2000). Thirteen percent of pregnancies registered in 2006

were for adolescents aged 15 – 19 (GHS, 2006). This is high compared to the worldwide average delivery rate of 6.5% (Bearinger et al., 2007).

Adolescent pregnancy is due to the non use or inconsistent use of contraceptives. Worldwide 29 million adolescents aged 15 -19 years lack the contraceptive protection they need to prevent unwanted pregnancy (Guttmacher Institute, 1998). Lassey (1995) observed that out of 212 cases with complications of induced abortion over a 12 month period at the Korle-Bu Teaching Hospital, 85 (40.5%) were 15 - 20 years old and none of them had used a modern contraceptive in the preceding 3 months to the pregnancy. From the Ghana Demographic and Health survey (GDHS) (2003), only 6.9% of adolescents between 15 – 19 years were on contraception and the unmet need for contraception for the same age group was approximately 57%.

The non use of contraceptives by adolescents is however, against the background of high contraceptive knowledge, 85% - 98% (Bankole et al., 2007; Agyei et al., 2000) and the fact that the Ghana Health Service (GHS) endorses the counselling and provision of contraceptives to sexually active adolescents (GHS, 2003). Contraceptives are also available at highly subsidized and relatively cheaper prices.

Religious and traditional cultural beliefs and codes favour the idea that adolescent girls should remain virgins until they are married. This ideal however is in conflict with the natural biological and emotional impulses for these young people. They want to find love and sexual intimacy which in most cases occur before marriage (Singh et al., 2009). The

early age at menarche and increased median age at first marriage has also created an enabling environment for a long period of premarital sex (NPC, 2000).

Because majority of these adolescents pregnancies are unwanted, they end up as induced abortions, most of which are unsafe. Unsafe abortion is a major cause of maternal morbidity and mortality in Ghana (GHS, 2006). Autopsy reports from the Korle-Bu Teaching Hospital revealed that abortion and its complications were the leading cause of maternal mortality constituting 30% of the maternal deaths. Adolescents constituted 10.4% of all the maternal deaths. Out of the 25 adolescent maternal deaths, 16 (64%) were as a result of complications of abortion (Aboagye et al., 2000). For each death, many others are left with complications such as infertility, chronic pelvic pain and genital trauma (Grimes, 2003).

Majority of adolescent girls are poor or do not have monetary resources of their own either because they schooling, unemployed or can only be engaged in very low wage jobs (Ganatra et al., 2002). As a result an unintended pregnancy presents severe economic hardships to these adolescents and also their children in case they deliver. For those in school the pregnancy may bring their education to an abrupt end.

Although parents are responsible for the welfare of their adolescents, their opinions are usually not taken into consideration when tackling adolescent reproductive health issues both at national and even international forums (Mturi, 2001).

Much as there is no official information on adolescent reproductive health in Alajo, anecdotal information indicates that adolescent pregnancy, induced abortions and teenage childbirth are common. In Ghana not much work has been done to look at the opinion of both parents and adolescents on contraceptive use among adolescents.

### **1.3 Conceptual framework**

#### **Fig 1 Conceptual framework**

#### **1.4 Justification for the Study**

There is paucity of research data on parental attitude towards adolescent contraceptive use (Mturi, 2003). This study will add to the little knowledge that exist on the attitude of

parents towards contraceptive use by adolescents in the sub region and also provide information on some adolescent reproductive health needs in urban deprived communities.

Again, concentrating on the needs of adolescents is crucial. They do not have the knowledge and skills to avoid pregnancy and STIs; they constitute the majority of the population and hold the key to reducing future fertility (Mulugeta, 2003).

The findings can be used to design appropriate reproductive health programmes not only for adolescents but also for adult family members whose attitudes may enhance or prevent adolescents from using contraceptives. Improving contraceptive use among adolescents will prevent the unwanted pregnancies and hence the problems associated with it.

## **1.5 Research Questions**

In order to know the attitudes of parents and adolescents towards contraceptive use by adolescents and thus help to improve the use of contraceptive by adolescents, the following questions must be answered.

- What knowledge do parents and adolescents have about contraceptives in general?
- Is it acceptable for unmarried adolescents to use contraceptives?
- Do parents and adolescents discuss contraception at all? And if so do they encourage the sexually active ones to use them?
- What are the reasons for and against the use of contraceptives by adolescents?

## **1.6 Objectives**

### **1.6.1 General objective**

The general objective of the study is to describe the knowledge and attitude of parents and adolescent towards contraceptive use by adolescents

### **1.6.2 Specific objectives**

1. To describe the general knowledge of parents and adolescents on contraceptives
2. To determine the proportion of parents and adolescents who are in favour of contraceptive use among adolescents
3. To determine the proportion of parents and adolescents who discuss contraception
4. To describe how selected sociodemographic factors affect the attitude of parents and adolescents towards contraceptive use among adolescents.

## **CHAPTER TWO**

## **2.0 Literature Review**

### **2.1 Introduction**

Contraceptive use among adolescents is a contentious issue in our society. Abstinence is the best method for preventing pregnancy, but for a sexually active fecund adolescent it is effective contraception that will prevent pregnancy.

Adolescents are not a homogenous group. They differ in age, religion, family circumstances, socioeconomic status and sociocultural practices (GHS et al., 2005). Parents as gatekeepers for adolescents with whom they are in regular contact are important when it comes to issues involving adolescents (Mturi, 2003). Parents should therefore be better placed to know the circumstances of their adolescents and therefore discuss contraception with them.

In a survey of some secondary school teachers in Nigeria (Briggs, 1994) almost 34% were of the opinion that adolescents should abstain from sex until they are married and 20.8% of respondents indicated they will advise the use of contraception by sexually active adolescents to prevent pregnancy. Briggs (1998) observed that 79.1% of parents of pregnant adolescents did not favour the use of contraceptives by sexually active adolescents.

In a community survey conducted at Dodowa, Ghana, majority of opinion leaders and parents approved condom use by sexually active adolescents despite their opinion that abstinence should be the main form of family planning for adolescents. On the contrary the use of other contraceptives was less acceptable to them. This same study revealed that

while about 60% of adolescents use condoms they are not used consistently. The males refuse to use condoms with their regular partners while the females could not insist on condom use for fear of losing their boy lovers or loss of monetary support from older partners (Afenyadu et al., 2003). The demand for condom use may be equated to mistrust and infidelity (Smith, 2007, Glover et al., 2003).

As shown in the Conceptual framework (Fig 1) the attitude of both parents and adolescents towards adolescent contraceptive use may depend on several factors. These include personal characteristics such as age, sex, level of education, occupation, and hence earnings and ones own experience with contraceptives. Sociocultural factors such as gender issues, socioeconomic status which to a large extent depends on occupation, fear (of side effects and reprisals from significant others) and social networks (friends, family). Health service factors such as the attitude of providers, availability of contraceptives and affordability may also affect the attitude individuals towards adolescent contraceptive use

### ***Factors that influence contraceptive use***

#### **2.2.1 Age and sex**

Glover et al., (2003) demonstrated that contraceptive use among the youth increases with age even though there was no significant difference with respect to sex. The younger adolescents are when they begin sexual activity, the less likely they are to practice contraception, thus increasing their risk of pregnancy (Oindo, 2002).

With regards to adults, gender may play a role in their attitude towards contraceptive use by adolescents. In a study conducted in Lome, Togo; while 48% of adult women disapproved of adolescents using contraceptives only 31% of men did so. It was also observed that younger adults approve of contraceptive use by adolescents as compared to their older counterparts (Speizer et al., 2001).

### **2.2.2 Sociocultural Factors**

In many cultures, family and societal norms demands that female adolescents remain virgins and innocent before marriage while the same is not expected of their male counterparts. As a result sexually experienced female adolescents are reluctant to seek contraceptives lest they will be suspected of being sexually active contrary to the norm. For these adolescents this negative social consequence appears to override the health consequences of an unwanted pregnancy (Weiss et al., 2000).

Another cultural factor that significantly affects contraceptive use is religion. Religion has influence on the morals and values of the society. It promotes chastity and moulds attitudes towards contraception for the youth and society (Oindo, 2002). Adolescents in religions that are against modern contraception are less likely to use modern contraceptives (Kramer et al., 2007).

### **2.2.3 Level of education**

Adults with higher education are more likely to approve of adolescent contraceptive use (Speizer et al., 2001). Not surprisingly, adolescents whose parents have low educational background are less likely to use contraceptives ((Lynch, 2001) probably because of

parental disapproval. Condom use among the youth for instance has been associated with higher level of education (Glover et al., 2003). Education generally exposes one to more interactions and other sources of information thus enhancing one's ability to take good decisions such as using a contraceptive when sexually active (Oindo, 2002).

#### **2.2.4 Communication between parents and adolescent**

A non randomized study among Hispanic American adolescents showed that good communication with the mother about sex could prevent adolescent pregnancy (Adolph et al., 1995). In a Tanzanian study, while majority of adults strongly supported the idea that they should talk with their adolescents about sexuality and reproductive health they contended that their culture prohibits them from doing so (Mbonile et al., 2008). Briggs (1998) observed that just about 12% of parents discussed sexual matters with their adolescent girls.

Parents themselves are not comfortable discussing sexual matters with their adolescents. Some have the notion that such issues should be discussed in a reactive manner, for example when a sex-related problem such as adolescent pregnancy has occurred to someone in the neighbourhood rather than in a proactive manner (Oindo, 2002). Such reactive approach may defeat the purpose of helping the adolescents to protect themselves against these problems.

Other reasons why parents do not discuss issues related to sex with their adolescents may be shyness, inadequate knowledge on contraceptives themselves while others think doing

so will encourage the adolescents to have sexual intercourse or worse of all become promiscuous (Mturi, 2003, Briggs, 2002, Smith, 2000).

Similarly, adolescents also do not know how to approach the topic. In their opinion initiating such a discussion may alert the adults to their sexual activities (Oindo, 2002).

Adolescents are often afraid to obtain contraception because they fear parental reaction. They therefore turn to their friends and peers for information which is often inaccurate (Zieman et al., 2007). Only about one in five adolescent females discuss sex-related matters with their parents (Babalola et al., 2005; Mturi 2000).

Informing adolescents about contraception however does not result in increased rates of sexual activity, earlier age at first intercourse or a greater number of sexual partners (Kirby et al., 2007).

### **Social Networks**

Adolescents show high levels of connectedness to family, adults, friends, school and religious groups (Kumi-Kyereme et al., 2007). The fears and misconceptions expressed about contraceptives by these people may hinder their uptake of contraceptives. Studies in southern Ghana have shown that the use of modern contraceptives is strongly influenced by the attitudes and behaviours of social network partners such that the motivating factor for someone to use contraception may just be to the fact that a friend is using one (Montgomery et al., 2001).

Studies into condom use in Uganda revealed that adolescents who reported not having parental supervision were 45% less likely to have used a condom at their last sexual

intercourse as compared to their counterparts who had parental supervision (Twa-Twa et al., 2008). Thus parental attitude towards contraceptive use by adolescents can influence adolescent contraceptive use.

### **2.2.5 Fear of side effects and misconceptions**

Briggs (1998, 1994) observed that parents of pregnant adolescents and teachers who did not favour the use of contraceptives by sexually active adolescents stated among other things that contraception kills and will destroy their reproductive organs. Similarly the fear of future infertility and promotion of sexual promiscuity were mentioned as some of the reasons why adolescents should not use contraception.

Misconceptions and incorrect beliefs may prevent the wide use of contraceptives by adolescents and lead to discontinuation in those who are using it. This increases their risk of undesirable pregnancies (Hamani et al., 2007).

In a qualitative study done in Mali, young girls did not like the pill or injectable contraceptives because the amenorrhoea or menstrual irregularities that are associated with them could lead to serious social consequences such as being accused of witchcraft and immoral behaviour (Castle, 2004).

In Nigeria, adolescents relied on induced abortion (many of which were unsafe) to control their fertility rather than use modern contraception. They contended that the effect of modern contraception on fertility is continuous, prolonged and may cause future

infertility whereas abortion was seen as a one stop solution to an unplanned pregnancy (Otoide et al., 2001).

Despite these misconceptions, modern contraceptives have a lot of advantages which go beyond their contraceptive benefits. The earlier these misconceptions are corrected and the advantages of modern contraceptives highlighted the better it will be for the use of contraceptives by adolescents. Experts of reproductive health are of the opinion that sexually active adolescents should be encouraged to use contraceptives to prevent unwanted and mistimed pregnancies (Briggs 1998).

### **2.2.6 Health service factors**

Health service factors which include the attitude of the providers, availability and affordability of contraceptives can affect the attitude of individuals' towards adolescent contraceptive use. Attitude of providers may be classified as sympathetic and supportive, less sympathetic and judgmental. While sympathetic providers create youth friendly images for their centres and thus promote patronage from adolescents, the less sympathetic and judgmental ones serve as barrier to the utilization of their services. (Awusabo-Asare et al., 2008).

Some providers stigmatize adolescent sexuality and are unwilling to acknowledge adolescents' experiences as contraceptive users. Others may even scold or treat adolescents who seek treatment from them harshly. Such attitudes undermine adolescents' utilization of contraceptives (Wood et al., 2006). Other factors such as lack

of privacy and confidentiality at the health facilities deters adolescents from patronizing their services (Katz et al., 2002).

## **CHAPTER THREE**

### ***3.0 Methods***

#### **3.1 Type of study**

The study was a cross-sectional descriptive survey which employed both qualitative and quantitative methods. There was simultaneous data collection. In a survey, investigations

are carried out by systematically collecting information without any experiment being carried out. For a descriptive study, the researcher only describes things as they exist (Abramson, 1990).

In cross-sectional studies, the variables are measured at a particular point in time and the measurements take place only once. Since both dependent and independent variables are measured at the same time the sequence of events cannot be established. Another disadvantage is that a large sample size is required for the study and a true incidence rate cannot be calculated. It is however a good study for describing the variables and how they are distributed, it can be carried out over a relatively short time at a relatively lower cost. In addition, the researcher has control over the selection of the subjects and measurement of the variables (Hulley et al., 1988).

Due to the limited time and resources available for the researcher, the cross-sectional descriptive study was an ideal study design. Employing both quantitative and qualitative methods enabled a lot of information to be gathered within a short time. It also enriched the study results.

### **3.2 Study area**

The study area was Alajo in the Ayawaso Central Submetro of the Accra Metropolitan Authority (A.M.A). The population of Alajo from the 2000 population census was 23,439. The estimated population of adolescents (10 – 19 years) which constitute about 22.7% of the total population was 5321.

Alajo has a variety of ethnic groups namely Gas, Akans, Ewes, various tribes from the Northern part of Ghana and other nationals from the neighbouring countries; Burkina Faso, Niger, Mali, Togo and Nigeria. The languages spoken include Ga, Akan, Hausa, Ewe, Kotokoli, and Dagbani.

The occupations here vary. Most of the women are petty traders. A variety of artisans (masons, carpenters, auto mechanics, hairdressers, seamstresses tailors, bakers) are also found. Civil Servants of low income group are also found likewise small scale farmers. The religious groups found in the community include Christians of all denominations, Moslems, and people who practice traditional African religion.

There are a variety of private clinics, maternity homes, pharmacies and chemical shops in the community. The major hospital serving the people is the Maamobi Polyclinic which is in the Ayawaso East Submetro. There is no adolescent friendly reproductive health centre in the community. Traditional medical practitioners and Spiritual churches performing psychic healing can also be found. Both private and public educational institutions which include nurseries, primary, junior and senior high schools and vocational institutions can be located in the community.

Alajo is densely populated. The houses are poorly demarcated and infrastructure is poor. The area is supplied by pipe-borne water. Sanitation is a serious problem for the A.M.A in this area. Both drains and the Odaw River which flows through the place are silted with solid waste. Refuse is not disposed of properly and this leads to unhealthy surroundings.

### **3.3 List of variables**

A **variable** is the characteristic of the study unit that is measured and it can be measured numerically e.g. weight; or categorically e.g. sex; or agreement with a statement (Abramson, 1990).

The dependent variable of interest is:

- the acceptability of modern contraceptive use among adolescents by
  - (i) adolescents themselves and
  - (ii) (ii) parents

As shown in the conceptual framework (Fig 1), several factors can affect the attitude (in this study acceptability of adolescent contraceptive use) of people towards adolescent contraceptive use, the independent variables that were examined in this work were:

Age

Sex

Marital status (for parents only)

Religion

Educational level

Occupation (employment) for parents only

Personal experience with contraceptives

### **3.4 Study population**

Population is a complete set of people with specified characteristics and a sample is a subset of the population (Hulley et al., 1988). The study population for the survey comprised two groups. The first group were all parents from 35 years and above who had taken care of an adolescent before (either previous or current experience). The second

group were adolescents aged 12 -19 years. All the participants were residents at Alajo in the Ayawaso Central Submetro of the Accra Metropolitan Authority at the time of the survey.

The adult population was deliberately selected because adults who are caring for adolescents or had cared for an adolescent before are likely to have been confronted with the problem of sexually active adolescents and contraceptive use. The lower limit of adolescents was set at 12 years because during the pretesting of the questionnaires, it was realised a greater proportion of those below 12 years did not know about contraception.

### **3.5 Sampling**

The ideal way to be able to describe what exists in a population will be to study all individuals in the population. But due to restriction of resources (both human and material) it is practically impossible to study the whole population.

However, if a sample of the population is selected such that it represents the parent population, is sufficiently large and adequately covered, the findings from the sample can be extrapolated to cover the whole population. A probability sample can achieve this requirement in which case each individual unit in the study population is given an equal chance of being selected (Abramson, 1990). A representative sample of the study population was selected. This was done by simple randomly selecting the study participants for the interview (as shown in the sampling procedure below **3.7**) and thus giving each individual in the parent population an equal chance of selection. In addition

the sample was large enough (as indicated by the sample size calculated below **3.6**) and adequately covered as shown by the high response rate. The results thus can be generalised to the parent population.

### **3.6 Sample size:**

The sample size calculation helps to determine the minimum number of study units that can be studied. For a population survey, the greater the suspected frequency of an outcome variable in the population, the fewer the number of study units required for the study and vice versa. Thus for a study with more than one outcome variable, the outcome variable with the least suspected frequency in the population which will give the highest sample size is used to calculate the sample size.

The proportion of parents who discuss sex-related matters with their adolescents was estimated at 12% (Briggs, 1998). [Not much work has been done in Ghana]. The population of Alajo from the 2000 census (GSS, 2005) was 23 439. The estimated population of adolescents (10 – 19 years) which constituted about 22.7% of the total population was 5321. Adults who were 35 years and above constituted 26.8% of the population (GSS, 2005). The population from which the adult sample was taken was 6283 and that of the adolescents was 5321.

Worst acceptable results 8%, Confidence level 95%

Using Epi Info Software Version 3.4.1 Statcalc the minimum sample size calculated was 245. A mark up of 15% was applied to make the sample size 285. This was done to make room for non response and also ensure that more people from different houses were

interviewed. Thus 285 parents and 285 adolescents were supposed to have been selected for interview.

For the qualitative study two focus group discussions were carried out. There was one each for adult males and females respectively. The number of participants was 6 in each group and they were selected purposefully.

### **3.7 Sampling procedure**

Participants for the study were selected from houses in the community. With the aid of enumeration area maps obtained from the Ghana Statistical Service, all the houses in the community which were occupied were first enumerated. There were 715 houses. The house numbers were written on pieces of paper and put in a box. The box was shaken vigorously to ensure that the papers were thoroughly mixed and 285 houses were then picked from the box one after the other. On entering each house and explaining our mission, all the adults who were 35 years and above and had adolescents under their care or had taken care of adolescents before were briefed about the study and enumerated. Their names were written on small pieces of paper folded and placed in a box. The box was vigorously mixed after which one person was selected. A similar procedure was adopted for the adolescents after the procedure has first been explained to the parents and then to the adolescents. One parent and one adolescent were selected from each house. The parents and adolescents were selected at random. They were not necessarily parent-adolescent dyad. In all 285 adolescents and 274 parents were selected for the interview as some of the houses did not have the requisite parents.

### **3.8 Data collecting technique/methods and tools**

An interviewer-administered structured questionnaire with both open and close ended questions was used to collect the quantitative data. While closed ended questions limit the response options for the respondent, they are easy to analyse. Open ended questions on the other hand do not limit the response options but are difficult to analyse. Blending the two enriched the quality of the data. The interviews were conducted by well trained and experienced research assistants under the supervision of the researcher and a field supervisor.

The qualitative data was collected through focus group discussions with the aid of a focus group discussion guide. The proceedings were modulated by the researcher who was assisted by two of the interviewers. The proceedings were audio recorded while the assistants also took notes.

### **3.9 Quality control**

The quality of the data collected was ensured first by employing four interviewers who had experience in collecting data from the community. All of them had worked with a research institution and had conducted several community interviews. In addition an experienced field supervisor was also employed who supervised the collection of the data. Two of the interviewers and the field supervisor were involved in the pretesting of the questionnaires.

Secondly, two days training was done. The questionnaires were sent to the field supervisor and interviewers two days prior to the commencement of the training. This

made it possible for them to get a fair understanding of the questions even before the training. The research objectives as well as questions on the interview schedule were explained to the interviewers. The questions were also interpreted in Twi and Ga. This enabled all the interviewers to get the same understanding of all the questions irrespective of the language used in administering the questionnaires. Role plays were then done.

Pretesting of the questionnaires for the quantitative data was conducted at New Town, an adjoining community to Alajo with similar characteristics as Alajo. Twenty adolescents and adults each were interviewed. That data was entered into the Statistical Package for the Social Sciences Version 16 (SPSS 16) and frequencies and cross tabulations ran on them. This provided the opportunity to have an idea how the analysis would look like. The lessons learnt from the pretesting of the questionnaires were used to finalise the questionnaires that were used in the main study.

The data was collected between 25<sup>th</sup> May and 12<sup>th</sup> June, 2009. During the survey each filled questionnaire was checked by the interviewer at the point of interview to avoid missing responses. At the end of each day of interview the filled questionnaires were cross checked again by the principal investigator and field supervisor for missing responses. Where need be the respondents were contacted the following day to supply whatever was missing.

### **3.10 Ethical considerations**

#### **3.10.1 Before the study**

First and foremost, ethical approval to undertake the study was obtained from the Ethical Review Committee of the Ghana Health Service.

Secondly, permission to enter the community was sought through letters and personal contact with the Accra Metropolitan and Ayawaso Central Submetro directors of health.

Furthermore, the Honourable Member of Parliament and his representatives, local Assembly and some Unit Committee members were also consulted likewise some religious and youth leaders.

#### **3.10.2 Consent from study participants**

Consent to take part in the interview was obtained from all selected participants who agreed to be part of the study. Participants were informed about the nature of the study and the study objectives.

They were made to understand that partaking in the study was voluntary and there were no monetary rewards. They were also not obliged to answer all questions in case they found them too sensitive. Again they were at liberty to withdraw from the study at any time they wished to do so without any consequences. They were also told that since the study involved only answering of questions we did not expect them to have any physical harm. Finally they were assured of confidentiality of whatever information they provide.

All those who could read and write in English were given written consent in English to read and sign. For those who could not read in English the interviewers translated the consent form into the commonly spoken dialects (Twi, Ga, Ewe) after which they signed or thumb printed the consent form.

With regard to respondents who were less than 18 years, consent was first sought from their parents after which additional consent was sought from the respondents themselves. The consent procedure for reading and signing followed similar patterns to that of the adults.

It was observed that majority of the respondents preferred to give verbal consent rather than signing or thumb printing the consent forms provided. The few consent forms which were signed were detached from the main questionnaires and kept separately to prevent the identity of the respondent being known through that.

### **3.10.3 During Interviews**

The identities of the respondents were concealed by not putting down their names on the questionnaires. Parents and adolescents were interviewed separately. In addition the interviews were conducted privately as much as the environment could provide. During the focus group discussions, no names of the participants were used.

#### **3.10.4 Safety of data/information collected**

The filled questionnaires, audio recordings, notes and transcripts of interviews are being kept under lock and key by the principal investigator (author).

#### **3.11 Limitations:**

1. The community had crowded houses with poor network of streets. Some of these streets go through the middle of houses. This sometimes made it difficult to conduct the adolescent interviews as privately as one would have preferred without the prying eyes of an adult or a passer by. This might have affected the response for sensitive issues such as an adolescent reporting of having had sexual intercourse before and the use of contraceptives. This notwithstanding the level of reported contraceptive use was comparable to what pertains in the country as a whole.
2. It would have been very appropriate to conduct focus group discussion for the adolescent's too but limited financial resources and time could not permit this.

#### ***3.12 Data analysis***

##### **3.12.1 Data processing and analysis**

For the quantitative data, responses from the filled questionnaires were audited, and all necessary corrections made after which they were coded. The coded questionnaires were entered manually into a personal computer using SPSS 16. There was single data entry but checks were put in place to ensure that only appropriate entries were made. The data was cleaned by running the frequencies for each response and cross tabulations for responses that were supposed to match up. Where inconsistencies existed the

questionnaires were retrieved and the appropriate corrections were done. The cleaned data was then analysed using the same SPSS 16. Categorical data were analysed with frequencies, cross-tabulations and the results were presented in tables, pie charts and graphs. Continuous data was analysed by the means of the groups. Test of associations were done using Chi-square test with statistical significance at 5% (p-value <0.05).

Analysis of the qualitative data was done manually. Recorded responses from the focus group discussions were transcribed verbatim and translated into English. It was then coded and organized into themes and sub-themes according to the study objectives.

## **CHAPTER FOUR**

### **4.0 RESULTS**

## **4.1 Results of adolescent interview**

### **4.1.1 Background characteristics**

Table 1 shows the background characteristics of the respondents. A total of 285 adolescents were selected of which 281 consented and were interviewed yielding a response rate of 98.6%. Out of the 281 adolescents interviewed, four were further excluded due to inconsistent responses leaving 277 for analysis.

Out of the 277, the males formed 46.2% (128) while the females were 53.8% (149). Young adolescents (12 -14 years) made up 33.2% (92) of the respondents while their older counterparts (15 -19) formed the remaining 66.8% (185). While the mean age of all the respondents was 15.6 years (SD 2.1), that of the males and females were 15.2 years (SD 2.2) and 16 years (SD 2.1). The modal age group among the males was the 15 year olds 16% (21) and that of the females was the 18 year olds 23% (34).

Almost all the participants, 99.3% (275) had never been married. Whereas 58.5% (162) were living with both biological parents, 19.5% (54) were with single parents. For the remaining, 11.9% (33), 3.3% (9) and 6.1% (17) respectively lived only with a female guardian, male guardian and both male and female guardians. The rest 0.7% (2) were living on their own.

Table 1. Percentage distribution of background characteristics of adolescents 12 to 19 years according to sex

Characteristic	Male	Female	Total
	N=128	N=149	N=277
<b>Age</b>	n(%)	n(%)	n(%)
12	15(11.7)	8(5.4)	23(8.3)
13	19(14.8)	14(9.4)	33(11.9)
14	19(14.8)	17(11.4)	36(13.0)
15	21(16.4)	22 (14.8)	43(15.5)
16	16(12.5)	22(14.8)	38(13.7)
17	14(10.9)	18(12.1)	32(11.6)
18	12(9.4)	34(22.8)	46(16.6)
19	12(9.4)	14(9.4)	26(9.4)
<b>Marital Status</b>			
Never married	128(100)	147(98.0)	275(99.0)
Married	0(0)	1(1.0)	1(0.5)
Cohabiting	0(0)	1(1.0)	1(0.5)
<b>Religion</b>			
Catholic	30(23.4)	14(9.4)	44(15.9)
Protestant	23(18.0)	30(20.1)	53(19.1)
Charismatic	57(44.5)	81(54.4)	138(49.8)
Moslem	14(10.9)	24(16.1)	38(13.7)
No religion	4(3.1)	0(0)	4(1.4)
<b>Ethnicity</b>			
Ga/Adangme	21(16.4)	34(22.8)	55(19.9)
Akan	47(36.7)	67(45.0)	114(41.2)
Ewe	29(22.7)	23(15.4)	52(18.8)
Northern tribes	19(14.9)	14(9.7)	33(11.8)
Hausa	8(6.2)	9(6.0)	17(6.1)
Guan	4(4.1)	2(1.3)	6(2.2)
<b>Educational Level</b>			
No education	1(0.8)	3(2.0)	4(1.4)
Primary education	34(26.6)	27(18.1)	61(22.0)
JSS	66(51.6)	71(47.7)	137(49.5)
Secondary +	27(21.0)	48(32.2)	75(27.1)

In all, 1.4% (4) had no formal education while the remaining had some form of formal education. The level of education with the highest number of respondents was Junior Secondary School (JSS) 49.5% (137). About 77% (214) were in school while the

remaining were out of school. For the 63 who were out of school, 54% (34) were unemployed, 23.8% (15) were unskilled workers (i.e. labourers, house helps, cleaners, gardeners), 14.3% (9) were either artisans or apprentice artisans, 6.3% (4) were traders and one was a clerk (1.6%).

About 85% (235) were Christians, 13.7% (38) were Moslems while the remaining 1.4% (4) had no religion. The major ethnic group found was the Akans who constituted 41.2% (114) of the respondents followed by the Ga/Adangmes who were 19.9% (55).

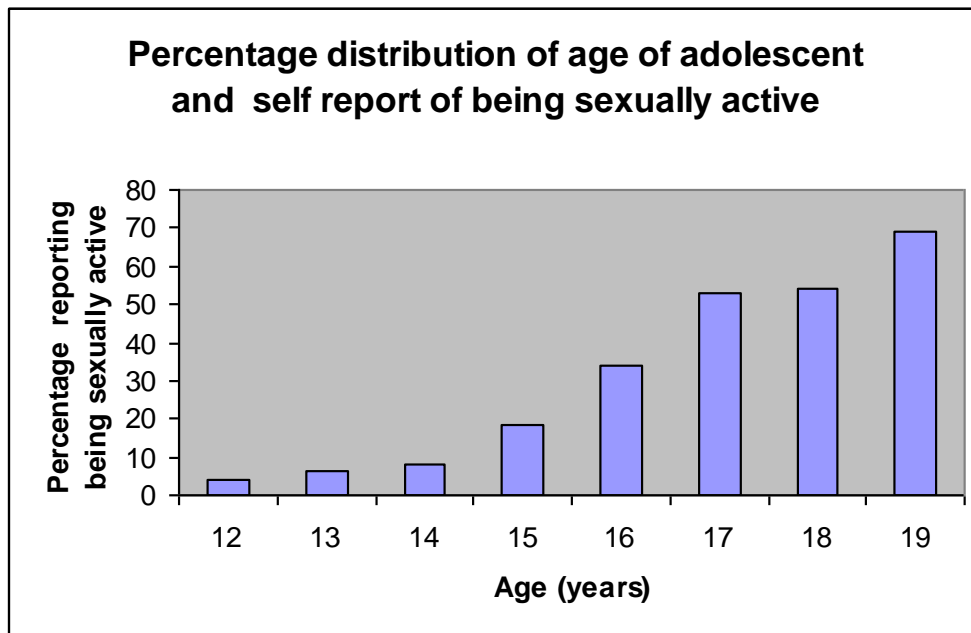
#### **4.1.2. Sexual activity and pregnancy**

Out of the total of 277 respondents, 31.4% (87) reported being sexually active (i.e. having ever had penile vaginal sexual intercourse) at the time of the interview. However, 67.1% (186) reported that they either have a friend or knew someone about their age who was sexually active in the community. Out of the 87 who reported being sexually active, 37.9% (33) were males and 62.1% (54) were females. More females 36.2% (54/149) than males 25.8% (33/128) reported being sexually active. Report of being sexually active was significantly higher in the older adolescents as compared to the younger ones [43.8% vs 6.5%,  $p < 0.001$ ]. The distribution between age and report of being sexually active is shown in Figure 2. The chance of coming across a sexually active adolescent was higher among the out of school adolescents as compared to those who were in school (1 in 2 vs 1 in 4).

Out of the 87 sexually active ones, 17.2% (15) reported ever being pregnant while 3.4% (3) reported ever impregnating someone. Among the 18 pregnancies, the outcome of 55.6% (10) was induced abortions and this gave an induced abortion ratio of 3.6% among

all the respondents. About 39% (7) ended up in delivery and 5.6% (1) ended up as a miscarriage. All the children delivered were reported to be alive at the time of the interview.

Fig 2.



#### 4.1.3. Knowledge about contraceptives

Almost all the respondents 99.6% (276) knew about modern contraceptives. About 95% of both males and females (122) and (141) respectively knew about the male condom. Generally, the level of knowledge about the rest of the modern contraceptives was higher in the females than the males and reached statistically significant levels ( $p < 0.05$ ) for the pill, implant and calendar methods [ 53% (79) vs 34.4% (44); 6.0%(9) vs 0.8%(1); 13.4%(20) vs 5.5%(7)] respectively.

Knowledge about the different types of contraceptives was higher in the older adolescents except the male condom which was higher in the younger ones [96.7% (89) vs 94.1%

(174)]. In all, the least mentioned contraceptive was the diaphragm which was mentioned by only one female. With the exception of the pill and the male condom the level of knowledge about the various contraceptives increased as education level increased, the details of which are shown in Table 2.

Table 2. Percentage distribution of age group, level of education and contraceptive knowledge

Contraceptive	Adolescent Age group		Level of education			
	Young(12-14)	Old (15-19)	None	Primary	JSS	Secondary+
	N=92	N=185	N=4	N=61	N=137	N=75
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Pill	17(18.5)	106(57.3)	3(75)	9(14.6)	62(45.3)	49(65.3)
Male condom	89(96.7)	174(94.1)	2(50)	60(98.3)	130(94.9)	71(94.7)
Female condom	35(38.0)	85(45.9)	1(25)	21(34.4)	60(43.8)	38(50.1)
IUCD	1(1.1)	4(2.2)	0(0)	0(0)	1(0.7)	4(5.3)
Injectable	4(4.3)	42(22.7)	0(0)	1(1.6)	21(15.3)	23(30.7)
Implant	0(0)	10(5.4)	0(0)	1(1.6)	5(3.6)	4(5.3)
Diaphragm/	0(0)	1(0.5)	0(0)	0(0.0)	0(0.0)	1(1.3)
Vaginal tabs	0(0)	7(3.8)	0(0)	0(0)	2(1.5)	5(6.7)
Natural/	0(0)	27(14.6)	0(0)	1(1.6)	10(7.3)	16(21.3)

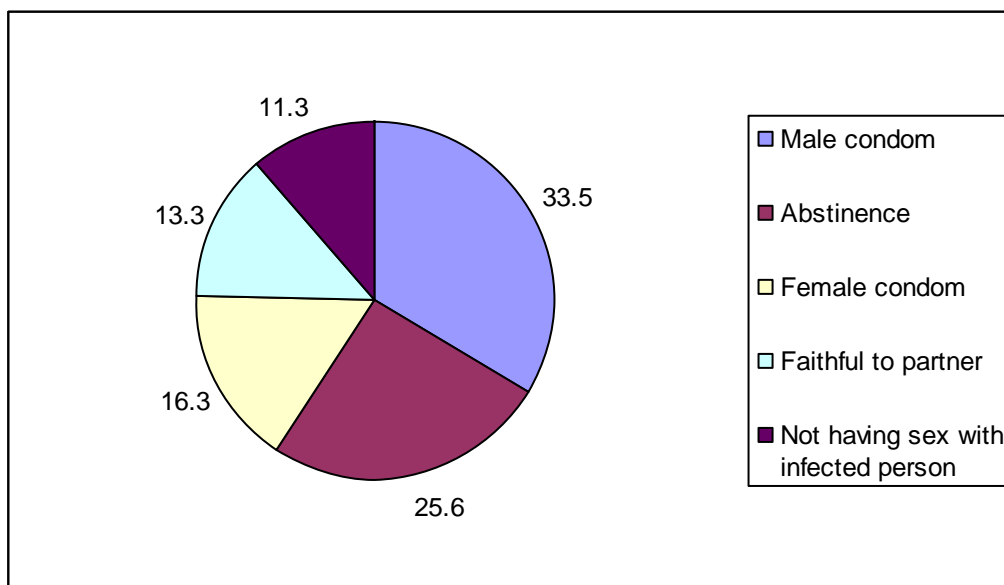
#### 4.1.4. Prevention of sexually transmitted infections (STIs)

The main aim of this segment was to find out if the adolescents knew which contraceptive methods can be used to avoid STI. In all 96.8% (268) of the respondents knew at least one correct method to prevent STIs. Out of the 268, about 96% (256) and

46% (124) mentioned the male condom and female condom respectively. Knowledge between males and females was almost the same.

Knowledge that the male and female condoms can prevent STIs was lower in the young adolescents compared to their older counterparts and reached significant levels ( $p < 0.05$ ) for the female condom [(32.6% (30) vs 50.8% (94)]. All those who mentioned the female condom also mentioned the male condom. However, 1.1% (3) in addition to mentioning correct methods for preventing STI also mentioned the vaginal foaming tablets/gel. They were all older adolescents, the details of these and other methods of preventing STI are shown in Fig. 3. The responses were multiple.

Fig 3. Methods for preventing STI as a percentage of the total of 762 responses



#### 4.1.5. Source of information on contraceptives

In all there were 784 multiple responses for the source of information on contraceptives.

The major sources of information on contraceptives were the radio and television which all had about 29% of the total responses each, (226) and (225) respectively. Teachers also played a significant role in providing information contributing about 20% (153) of the responses. While friends provided about 9% (74) of information, parents were involved in only 3% (23) of cases. Other sources of information were newspapers 4% (31) with siblings, health workers, and churches providing the remaining 6% (52).

#### 4.1.6. Contraceptive use by respondents and their peers

In all 23.5% (65) of the respondents reported having ever used a family planning method.

Out of the 65, 88% (57) reported still using a method at the time of the interview. Out of the 69 multiple responses received for the various methods in use, the male condom 52.2% (36) was the highest followed by the female condom and the pill, 15.9% (11) each.

One person each was using the IUCD and the calendar methods whereas two each were

relying solely on withdrawal and periodic abstinence. Thus 19.1% (53) out of the total respondents (277) were on modern contraceptives at the time of the interview. Failure of the condom (4 female and 1 male) resulting in pregnancy was the major adverse effect reported. For those who reported being sexually active, 25.3% (22) had not used a contraceptive before.

Contraceptive use among the older adolescents increased from 11.6% (5/43) for the 15 year olds to 53.8% (14/26) in the 19 year olds. The 16, 17 and 18 year olds had 18.4% (7/38), 34.4% (11/32) and 39.1% (14/26) contraceptive use respectively. Among the old female adolescents, 28.2% (31) were on contraceptives.

Again for those with formal education contraceptive use was 6.6% (4) for the respondents with primary education, 14.6% (20) for those with JSS education and 41.3% (31) for those with secondary education and above. Among the sexually active ones who were current users, modern contraceptive use among the Catholics was higher than that of the other Christian denominations, but the difference was not significant statistically [68.4% (13/19) vs 53.7% (29/54), p-value 0.2)

As to whether respondents had friends who have ever used contraceptives 46.6% (129), 23.1% (64) and 30.3% (84) reported “yes”, “no”, and “do not know” respectively. About 91% (52) of current contraceptive users reported having friends who had ever used contraceptives. The remaining 9% (5) did not know whether their friends had used contraceptives or not.

#### **4.1.7. Advantages of contraceptive use**

In all 86.3% (239) of the respondents reported that contraceptive use has advantages for the adolescent user while 4.3% (12) and 9.4% (26) respectively said there are “no” advantages or “did not know” whether there are advantages. That contraceptive use has advantages for the adolescent user was similarly reported in males and females, 85.2% (109) and 87.2 % (130) respectively.

All the females who have ever been pregnant and the males who have ever impregnated someone were of the view that contraceptive use has advantages for the adolescent user. As expected almost all those on contraceptives at the time of the interview 98.2% (56) said adolescent contraceptive use has advantages for the user. Furthermore, 96.9% (63) of the ever-users shared similar views of advantage. In addition all those who even reported having had side effects from contraceptive use said contraceptive use have advantages for the adolescent user.

Those who reported being sexually active were more likely to say contraceptive use has advantages for adolescents than those who reported not being sexually active (96% vs 81.6%;  $p < 0.05$ ). While 12.6% (24) of those who reported not being sexually active said they did not know whether contraceptive use have advantages or not for the adolescent user only 2.6% (2) of those who reported being sexually active said so.

In terms of education, all the four respondents with no education agreed that contraceptive use by adolescents has advantages. These respondents however were 18

and 19 years old. From the primary, through the JSS and secondary education and above, the proportions that agreed were 75.4% (46), 86.1% (118) and 94.7% (71) respectively.

Out of the 239 respondents who agreed that contraceptive use has advantages for the adolescent user, 99.6% (238) mentioned either the prevention of unwanted pregnancy, the prevention of STI or both as the advantage of contraceptive use. The remaining one respondent said contraceptive use by adolescents increases one's standard of living. For the 238, 77.7% (185) mentioned both pregnancy and STI, 18.9% (85) mentioned pregnancy alone and the remaining 3.4% (8) mentioned STI alone.

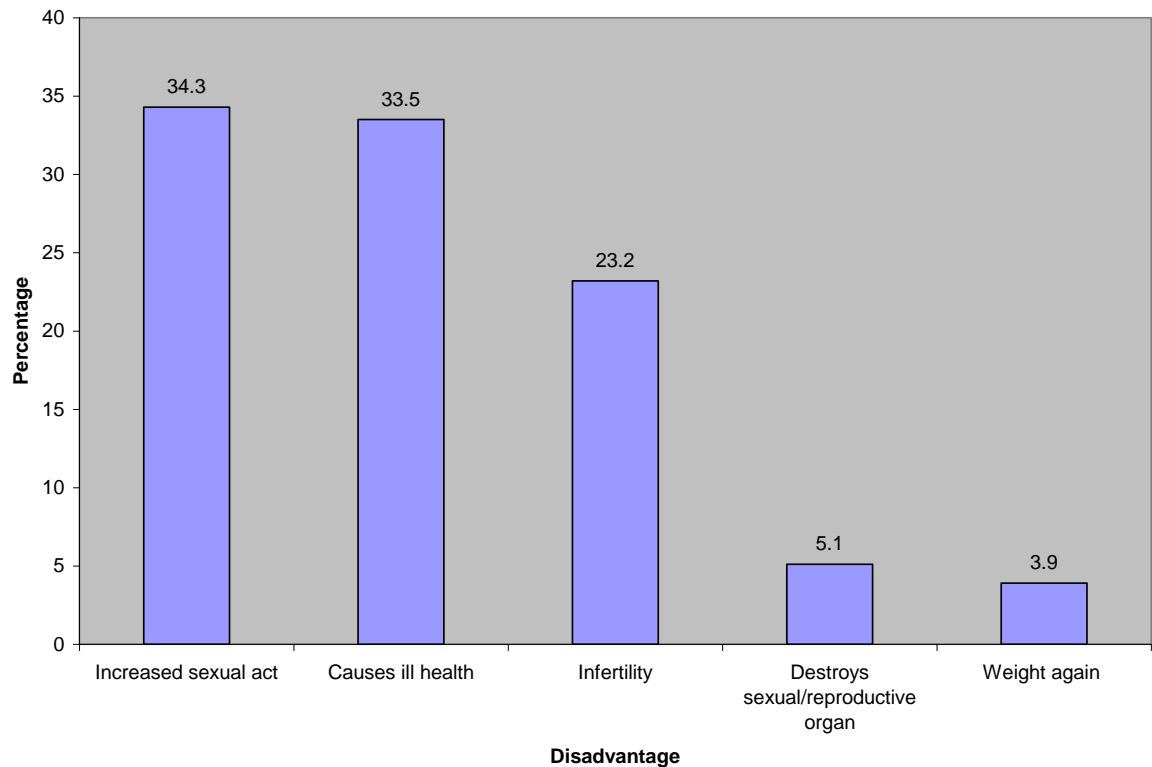
#### **4.1.8. Disadvantages of contraceptive use**

In all 51.3% (142) of the respondents said contraceptive use has disadvantages for adolescent users. This number included 56.5% (135) of those who said contraceptive use has advantages for the adolescent user. Seventeen per cent (47) and 31.8% (88) respectively said there are "no" disadvantages or "did not know" whether there are disadvantages.

The most common disadvantages mentioned were increase in sexual activity 34.3% (87/254 multiple responses) and ill health 33.5% (85/254 multiple responses) While among the males the most common disadvantage mentioned was increase in sexual activity; 40.9% (36) in the females it was ill health 32.5% (54) responses. Details of the

various disadvantages mentioned are shown in Figure 4. There were 254 multiple responses

Fig 4. Percentage distribution of reported disadvantages of contraceptives use by adolescents



#### 4.1.9. Anticipated guardian/parental response to assumed contraceptive use by adolescent

The responses to this section were based on what action respondents expected from their parents assuming they were using contraceptives without their knowledge and they find out. Responses to this question were multiple and the commonest response expected was anger, 45% (143/318) and 44.3% (146/330) from their male and female parents

respectively. This was followed by punishment 25.4% (81) and 25.5% (84) from their male and female parents respectively.

The probability that the adolescent expect to be asked by either parent to stop using the contraceptive was significantly higher than not saying anything (8.2% vs 2.2% and 10.6% vs 2.1% for the male and female parents respectively,  $p < 0.001$ ). The details of these and other responses are shown in table 3.

Table 3. Percentage distribution of anticipated parental reaction to assumed contraceptive use by sex of parent

<b>Action</b>	<b>Male parent</b>	<b>Female parent</b>
	N=318*	N=330*
Will be angry with me	45.0	44.3
Will punish me	25.4	25.5
Can't tell his reaction	11.3	10.3
Will ask me to stop	8.2	10.6
Will disown me	3.5	1.8
Will sack me from the house	2.8	3.3
Will not say anything	2.2	2.1
Will kill me	1.6	2.1
<b>Total</b>	<b>100</b>	<b>100</b>

\* Responses were multiple

#### 4.1.10. Opinion on contraceptive use by sexually active adolescents

In all 63.2% (175) of the respondents were of the opinion that sexually active adolescents should use contraceptives, 32.5% (90) felt they should not use contraceptives, while 4.3% (12) remained neutral. With regard to the female adolescents, 66.5 % ( 99) agreed, 29.5 % ( 44) disagreed and 4 % ( 6) remained neutral. Among the males, 59.4% (76) agreed, 35.9% (46) disagreed while 4.7% (6) remained neutral. Table 4 shows factors that were significantly associated with adolescents agreeing to contraceptive use by adolescents.

Table 4. Factors associated with adolescents agreeing that sexually active adolescents should use contraceptives

Characteristic	Percentage who agree	P- value
<b>Sex of adolescent</b>		
Male	62.3	
Female	69.2	>0.05
<b>Age</b>		
Young (12-14years)	50.6	
Old (15-19years)	73.6	<0.001
<b>Education</b>		
None	50.0	
Some education	66.3	>0.05
<b>Religion</b>		
Catholics	70.7	
Non Catholics	65.2	>0.05
<b>In or out of school</b>		
In school	64.2	
Out of school	27.8	<0.001
<b>Sexually active</b>		
Yes	91.9	
No	53.6	<0.001
<b>Contraceptive use</b>		
Ever used-Yes	93.8	
Ever used-No	57.2	<0.001

Being an old adolescent, sexually active, having ever used contraceptives and being in school were significantly associated with an adolescent agreeing to contraceptive use by adolescents ( $p < 0.001$ ). Being sexually active remained significant after logistic regression.

For those who agreed to contraceptive use by adolescents, the most cited reason was for the prevention of pregnancy alone 53.8% (88) followed by the prevention of both pregnancy and STIs 34.9% (61) and the prevention of STIs alone 14.8% (26).

For the 90 respondents who disagreed to contraceptive use by adolescents, 46.7% (42) thought doing so will increase sexual activity among adolescents. Another 24.4% (22) were of the opinion that adolescents are supposed to abstain from sex while 13.3% (12) and 8.9% (8) mentioned the causation of ill health and the fact that contraceptives are not completely effective as their reasons. The remaining 6.7% (6) mentioned various reasons including the fact that it is morally wrong, that adolescents are too young to use contraceptives and religious beliefs. Adolescent males were more likely to disagree to contraceptive use by adolescents than their female counterparts (36% vs 30%).

Concerning those who remained neutral, 75% (9) mentioned lack of adequate knowledge on contraceptives as their reason while 16.7% (2) did not give any reason. The remaining 8.3% (1) respondent did not care whether adolescents use contraceptives or not.

#### **4.1.11. Initiation of discussion with male parent by adolescent**

In all 123 male adolescents and 135 female adolescents had a male parent. Out of the total of 258 respondents with male parent, 6.2% (16) made up of 8.1% (10) and 4.4% (6) males and females respectively reported having initiated a discussion that involved contraception with their male parent.

Of the 16, 43.8% (7) of the discussion came about when the adolescents were taught about family planning in school and they wanted to know more. In another 31.2% (5), nocturnal emissions caused the male adolescents to engage their male parents in the discussion. For the remaining 25% (4), the discussions were prompted by the adolescent telling their male parent about either a friend who was pregnant or had impregnated someone. There was no particular background characteristic that was significantly associated with an adolescent initiating a discussion with the male parent.

At the end of majority of the discussions 93.7% (15), the adolescents were advised to abstain from sex while the remaining 6.3% (1) were advised to use contraceptives if they cannot abstain from sex. In 62.5% of cases subsequent discussions following the first one were however rarely held.

#### **4.1.12. Initiation of discussion with female parent by adolescent**

One hundred and twenty five male adolescents and 148 female adolescents had a female parent. In all 9.5% (26) adolescents made up of 3.2% (4) of the males and 14.9% (22) of the females reported they had initiated a discussion that involved contraception with their female parent. Being a female, old adolescent, Catholic, sexually active and prior

contraceptive use were factors significantly ( $p < 0.05$ ) associated with an adolescent initiating a discussion with the female parent.

In 38.5% (10) of the cases, (all of them females) the first of such discussions came about when the girls attained menarche and asked their mothers questions about it. In another 26.9% (7) they were taught in school about family planning and so wanted to know more while in 19.2% (5) the discussion occurred when either a friend or someone in their community had become pregnant or had an abortion and they told their parents about it. For the remaining 15.4% (4) the discussion came about after listening to a radio or watching a television programme on family planning and abortion and they engaged the parent in a discussion involving what they have heard or watched.

In 88.5% (23) of the cases, the adolescent was advised to abstain from sex at the end of the discussion, while the remaining 11.5% (3) were advised either to abstain from sex or use contraceptives if they cannot abstain. In about 53.8% (14) of cases, subsequent discussions following the first one were however rarely held.

Most of the adolescent initiated discussions were secondary to incidents such as puberty and pregnancy or as a follow up introduction of family planning at school or issues related to family planning and abortion on the mass media. While male adolescents initiate discussions more with their male parents, female adolescents also tend to lean more towards their female parents. Male adolescents discuss their puberty related issues

(nocturnal emissions) with their male parents and their female counterparts go their female parents with problems of menarche.

All the adolescents however routinely discuss other issues such as education, apprenticeship, religion, health and domestic issues freely with their parents. Among the adolescents themselves 74.2% (95) and 80.5% (120) of the males and females respectively had discussed contraceptives with their friends.

#### **4.1.13. Initiation of discussion with adolescent by male parent**

Out of a total of 258 adolescents who had a male parent, 18.6% (48) reported that their parents had ever initiated a discussion with them that involved talking about contraceptives. This number was made up of 19.5% (24) of adolescent males and 17.8% (24) of the adolescent females.

In a third (8) of the cases involving the male adolescents, the first of such discussions occurred as part of routine advice given by the male parent. In another third (8), the discussion was prompted by the male parent suspecting or having evidence that the adolescent was involved in an amorous relationship. For the last third (8), the discussions came about when a sister, friend or someone else in the vicinity had become pregnant or impregnated someone.

In the case of the female adolescents, a quarter (6) of such discussions first took place as part of routine advice especially at menarche, a quarter came about after listening to a

radio or watching a television programme on family planning and abortion together. Suspicion or evidence of amorous relationship on the part of the adolescent prompted 45.8% (11) while for 4.2% (1) the first of such of discussions started when her friend became pregnant.

In all, 95.8% (46) of the adolescents were advised to abstain from sex at the end of the discussion while the remaining 4.2% (2) were advised to abstain from sex or use contraceptives if they cannot abstain. In about 54% (26) of cases, subsequent discussions involving contraceptives following the first rarely occurred.

#### **4.1.14. Initiation of discussion by female parent**

In all 27.5% (75) adolescents who had a female parent, reported that their parents had ever initiated a discussion that involved contraception with them. This number comprised 16.8% (21) of males and 36.5% (54) of the females.

In 38.1% (8) of the cases involving the male adolescents, the first of such discussions occurred as part of routine advice given by the female parent. Another 38.1% (8) had such a discussion when the female parent suspected or had evidence that the adolescent was involved in an amorous relationship. For a further 14.3% (3) the discussion was prompted by television programmes on family planning or abortion while the remaining 9.5% (2) had the discussions when a friend got pregnant.

With regards to the female adolescents, the first of such discussions in 48.1% (26) of cases was as part of routine advice especially at menarche. About 28% (15) also had the

first discussion when the parent had suspicion or evidence of amorous relationship on the part of the adolescent. Another 13% (7) had the discussions when their friend or neighbour got pregnant. In 11.1% (6) the discussion was as a result of listening to a radio or watching a television programme on family planning and abortion together.

On the whole, 92% (69) of the adolescents were advised to abstain from sex at the end of the discussion, 5.3% (4) were advised to use contraceptives if they cannot abstain from sex while the remaining 2.7% (2) were discouraged from using contraceptives.

In all, female parents initiated most of the discussions (27.5%) and tend to discuss more with their female adolescents (36.5%) than male adolescents (16.8%). The male parents however seem to talk to both male and female adolescents almost equally (19.5% vs 17.8%). Both male and female parents routinely advice their male adolescents at the same rate as they do secondary to amorous relationship. However, while most male parents/guardian to female adolescent discussions were due to amorous relationship than routine advice (45.8% vs 25%), the opposite holds for the female parent (48.1% for advice and 28% for amorous relationships).

## **4.2 RESULTS OF PARENTS INTERVIEW**

### **Background characteristics**

Table 5 shows the background characteristics of the respondents. A total of 274 adults were selected for interview. Respondents were expected to be parents who had current or prior experience with adolescents. Adults in this category might have faced or may be facing the problem of adolescent premarital sexual activity and contraceptive use.

Out of the 274 selected, 97.8% (268) consented and were interviewed. Of the total number interviewed four were further excluded because they responded “No” to the question asking whether they had taken care of an adolescent before. Of the remaining 264, males formed 44% (116) and the females were 56% (148).

The mean age of the respondents was 49 years (S.D 12) and ranged from 35 to 81 years. The most frequent age group among both males and females were the 35-40 year age group 29.3% (34) and 40.5% (60) respectively. Sixty one percent (161) were married, 8% (21) had never married, 17.4% (46) were either separated or divorced, 9.8% (26) were widowed while 2.6 % (3) were cohabiting. The number of children the respondents had ranged from 0 to 16. Four respondents had 10 or more children and they were all males. Even though all the respondents have ever had experience with adolescent care, it was 59.5% (157) who were having adolescents under their care at the time of the interview.

Table 5. Percentage distribution of background characteristics of parents 35 years and above according to sex

<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
	n (%)	n (%)	n (%)
35-40	34(29.3)	60(40.5)	94(35.6)
41-46	21(18.1)	21(14.2)	42(15.9)
47-52	17(14.7)	25(16.9)	42(5.9)
53-58	17(14.7)	14(9.4)	31(1.8)
59-64	7(6.0)	10(6.8)	17(6.4)
65+	20(17.2)	18(12.2)	38(14.4)
<b>Religion</b>			
Catholic	17(14.7)	23(15.5)	40(15.2)
Protestant	27(23.3)	35(23.6)	62(23.5)
Charismatic	41(35.3)	63(42.7)	104(39.4)
Moslem	17(14.7)	19(12.8)	36(13.6)
Traditionalist	4(3.4)	5(3.4)	9(3.4)
No Religion	10(8.6)	3(2.0)	13(4.9)
<b>Ethnicity</b>			
Ga/Adangme	18(16)	36(24)	54(20.5)
Akan	47(41)	61(41)	108(40.9)
Ewe	24(21)	25(17)	49(19)
Northern tribes	20(17)	18(12)	38(14)
Hausa	7(6)	8(5)	15(6)
<b>Educational Level</b>			
No education	20(17.2)	36(24.3)	56(21.2)
Primary education	12(10.3)	20(13.5)	32(12.1)
JSS/Middle	53(47.5)	68(46.0)	121(45.8)
Secondary	17(14.7)	21(14.2)	38(14.4)

Tertiary	14(12.1)	3(2.1)	17(6.5)
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As regards formal education, about 21% (56) had none. Those with Middle school/JSS education formed the majority 45.8 % (121) of those with formal education. The men had more formal education than the women [82.8% vs 75.7%]. The level of education indicated refers to the highest level of education attended, whether or not one completed that level.

The most common religion was Christianity and most of the respondents 39.4% (104) belonged to the Charismatic and Pentecostal churches. The Akans were the dominant tribe, constituting 40.9% (108) followed by the Ga/Adangmes who were 20.5% (54).

For the males, the most common occupation were artisans 25.9% (30), followed by traders 20.7% ( 24) and professionals (teachers, accountants, engineers etc) 15. 2% (18). About 66% (98) of the women were traders, 3.4% (5) were professionals while 2.7% (4) were artisans. About 10% (12) and 12% (17) of the males and females respectively were unemployed.

#### **4.2.2. Knowledge about contraceptives**

The interest here was to look at knowledge about contraceptive use in preventing both pregnancy and STI especially when the focus was on adolescents. Table 6 shows the response rate for the known methods of pregnancy prevention.

Table 6. Distribution of knowledge of some modern contraceptives by sex

Contraceptive	Male	Female	Total
	N=380*	N=561*	N=941*
	n(%)	n(%)	n(%)
Pill	82(21.6)	120(21.4)	202(21.5)
Male condom	111(29.2)	133(23.7)	244(25.9)
Female condom	69(18.2)	76(13.5)	145(15.4)
IUCD	0(0.0)	11(2.0)	11(1.2)
Injectable	55(14.5)	84(15.0)	139(14.7)
Implant	19(5.0%)	47(8.3)	66(7.0)
Vagina foaming tablets/gel	5(1.3)	11(2.0)	16(1.7)
Diaphragm/cervical cap	2(0.5)	10(1.8)	12(1.3)
Natural/Calendar	37(9.7)	69(12.3)	106(11.3)
<b>Total responses</b>	<b>(100)</b>	<b>(100)</b>	<b>(100)</b>

\* Responses were multiple

#### 4.2.2.1. Prevention of pregnancy

Almost all the respondents, 99.6% (263) mentioned at least one modern contraceptive.

The remaining one respondent mentioned squatting by the woman to let the semen come out after sexual intercourse as the method to prevent pregnancy. Out of the 941 multiple responses, the most mentioned contraceptive was the male condom 25.9% (244) which

remained the most mentioned in males and females, 29% (111) and 24% (133) respectively. The least mentioned contraceptive was the IUCD 1.2% (11).

Knowledge about the different types of contraceptives was highest in those who have secondary education as compared to those without formal education and other levels of education. The details of the proportion of individuals in each group, according to background characteristic and knowledge of selected contraceptives are shown in Table 7.

#### **4.2.2.2. Prevention of STIs**

The interest here was to find the knowledge of respondents about which contraceptive/family planning practices can help prevent STIs. Among the 264 respondents, 96.2% (254) knew correctly how STIs can be prevented by either abstaining from sexual intercourse or using the male/female condom. The remaining 3.8% (10) did not know which family planning methods can prevent STIs.

For those who knew how STIs could be prevented, knowledge was similar among the men and women [95.7% (111) and 96.6% (143) respectively]. Out of the total responses of 597, the male condom, abstinence and female condom were reported at a rate of 40.7% (243), 34.7% (207) and 24.6% (147) respectively. There was no significant difference between the responses given by the men and women [*p-values* 0.07, 0.42 and 0.33]. However, in addition to mentioning a correct method of STI prevention, about 6% (15) of

the respondents made up of 5 men and 10 women mentioned the vaginal foaming tablets/gel too.

Table 7. Distribution of contraceptive knowledge against some background characteristics.

	<b>Contraceptive</b>					
	Pill n(%)	Male condom n(%)	Female condom n(%)	Injectable n(%)	Implant n(%)	Natural n(%)
<b>Age group</b>						
35-40	74(78.7)	86(91.5)	42(44.9)	60(63.8)	32(34.0)	41(43.6)
41-46	30(71.4)	38(90.5)	23(54.8)	23(54.8)	9(21.4)	22(52.4)
47-52	33(78.5)	41(97.5)	23(54.8)	21(50.0)	9(21.4)	12(28.6)
53-58	24(77.4)	30(96.8)	24(77.4)	13(41.9)	6(19.4)	10(32.3)
59-64	14(82.4)	16(94.1)	11(64.7)	8(47.1)	4(23.5)	7(41.2)
65+	27(71.1)	33(86.6)	22(57.9)	14(36.8)	6(15.9)	14(36.8)
<b>Educational status</b>						
No education	40(71.4)	51(91.1)	29( 56.9 )	23(41.1)	11(19.6)	20(35.7)
Primary	21(65.6)	29(90.6)	19(59.4)	14(43.8)	9(28.1)	10(31.3)
JSS/Middle	95(78.5)	113(93.4)	67(55.4)	68(56.2)	31(25.6)	49(40.5)
Secondary	32(84.2)	36(94.7)	23(60.5)	24(63.2)	11(28.9)	19(50.0)
Tertiary	14(82.4)	15(88.2)	7(41.2)	10(58.8)	4(23.5)	8(47.1)
<b>Marital status</b>						
Never married	15(71.4)	19(90.5)	11(52.4)	10(47.6)	3(14.3)	8(38.1)
Married	122(75.8)	149(92.5)	77(47.8)	88(54.7)	42(26.1)	67(41.6)

Divorced	27(81.8)	29(87.8)	23(69.7)	17(51.5)	3(9.1)	12(36.4)
Separated	16(80.0)	20(100)	14(70.0)	10(50.0)	9(45.0)	9(45.0)
Widowed	19(73.1)	24(92.3)	17(65.3)	12(46.2)	7(26.9)	9(34.6)
Cohabiting	3(100)	3(100)	3(100)	2(66.7)	2(66.7)	1(33.3)

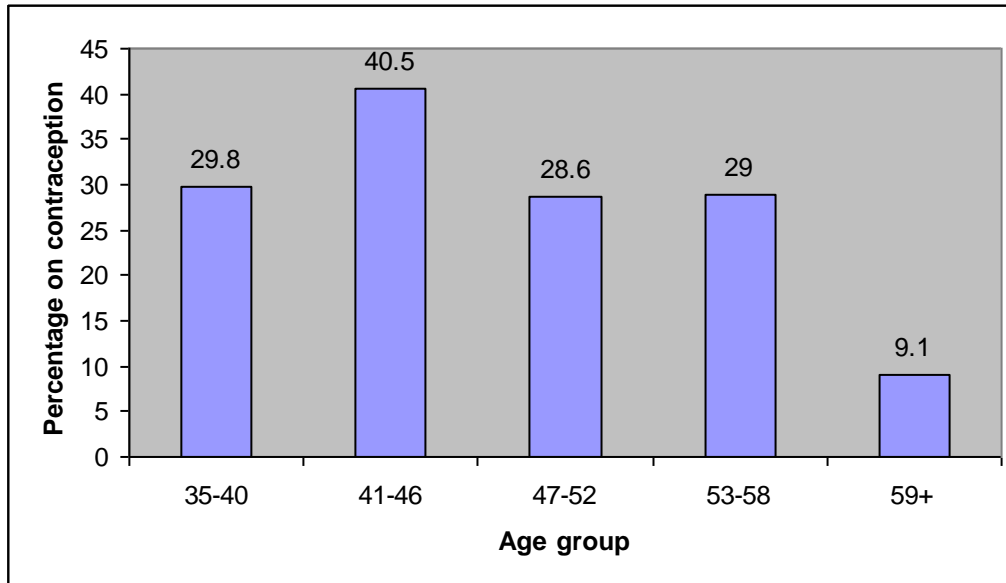
#### 4.2.3. Source of information about contraceptives/family planning

The major sources of information were the radio, television, health workers and friends in that order. Out of the 687 multiple responses received, their respective proportions were 34.8% (239), 30.6% (210), 14.8% (102) and 13.1% (90). The other sources were news papers, siblings and books 6.7% (46).

#### 4.2.4. Attitude towards contraceptive use

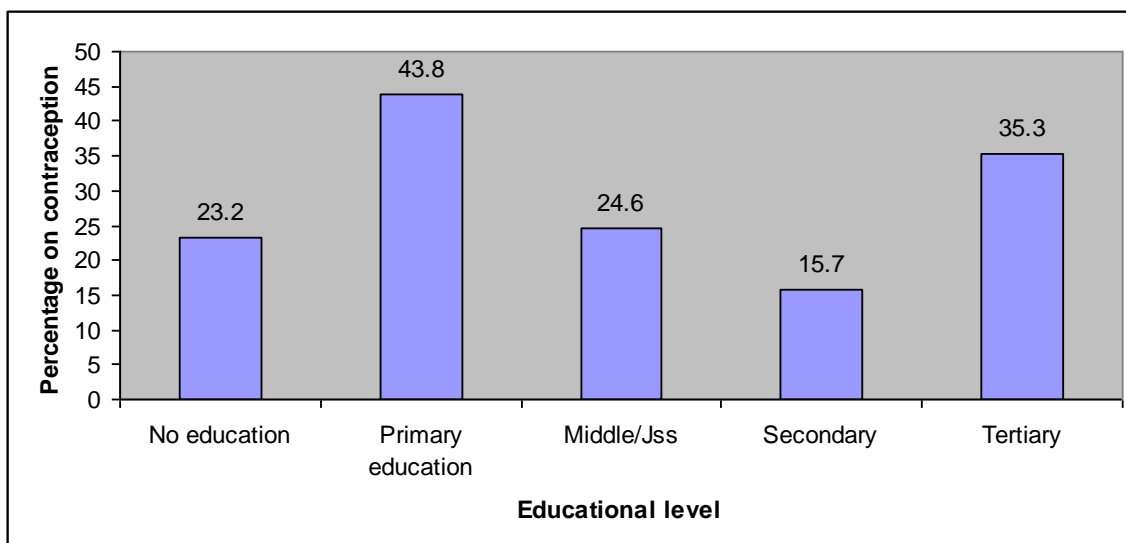
Out of the 264 respondents, 65.5% (173) had ever used contraceptives (both modern and traditional). However at the time of the interview, 26.9% (71) were using all methods while 25% (66) were on modern contraceptives. The age group with the highest proportion of the individuals using contraceptives was the 41 – 46 year group 40.5% (17/42) while the lowest was among the 59 years and above group 9.1% (5/55). The details of the age groups and contraceptive use are shown in Figure 5.

Fig 5. Percentage distribution of age group and contraceptive use



There were 89 married women. Among them 23.6% (21) were using contraceptives at the time of the interview. Contraceptive use among the Catholics was similar to the non-Catholics; 27.5% (11) vs 26.8 % (60). In addition only 2 out of the 8 responses for withdrawal, abstinence and natural/calendar methods belonged to Catholics. With regards to education, contraceptive use was 4.7% higher in those with some form of formal education than those without any formal education (27.9% vs 23.2%). Among those with formal education, those having primary education had the highest level of contraceptive use. The details of contraceptive use among the respondents at different levels of education are shown in figure 6.

Fig 6. Percentage distribution of educational level and contraceptive use



There were 71 multiple responses for the types of modern contraceptives in use. The most commonly used one was the male condom 62.0% (44) followed by the pill 19.7% (14). Only one person (1.4%) was using the female condom. The remaining were made up of the natural/calendar method 7% (5), implant 5.6% (4) and the injectable 4.2% (3). No one was using the IUCD and vaginal foaming tablets/gel. In all 23.1% (40) of the ever users of contraceptives reported side effects.

#### 4.2.5. Advantages of contraceptives for adolescents users

In all 78.8% (208) of the respondents reported that contraceptive use has advantages for the adolescent user while 6.8% (18) and 14.4% (38) respectively said there are “no” advantages or “did not know” whether there are advantages. More men than women [82.8% (96) vs 75.7% (112)] reported that contraceptive use has advantages for the adolescent user, however this difference was not statistically significant ( $p\text{-value} = 0.16$ ).

There were a total of 209 multiple responses from those who said contraceptive use has advantages for the adolescent user. Out of these responses, 74.2% (155) mentioned both the prevention of pregnancy and STI while 23.9% (50) and 1.9% (4) respectively mentioned the prevention of pregnancy alone and the prevention of STI alone.

#### **4.2.6. Disadvantages of contraceptives for adolescents users**

In all 45.1% (119) of the respondents said contraceptive use has some disadvantages for the adolescent user and this included 50% (104) of those who reported of the advantages. Another 19.7% (52) said there are ‘no disadvantages’ while the remaining 35.2% (93) did not know whether there are any disadvantages. That there are disadvantages was similarly reported by the men and women; 44.8% (52) and 45.3% (67) respectively. Among the 195 multiple responses for the disadvantages mentioned, increase in sexual activity among adolescents was the highest 38.4% (75) , followed by the causation of ill health 30.8% (60); future infertility, 15.9% (31); destruction of the reproductive organs, 7.7% (15) and weight gain,7.2% (14) in that order.

#### **4.2.7. Opinion on whether sexually active adolescents should use contraceptives**

Over all 65.2% (172) of the respondents agreed that sexually active adolescents should use contraceptives while 30.3% (80) and 4.5% (12) respectively disagreed and remained neutral respectively. While about 61% (90) of the females agreed that sexually active

adolescents should use contraceptives, about 71% (82) of their male counterparts agreed so.

For those who agreed, 49.5% (85) reasoned out that it will prevent adolescent pregnancies, while 30.2% (52) and 20.3% (35) respectively mentioned the prevention of both pregnancy and STI, and the prevention of STIs alone as their reasons.

With regards to formal education, 60.7% (34) of those with no education agreed that sexually active adolescents should use contraceptives. Those with primary, middle/JSS, secondary and tertiary educations had 71.9% (23), 65.3% (79), 68.4% (26) and 58.8% (10) respectively.

Table 8 shows factors that significantly affected parents' opinion on adolescent contraceptive use. These factors were not being a Catholic by religion, agreeing that contraceptives have advantages for adolescent users, that contraceptive use has no disadvantages for adolescent users and discussing contraceptives with another adult. Others were prior and current contraceptive use. Belief that contraceptive use has advantages for adolescent users and respondents' prior contraceptive use remained significant after logistics regression.

Table 8. Factors associated with parents agreeing that sexually active adolescents should use contraceptives

<b>Characteristic</b>	Percentage who agree	<i>p</i>
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<b>Sex of parent</b>		
Male	71.9	
Female	65.2	>0.05
<b>Age</b>		
</= 40 years	74.4	> 0.05
> 40 years	64.8	
<b>Education</b>		
None	62.9	>0.05
Some education	69.7	
<b>Religion</b>		
Catholics	47.4	<0.05
Non Catholics	72.0	
<b>Marital status</b>		
Married	72.7	>0.05
Never married	81.0	
<b>Occupation</b>		
Employed	68.8	> 0.05
Unemployed	62.9	
<b>Current adolescent care</b>		
Yes	69.5	>0.05
No	66.3	
<b>Contraceptive use</b>		
Ever used-Yes	78.8	<0.001
Ever used-No	48.3	
<b>Contraceptive use</b>		
Current use-Yes	84.5	<0.001
Current use- No	61.8	
<b>Contraceptive has adv</b>		
Yes	76.5	<0.05
No	41.2	
<b>Ever talked to male adol</b>		
Yes	75.9	>0.05
No	66.6	
<b>Ever talked to female adol</b>		
Yes	68.0	>0.05
No	68.4	
<b>Ever discussed with an adult</b>		
Yes	73.2	<0.05
No	56.1	

For the respondents who disagree to sexually active adolescents using contraceptives, the commonest reason given was that its use will increase sexual activity among adolescents 57.5% (46) followed by 18.8% (15) who said adolescents are supposed to abstain from

sexual intercourse. Another 12.5% (10) cited the causation of ill health, 5% (4) each mentioned religious reasons and the fact that adolescents are too young to use contraceptives as their reason. The remaining 1.2% (1) mentioned future infertility as the reason.

Lack of sufficient knowledge about contraceptives was the most frequent reason given by those who remained neutral 83.3% (10). One person (8.3%) said she had no child at that age and the other (8.3%) was undecided because according to him whereas the use of contraceptives will promote sexual promiscuity, non use will also lead to adolescent pregnancies.

#### **4.2.8. Hypothetical contraceptive use by adolescents**

To the question about what respondents will do in case they find an adolescent under their care using contraceptives without their knowledge, there were 333 multiple responses for the male and 334 multiple responses for the female adolescents.

For the male adolescent, 40.3% (143) of the responses were to “ask him to abstain from sex” and this was similarly reported by male and female parents at 39% and 41.1% respectively. This was followed by “asking him to stop using the contraceptive” 28.8% (96) which was also reported similarly in both male and female parents at 30.4% (45) and 27.6% (51) respectively.

With respect to the female adolescent, 44.3% (148) of the responses were for "asking her to abstain" from sex. About 44% (64) male responses and 45% (84) of female responses were for this. The second commonest response 29.9% (100) was to "ask her to stop using the contraceptive". There was 2.4% more responses for encouraging the male adolescent to use contraceptives than there was for the female [9.9% (33) vs 7.5% (25)]. The details of these and other responses are shown in Figures 7 and 8

Fig 7: Reaction of parents towards female adolescent

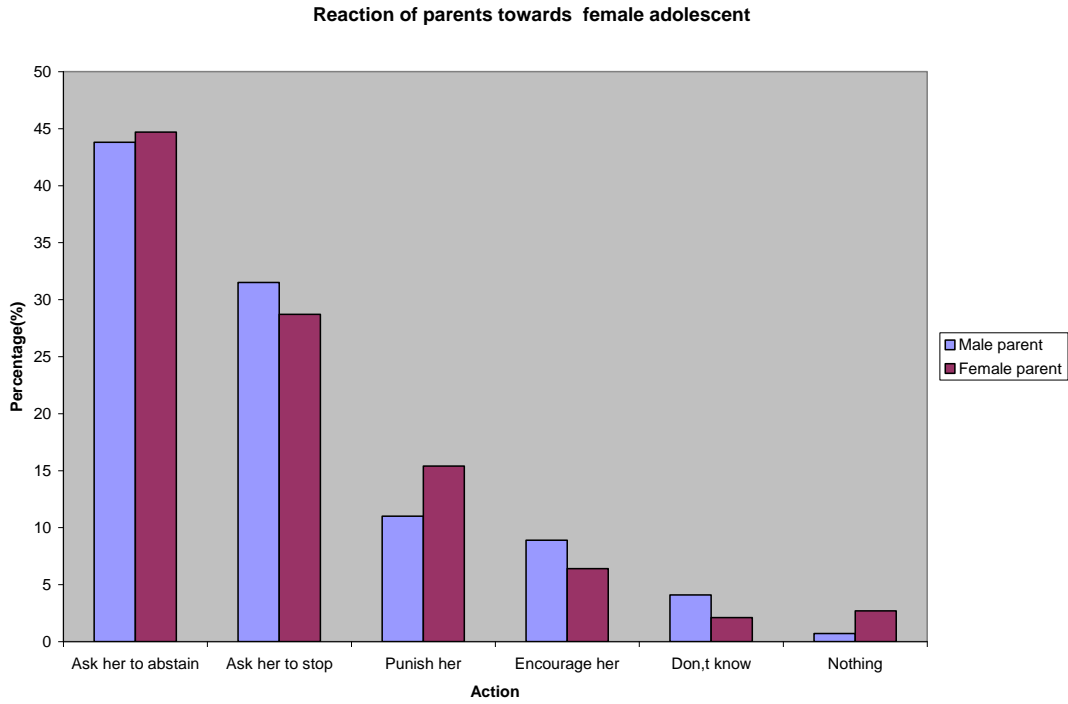


Fig 8: Reaction of parents towards male adolescent

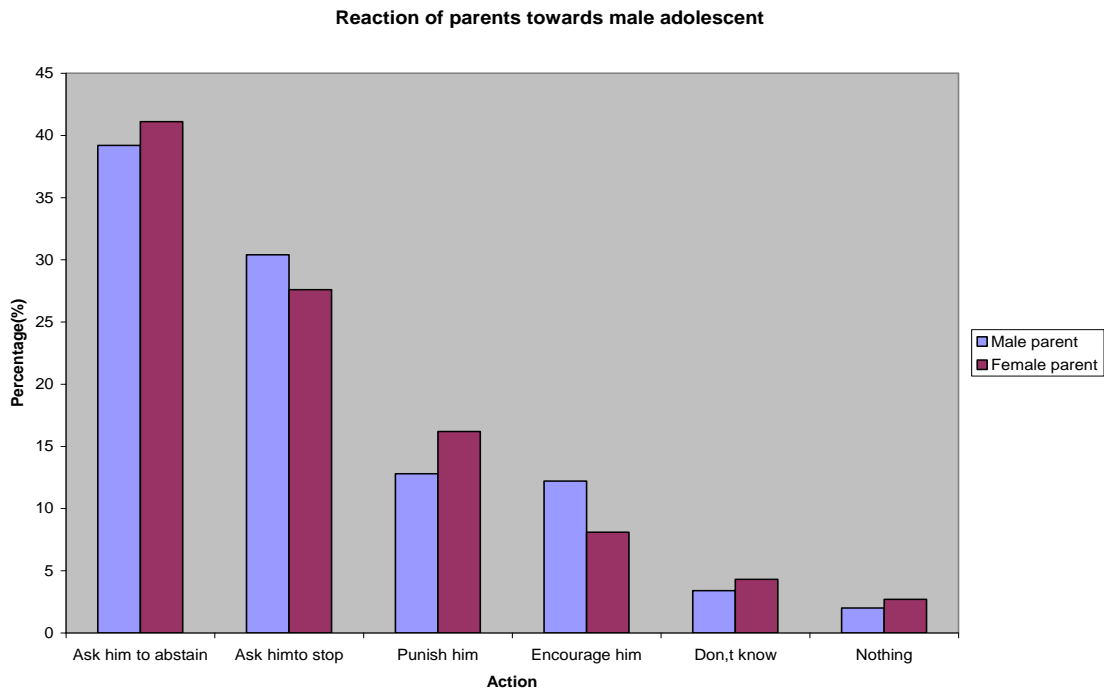


Table 9. Parental opinion on adolescent contraceptive use and response to hypothetical contraceptive use by male adolescent

Reaction to hypothetical adolescent contraceptive use	Opinion on adolescent contraceptive use					
	Male parent			Female parent		
	Disagree N=46	Agree N=98	p-value	Disagree N=63	Agree N=112	p-value
	%	%		%	%	
Stop	43.5	24.5	0.02	30.2	25.9	0.5
Punishment	19.6	9.2	0.07	19.0	14.4	0.4
Nothing	0	3.1	0.2	1.6	3.6	0.3
Encourage	0	18.4	0.001	1.6	12.5	0.01
Don't know	0	5.1	0.17	1.6	4.5	0.3
Abstain	36.9	39.7	0.7	46	39.2	0.3

Among male parents who agreed to adolescent contraceptive use, it was about 22% who would either encourage the male adolescent to use contraceptives or say nothing in case he is found using contraceptives. For the female parents who agreed to adolescent contraceptive use, about 16% would do the same as their male counterparts who agreed to adolescent contraceptive use.

Significantly, male parents who agreed to adolescent contraceptive use were more likely to encourage their male adolescents to use contraceptives rather than asking them to stop as compared to their counterparts who were not in favour of adolescent contraceptive use.

Female parents in favour of adolescent contraceptive use were also significantly more likely to encourage their male adolescents to use contraceptive in case they found them using contraceptives.

Table 10. Parental opinion on adolescent contraceptive use and response to hypothetical contraceptive use by female adolescent

Reaction to hypothetical adolescent contraceptive use	Opinion on adolescent contraceptive use					
	Male parent			Female parent		
	Disagree N=45	Agree 97	p-value	Disagree N=59	Agree N=117	p-value
	%	%		%	%	%
Stop	40	28.1	0.1	27.1	29.1	0.7
Punishment	15.6	8.2	0.1	13.6	15.4	0.7
Nothing	0	1.0	1.0	1.7	2.5	1.0
Encourage	0	12.4	0.008	0	10.3	0.009
Don't know	0	6.2	0.1	1.7	1.7	1.0
Abstain	44.4	43.3	0.8	55.9	41	0.06

Only about 13% each of the male and female parents who were of the opinion that sexually active adolescents should use contraceptives would either encourage the female adolescent to use contraceptives or say nothing in case she was found using contraceptives. Both male and female Parents who favoured adolescent contraceptive use were more likely to encourage the female adolescent to use contraceptive if found using one.

In addition female parents who were against adolescent contraceptive use were more likely to ask the female adolescent to abstain from sex rather than use contraceptives than their counterparts who favoured adolescent contraceptive use. This nearly reached statistical significance (p-value = 0.06).

#### **4.2.9. Communication with adolescents about contraceptives**

In all 78.8% (208) of all the respondents felt there was the need to talk to male adolescents about contraceptives while 21.2% (56) did not think so. While 81.1% (120) of the female parents thought so, 75.9% (88) of the male parents thought so.

For the female adolescent, 76.9% (203) of all the respondents agreed that she should be talked to about contraceptives while 23.1% (61) did not agree. While among the female parents the agreement proportion was 79.7% (118) it was 73.3% (85) of the male parents. Thus relatively more female parents thought adolescent needs to be talked to about contraceptives than their male counterparts. The difference of 5.2% and 6.4% for parental agreement for the male and female adolescents respectively was not statistically significant; (p-values of 0.2 and 0.3) respectively.

The most common reason given by the proponents for talking to adolescents about contraceptives was that it will help to prevent adolescent pregnancy 33.7% (70) and 42.3% (86) for the male and female adolescent respectively. For those against discussing contraceptives with adolescents, the most frequent reason given was that doing so will be tantamount to asking them to use it and hence sexual activity will increase among them.

This was similarly reported at 82.1% (46) for the male adolescent and 82.0% (50) for the female adolescent. The details of these and other responses are shown in Table 11.

All the 203 respondents who agreed that female adolescents need to be talked to about contraceptives also agreed that the same should be applied to male adolescents. However 2.4% (5) out of the 208 respondents who agreed that male adolescents need to be talked to did not agree that female adolescents should be talked to.

Table 11. Reasons why adolescents should or should not be talked to about contraception

<b>REASON</b>	<b>Male adolescent</b>	<b>Female adolescent</b>
	n (%)	n (%)
<b><u>Should be talked to</u></b>		
Prevent pregnancy	70(33.7)	86(42.3)
Prevent STIs	45(21.6)	40(19.7)
Need to educate them on contraceptives	36(17.3)	36(17.7)
Prevent both pregnancy and STI	33(15.8)	20(9.9)
To prevent them from using it	13(6.3)	16(7.9)
To prevent them from having sex	11(5.3)	5(2.5)
<b>Total</b>	<b>208(100)*</b>	<b>203(100)*</b>
<b><u>Should not be talked to</u></b>		
Will increase sexual activity	46(82.1)	50(82.0)
Too young	3(5.4)	5(8.2)
Not important	3(5.4)	3(4.9)
Others	4(7.1)	3(4.9)
<b>Total</b>	<b>56(100)</b>	<b>61(100)</b>

\* Responses are multiple

#### **4.2.9.1. Parental initiation of discussion with their adolescents involving contraception**

While about 38% (99) of parents reported that they had ever discussed contraception with their female adolescent, this was about 12% lower, 26% (70) for the male adolescent. Thus significantly more parents had discussed contraception with their adolescent females than males ( $p < 0.05$ ).

While 29.3% (34) of the male parents reported ever discussing contraception with their male adolescents 31% (36) reported doing so with their female adolescents. About 42% (63) of the female parents reported having discussed contraception with their female adolescents and 24.3% (36) had done so with the male adolescent. Male parents have talked about contraception with their adolescent males and females equally. Significantly however, female parents have talked to their female adolescents about contraception more than their male adolescents (42.3% vs 24.3%,  $p < 0.001$ ).

In addition while about 52% (33) of the female parent to female adolescent discussions were part of routine advice it was 44% (16) of the male parent discussion that was part of routine advice. Whereas 50% (18) of the male parent initiated female adolescent discussion arose when the parent either suspected or had evidence that the adolescent was involved in an amorous relationship, this occurred in 39.4% (22) of the female parent initiated discussions. The remaining cases of discussion in both the male and female parents came about when either an adolescent female in the community had become pregnant, had induced abortion or someone had died from unsafe abortion.

For the male adolescent, about 44% (15) of the male parent initiated discussions were part of routine advice while this was so in about 39% (14) of the female parent initiated discussions. The remaining discussions from both parents arose when the parents suspected or had evidence that the male adolescent was involved in an amorous relationship.

Overall 55.5% (51) and 58.6% (41) of the discussions with the female and male adolescents respectively were reactionary. In 81.4% (57) and 79.8% (79) of cases, the male and female adolescents respectively were advised to abstain from sex. The remaining 18.4% (13) of the male and 20.2% (20) of the female adolescents were advised to use contraceptives outright or to abstain from sex but to use contraceptives if they could not abstain.

#### **4.2.9.2. Ideal age to talk to adolescents about contraceptives**

The median age at which parents thought male adolescents are old enough to be talked to about contraceptives was 16 years while that for the female adolescents was 15 years. While 40.5% (107) of parents felt girls should be talked to as young adolescents, only 18.9% (50) expressed the same feeling for the male adolescents. The difference of 21.6% between them was statistically significant [ $p\text{-value} < 0.001$ ].

Among the 208 parents who agreed that there is the need to talk to male adolescents about contraceptives, about 95% (198) will feel comfortable discussing this issue with them. In addition 57.1% (32 out of 56) of those who did not agree that contraceptives should be discussed with male adolescents will also feel comfortable if they have to do

so. Furthermore, all the parents who had ever discussed contraceptives with their male adolescents felt comfortable doing so. About 80% (160) of the parents who have never discussed contraceptives with their male adolescents will feel comfortable if they had to do so.

With regards to the female adolescents, 94.1% (191) of the parents who agreed that there is the need to talk to female adolescents about contraceptives will feel comfortable doing that. About 57.4% (35) of the parents who did not agree that contraceptives should be discussed with female adolescents will also feel comfortable if they have to do so. About 98% (97) of those who have ever communicated with a female adolescent about contraceptives felt comfortable doing so. Also about 76% (125) of the parents who had never discussed contraceptives with their female adolescents will feel comfortable if they have to do so.

One hundred and fifty four parents have never discussed contraceptives with an adolescent. As to what message they will give if they should get the opportunity, 61% (94) said they would rather ask them to abstain from sex. About 18% (27) will advice them to abstain from sex but then to use contraceptives if they cannot abstain. While 14.3% (22) will advice them to use contraceptives outright, 4% (6) will advice them not to use contraceptives. The remaining include 4 who will not want to talk about contraceptives with adolescents and one who did not know what to say.

#### **4.2.10. Communication about contraception among adults**

On the whole about 70% (184) of all the respondents had ever discussed contraception with other adults and there were 235 multiple responses of such interactions. Most discussions had taken place between friends, 35.3% (83), followed by spouses, 32.8% (77), co-workers, 15.7% (37), health workers, 9.4%(22) and finally siblings 6.8% (16) in that order.

### ***4.3 RESULTS OF FOCUS GROUP DISCUSSION***

#### **4.3.1. Results of male parent focus group discussion**

The participants for the focus group discussion were selected with the help of the community elders. Six men were involved in the discussion and their ages ranged from 40 to 73 years. In terms of occupation there was one each of a retired civil servant, a mechanic, a driver, a businessman, self employed printer and an unemployed man

There was the general consensus that premarital adolescent sexual activity, pregnancy and termination of pregnancy were common in the community.

##### **4.3.1.1 Knowledge about modern contraceptives**

The participants knew about modern contraceptives. Among the methods for preventing pregnancy that were mentioned were temporary abstinence, calendar methods, implants, injectable, withdrawal, the male condom and the IUCD. Female sterilization was also mentioned. The sources of information for contraceptives included non governmental organization, radio, television and health workers.

The advantages of using contraception were to allow one to have the number of children he can cater for and also to space birth. Only one of the participants reported his wife had used the IUCD and experienced excessive bleeding.

#### **4.3.1.2. Communication between parents and adolescents**

Adolescents generally do not discuss contraception with their parents. Parents will not encourage the discussion of relationships even among the adolescents. One parent said;

“We have daughters and they have friends. You can see that when they meet they discuss about their boy friends and girl friends and to me if I am there and I hear that the girl from the other house has come to my house and my daughters are there, and they start talking about girl friend and boy friends I become worried. I don’t want to hear that or for those things to go on. The only thing I do is to stop them from mentioning or talking about girlfriends and boyfriend”

There was mixed response to the question whether adolescents should be talked to about contraceptives or not. One view was that doing so will lead to increase sexual activity among the adolescents. One participant put it this way:

“The children who have come, the moment you show them the way to family planning it means you are opening the gateway for them.”

Others felt there was the need to talk to adolescents about contraception so that they will know what to do as adults. One participant chipped in this;

“In modern society you need to let your children know about family planning for them to plan in their marriage. In future you will marry. In Africa the women suffer. It will help them in the future when they marry. It is your daughter who is

going to marry. The woman suffers more than the man, let us put education level aside. There is no work for the man. The woman will take care of the whole household. Three months after delivery no matter what you do your husband will have sex with you. You will have to go to family planning after delivery so that you can have about 2 or 1 year after delivery before you have another child”.

On the whole parents hardly discuss contraception with their children. The few occasions that they had done so, it was done in a reactionary manner. For example when a mishap such as teenage pregnancy or abortion has occurred and when they suspect the children were involved in amorous relationships. For those who discuss contraception with their children most of them tell them about the so called side effects and tend to put fear in the adolescents to deter them from using contraceptives. There was the general notion that once contraception is mentioned the focus is on the female adolescent

#### **4.3.1.3. Opinion on contraceptive use by adolescents**

Majority of the parents will not advice the use of contraceptives by the adolescents.

There was the general belief that contraceptive (especially the pill) use will have adverse health effects on adolescents. Even though they knew contraception will protect the adolescents against pregnancy, the fear of side effects will not allow them to encourage the adolescents to use them especially the females. There was the fear that the use of the pill over a long period will lead to infertility as indicated below:

“The more she uses it, it will give her problems. What I know, I don’t know whether it is true or not, if you use those pills for long it will affect your birth. The

doctor will have to wash your womb or do something before the women become pregnant so I'll advise them not to use it".

They will rather try to "control" them by making sure they do not go out, and tell the girls to avoid men. For those above 18 years they can use condoms to protect themselves against sexually transmitted infections if they refuse to abstain from sex.

#### **4.3.1.4. Parental reaction to adolescents who use contraception**

Most of the participants reported that they will not be happy if they should find their adolescents using contraceptives. As to how parents react when they find their adolescents with contraceptives, the consensus was that it was difficult to tell how people will react. Parents would not want to expose their children to others as they live in family houses and so may react in private as indicated by one parent:

"We live in a compound community, we share compound house Alajo, if I shout now to say hee! the number of people who will come out plenty people 20 or 30 people will come out. Why? Because I've seen that my child has something"

None of the participants has had the opportunity to react. However, none of the parents said he will encourage the adolescent to use contraceptives outright. This is what one participant said:

"For me if I see condom with my child, I've not seen some before. But if I see something like that I will be troubled. I will put fear in him because it can tear and fail. If he tries to use it at some point it will tear and it will bring problem".

Another person also said he will advise the child to stop using the contraceptive and to abstain from sex. Some of them will allow their children to use contraceptives only when the children refuse to heed the advice to abstain from sex.

#### **4.3.2. Female parent focus group discussion**

The participants for the focus group discussion were selected with the help of the community elders. Six women were involved in the discussion and their ages ranged from 35 to 70 years. One of them was unemployed, one was a housewife and the remaining were traders.

There was the general consensus that premarital adolescent sexual activity, pregnancies and induced abortions were common in the community.

##### **4.3.2.1. Knowledge about contraceptive**

Knowledge about modern contraceptives was very high among the participants. The methods mentioned included temporary abstinence, natural/calendar methods, implants and injectables. Others were the male and female condoms, vaginal foaming tablets, the IUCD and female sterilization. Again family planning was seen as a women's business. The radio, television, and health workers were the main sources of information.

#### **4.3.2.2. Communication between parents and adolescents**

Generally parents do not talk to their children about contraceptives. Participants were of the opinion that talking to adolescents about family planning will be equal to encouraging them to engage in sexual activity. What generally happens was that the female adolescents especially will be advised to keep away from men when parents suspect they are in amorous relationships. This is what one participant said:

“You need to check your child especially the girls. You have to know when they get their period and make sure they do not go out for the boys. You cannot call your child and say do family planning. If through their behaviour and dressing you think they have boyfriend you advise them to take good care of themselves. You advise them that what you are doing beware you can become pregnant.”

There was a general notion that contraceptives/family planning is for those who have already delivered. One of the participants said:

“I think family planning is good for those who have delivered. I don’t know that those who have not delivered can use family planning. When you deliver you can go to the hospital and do family planning”

Another participant also posed this question;

“But can someone who has not delivered before use family planning? I know it is used to stop delivering”.

#### **4.3.2.3. Opinion on contraceptive use by adolescents**

Most of the participants were of the opinion that adolescents should not use contraceptives. If anything at all they will prefer the male adolescents to use male condoms to prevent HIV. One parent put it this way;

“They can use the condom but not family planning. That one is normal, as for the boys they can use the condom to prevent HIV. The female one is not good”

#### **4.3.2.4. Parental reaction to adolescents who use contraception**

As to how parents react when they find their adolescents with contraceptives. None of the participants has found any adolescent under their care using contraception. They did not deny the fact that some adolescents may be on contraception. An elderly woman had this to say:

“Will you even know? Nowadays the children they will not let you know”

However none of the participants said they will be happy to see their children using contraceptives especially the hormonal ones. One participant summed up what her reaction will be as follows:

“I will shout and let every one know about it. I will tell her that these things you are doing will give you problems in the future. When you grow it can make it difficult for you to become pregnant. It is not good for those who have not delivered. I will give her strong warning to desist from using it”

## **CHAPTER FIVE**

### **DISCUSSION**

The study found that almost all respondents knew about modern contraceptives. In addition over 95% of the parents and adolescents knew how STIs can be effectively prevented by either using the condom or abstaining from sex.

Furthermore, above 60% of both parents and adolescents approve of contraceptive use by adolescents. For the adolescents, factors that were significantly associated with one approving of adolescent contraceptive use were being an old adolescent, being in-school, sexually active and exposure to contraceptive use. With regards to the parents, not being a Catholic by religion, agreeing that contraceptive use has advantages for adolescents, that there are no disadvantages of contraceptive use for adolescents, prior or current contraceptive use and discussing of contraceptives with another adult were positive factors associated with approval of contraceptive use by adolescents.

In terms of communication, fewer than 10% of the adolescents had initiated a discussion that involved contraception with their parents. Whereas almost 40% of parents indicated that they have initiated a discussion with their female adolescents, just under 30% of the female adolescents reported that their parents have initiated such a discussion. Similarly, while just under 30% of parents indicated that they have initiated a discussion with their male adolescent, just about 20% of the male adolescents reported that their parents have initiated such a discussion. Most of the parent initiated discussions were reactionary in nature and in majority of the cases; the adolescents were advised to abstain from sex

### **Knowledge and use of contraceptive methods**

The high level of knowledge of at least one modern contraceptive (99.6%) for both the adolescents and adults found in this study is comparable to what has been found in other studies in Ghana (GDHS, 2003; Agyei et al., 2000). It was also encouraging to note that majority of the respondents knew that condoms can be used to prevent STIs. In Ghana it is considered that provision of contraceptives to sexually active adolescents is in the right direction (Ghana Health Service, 2003). It is recommended that abstinence be used as the first line of protection against pregnancy and STIs for adolescents. However, for those who cannot abstain from sex then contraceptives must be used and dual protection with the condom is ideal (NPC, 2000).

This study has also supported Oindo's (2002) finding that parents are a poor source of information on contraceptives for adolescents as compared to peers and educational institutions. Parents contributed only 3% of the sources of information on contraception for adolescents as compared to the 20% and 9% from teachers and friends respectively. Much as adolescents would have liked to get sex-related information from their parents (Mturi, 2000; UG/GHS, 2000) this is not the case in most African countries (Mulugeta, 2003; Oindo, 2002).

That about 24% of the married women were on contraception was lower than the 33% for the Greater Accra region (GDHS, 2008). It is said that adolescents in religions that are against modern contraception are less likely to use modern contraceptives (Kramer et al., 2007). However for the adolescents in this study contraceptive use among the sexually

active Catholics was higher than the other Christian denominations (68% vs 54%). For those who reported being sexually active, 25.3% (22) had not used a contraceptive before.

About 31% (87) reported being sexually active (i.e. having ever had penile vaginal sexual intercourse) at the time of the interview. However, 67.1% (186) reported that they either have a friend or knew someone about their age who was sexually active in the community. In societies where adolescent premarital sex and pregnancy are frowned upon, self reports of such activities are more likely to be lower than expected. The actual level may be what they say their friends are doing (Bankole et al., 2007). During the focus group discussions parents were of the view that adolescent sexual activity, pregnancy and abortion were common in the community.

### **Opinion on contraceptive use by adolescents**

It is said that parents with higher education tend to approve of contraceptive use by adolescents (Speizer, 2001). In this study however parents with primary education had the highest proportion of those approving of contraceptive use by adolescents (71.9%). Those with tertiary education rather had the lowest percentage (58.8%) of those agreeing to contraceptive use by adolescents.

With regards to adults, sex may be important in their opinion towards contraceptive use by adolescents. While 72% of the adult males approved of contraceptive use by adolescents it was 65% of females that approved. Speizer et al., (2001) found that 52%

and 69% of women and men respectively approved of contraceptive use by adolescents. The 65% approval rate for the females is very high compared to the 28.1% observed by Briggs (1998) in Nigeria. This discrepancy could be due to the fact that Briggs study concentrated on the parents of pregnant adolescents. These parents own personal ideas against contraception might have played part in their children not using contraceptives and hence their pregnancies.

Among the parents in this study, belief that contraceptive use has advantages for adolescent users and respondent's prior contraceptive were significantly associated with agreeing that sexually active adolescents should use contraceptives.

For the adolescents 63% were in favour of contraceptive use by adolescents. The major reasons given for this opinion were the prevention of pregnancy and STI. Being an old adolescent, sexually active, having ever used contraceptives and being in school were significantly associated with an adolescent agreeing to contraceptive use by adolescents. . Adolescent males were more likely to disagree to contraceptive use by adolescents than their female counterparts (36% vs 30%)

In both the adolescents and parents some of the reasons given against the use of contraceptives by adolescents such as, increase sexual activity, ill health and future infertility are based on misconceptions. One male participant in the focus group discussion put it this way:

“I in particular I do not teach them family planning. The children who have come the moment you show them the way to family planning it means you are opening the gateway for them”

These findings however are not peculiar to this community as it has been found in other parts of Africa (Mbonile et al., 2008; Otoide et al., 2001; Briggs, 1998). Again views held by some that adolescents are supposed to abstain from sex have also been expressed by some respondents in other countries (Mturi, 2003; Briggs, 1994).

Despite the fact that a significant proportion of the parents were of the opinion that sexually active adolescents should use contraceptive, they may not hold the same view in reality. During the focus group discussions, it was evident that most parents do not approve of contraceptive use by adolescents.

When asked what parents will do in case they find their male adolescents using contraceptives without their knowledge, true to their word, none of the male parents who disagreed to adolescent contraceptive use said he will encourage the adolescent to use the contraceptive. For those who agreed to adolescent contraceptive use, it was 18% who said they will encourage the adolescent to use the contraceptive. Actually 25% of them said they will ask the male adolescent to stop it while 9.2% will meet out punishment to the adolescent.

Similarly, only about 2% of the female parents who disagree to adolescent contraceptive use will encourage their male adolescent to use contraceptives should they find them

using one. However, only 13% of those who agree to adolescent contraceptive use will encourage the adolescent to use the contraceptive. Indeed while 26% said they will ask the adolescent to stop using the contraceptive, 14% will punish the adolescent.

While none of the male parents who disagreed to adolescent contraceptive use will encourage the female adolescent to use the contraceptive, only 12.4% of those who agree to adolescent contraceptive use will do so. About 29% and 8% of those who agree to adolescent contraceptive use will ask the adolescent to stop using the contraceptive or punish her respectively.

While none of the female parents who disagreed to adolescent contraceptive use will encourage their female adolescent to use contraceptives should they find them using one, only 10.3% of those who agree will encourage the adolescent to use it. In addition, 29% of those who agreed to adolescent contraceptive use said they will ask the adolescent to stop using the contraceptives while another 15% will punish the adolescent.

The above points clearly indicate parental ambivalence concerning their opinion and what they will do in the matter of promoting adolescent contraceptive use. It is rather unfortunate that some parents even view contraceptive use as a punishable offence. Again male parents will promote contraceptive use among their adolescent boys than girls.

The adolescents on their part fear parental reaction should they use contraceptives and are found out. Over 40% of the adolescents anticipate that their parents will be angry with

them in case they should find them with contraceptives. This fear was substantiated in the focus group discussion when one female parent gave the response below to the questions what she would do in case she finds her child using contraceptives:

“I will shout and let every one know about it. I will tell her that these things you are doing will give you problems in the future. When you grow it can make it difficult for you to become pregnant. It is not good for those who have not delivered. I will give her strong warning to desist from using it”

### **Communication**

Only about 6% and 10% of the adolescents have initiated a discussion that involved contraception with their male and female parents respectively. Relatively more male adolescents initiated the discussion with their male parents and vice versa. Majority of the discussions initiated by the male adolescents with the male parents came about when they were taught about contraceptives in school or when they started having nocturnal emissions. The female adolescents were engaging their female parents around the time of puberty.

In majority (90%) of the adolescent discussions with their parents they were advised to abstain from sex with just about 6% and 10% of the male and female parents advising the adolescents to use contraceptives if they cannot abstain from sex.

The notion that contraceptive use by adolescents will lead to increase sexual activity is a factor that was observed in both the adolescents and parents. This finding is not peculiar to the study community as other studies have also revealed this thought (Mbonile et al.,

2008; Oindo, 2002). Some studies have however shown that telling adolescents about contraception does not increase sexual activity (Kirby et al., 2007).

Of equal concern is the fact that about 7% of parents were of the opinion that telling adolescents about the negative effects of contraceptives will deter them from using it and thus abstain from sexual intercourse. During the focus group discussion, this is what one male parent said:

“For me if I see condom with my child, I’ve not seen some before if I see something like that I will put fear in him because it can tear and fail. If he tries to use it at some point it will tear and it will bring problem”.

As much as parents must be partners in providing reproductive health knowledge to adolescents some of them may rather deter sexually active adolescents from using contraceptives.

In all 78.8% of the parents felt there was the need to talk to male adolescents while 76.9% shared the same opinion for the female adolescent. However, only about 30% of the male parents reported that they have initiated a discussion on contraception with their male and female adolescents. In contrast about 20% of the male adolescents reported of such interaction. Similarly while 31% of the male parents reported having discussed contraception with their female adolescents only about 18% of female adolescents reported that their male parents have initiated a discussion of that sort.

Again while 42% of the female parents reported having initiated a discussion about contraceptives with their female adolescent's only 36% adolescent females reported of such initiation with the female parent. In addition while 24% female parents reported they had done so with their male adolescent only 16.8% of male adolescents reported such a discussion. During the focus group discussions however, it was made evident that parents hardly talk to their adolescents about contraception.

Despite the discrepancies, majority of the adult initiated discussions were reactionary to suspected amorous relationship of the adolescent or as a reaction to an adolescent pregnancy. Oindo (2002) indicated that more parents will rather prefer to talk on issues about sex in a reactive than a proactive manner. Invariably these adolescents were just advised to abstain from sex which might not be ideal. It has been observed that adolescent education based on abstinence only often fail as many are not able to observe the abstinence and have sex (Klein et al., 2007).

Majority of the parents who had not discussed contraception with adolescents before said they will feel comfortable to discuss contraception with adolescents. However, the fact that they had not done it may mean they shy away from the topic (Briggs, 1998). After all as indicated by the adolescents they freely discuss other issues such as education, religion and sports with their parents.

While 40% of parents felt girls should be talked to as young adolescents, fewer than 20% felt so for the male adolescents. Parents are therefore more likely to talk to their female adolescents at a younger age than their male adolescents.

Considering the fact that self reported sexual activity rose sharply between the transition from young to old adolescent, it would be advisable for parents to discuss contraceptives with adolescents while they are still young. Waiting for them to attain 15 years may be too late for some of them by which time they might have been pregnant or contracted STIs. The fact that more female adolescents had been talked to than their male counterparts could be due to the common notion held that contraception is a woman's business.

## **CHAPTER SIX**

### **CONCLUSION**

Most of the respondents knew that contraceptive use among adolescents will prevent sexually transmitted infections and pregnancies. Majority of parents and adolescents were of the opinion that sexually active adolescents should use contraceptives. For the parents belief that contraceptive use has advantages for adolescent users and respondents' prior contraceptive use were significantly associated with agreeing that sexually active adolescents should use contraceptives. In the case of the adolescents being sexually active was the only significant factor after logistic regression.

It was however clear that few parents would actually encourage adolescents under their care to use contraceptives even if they are sexually active. The adolescents also anticipated that parents would react adversely if they were found using contraceptives.

There was discrepancy between parents and adolescents on the level of discussion between them involving contraceptives with higher reporting by parents than adolescents. While majority of the parents were of the opinion that there was the need to talk to adolescents about contraceptives, less than half of them reported they had done so. This may mean they shy away from the subject. Most of the parent-adolescent discussions were reactionary to incidents such as pregnancy, puberty, or as a follow up to introduction to family planning at school. In all these, the main message given to the adolescents was to abstain from sex

Both parents and adolescents had misconceptions about what information on contraceptives and contraceptive use itself can do to adolescents. Among these misconceptions include the notion that contraceptive use among adolescents will lead to increase sexual activity, that family planning is meant to stop childbearing and that family planning is meant only for those who have delivered before. Others are that the use of contraceptives will cause ill health in adolescents and future infertility.

## **RECOMMENDATIONS**

1. To the Ayawaso Central Health Directorate, there is the need to educate both parents and adolescents to dispel misconceptions about contraceptive use by adolescents.
2. To the Ayawaso Central Health Directorate, there should be promotion of contraceptive use among adults as this may lead to positive attitude towards adolescent contraceptive use
3. Parents should be encouraged to discuss contraceptives with their adolescents and encourage the sexually active ones to use them. Such advice ideally should be given when the adolescents are young adolescent as sexual activity increases sharply between the transition from young to old adolescent

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## Appendix A: Adolescent questionnaire

Attitude of Parents and Adolescents towards Contraceptive use by Adolescents in Alajo, Ayawaso Central Submetro of Accra

### ADOLESCENT QUESTIONNAIRE

Study ID \_\_\_\_\_ Date of interview \_\_\_\_\_

Respondent's ID:

#### BACKGROUND CHARACTERISTICS

1. Age of respondent: [ ] yrs [ ] mths Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Sex: 1. Male [ ] 2. Female [ ]
3. Who do you live with?
  1. Mother [ ] 2. Father [ ]
  3. Both mother & father [ ] 4. Female guardian [ ]
  5. Male guardian [ ] 6. Both male & female guardians [ ]
  7. On my own [ ]
4. How long have you been living with your parent? [ ] yrs [ ] mth
5. Marital Status: 1. Never married [ ] 2. Married [ ]
  3. Divorced [ ] 4. Separated [ ]
  5. Widowed [ ] 6. Cohabiting [ ]
6. Religion: 1. Catholic [ ] 2. Protestant [ ]
  3. Charismatic/Pentecostal [ ] 4. Moslem [ ]
  5. Traditionalist [ ] 6. No religion [ ]
  7. Others (Specify) [ ]
7. Ethnicity: 1. Ga/Adangme [ ] 2. Akan [ ]
  3. Ewe [ ] 4. Mole-Dagbani [ ]
  5. Grushi [ ] 6. Gruma [ ]

7. Dagarti [ ]

8. Hausa [ ]

9. Guan [ ]

10. Others (state) [ ]

8. Highest education attained:

1. No education [ ]

2. Primary education [ ]

3. Middle school [ ]

4. JSS [ ]

5. Technical [ ]

6. Commercial [ ]

7. Vocational [ ]

8. SSS [ ]

9. Polytechnic [ ]

10. University [ ]

9. Are you currently attending school? 1. Yes [ ] 2. No [ ]

If “Yes” move to Q11

10. If “No” Occupation N/A [ ]

1. Clerical [ ]

2. Managerial [ ]

3. Professional [ ]

4. Owner of a business [ ]

5. Trader [ ]

6. Artisan [ ]

7. Housework [ ]

8. Apprentice [ ]

9. Unemployed [ ]

10. Farmer [ ]

11. Security [ ]

12. Labourer/cleaner [ ]

13. Others (Specify) [ ]

11. (Currently attending school) do you do any thing to earn some income for yourself?

N/A [ ]

1. Yes [ ] 2. No [ ]

If “No” move to Q 13

12. If “Yes” what do you do? N/A [ ]-----

13. Have you been pregnant/made someone pregnant before? 1. Yes [ ] 2. No [ ]

If “No” move to Q 16

14. If “Yes” what happened to the pregnancy? N/A [ ]

1. Miscarriage [ ]

2. Induced abortion [ ]

3. Delivered [ ]

15. Do you have a child? N/A [ ]  
1. Yes [ ] 2. No [ ]

**KNOWLEDGE ABOUT CONTRACEPTIVE (FAMILY PLANNING)**

16. Do you know/heard of any method/way to prevent pregnancy?  
1. Yes [ ] 2. No [ ]

If “No” move to Q 18

17. If “Yes” name it/them N/A [ ]

- |                               |                                    |
|-------------------------------|------------------------------------|
| 1. Pill [ ]                   | 2. Male condom [ ]                 |
| 3. Female condom [ ]          | 4. IUCD [ ]                        |
| 5. Injectable [ ]             | 6. Implant [ ]                     |
| 7. Diaphragm/Cervical cap [ ] | 8. Vaginal foaming tablets/gel [ ] |
| 9. Vaginal ring [ ]           | 10. Patch [ ]                      |
| 11. Abstinence [ ]            | 12. Withdrawal [ ]                 |
| 13. Natural/Calendar [ ]      | 14. Others (specify) [ ]           |

18. Do you know/heard of any method/way to prevent sexually transmitted infections?

1. Yes [ ] 2. No [ ]

If “No” move to Q 20

19. If “Yes” name it/them: N/A [ ]

- |   |                         |
|---|-------------------------|
| 1. Male condom [ ]                            | 2. Female condom [ ]    |
| 3. Vaginal foaming tablets [ ]                | 4. Abstinence [ ]       |
| 5. Being faithful to your partner [ ]         |                         |
| 6. Not having sex with an infected person [ ] | 7. Others (Specify) [ ] |

20. Have you heard about contraceptives (family planning methods)? :

1. Yes [ ] 2.No [ ]

If “No” end interview

21. If “Yes” where did you hear about contraceptives?

- |                  |                   |
|------------------|-------------------|
| 1. Radio [ ]     | 2. Television [ ] |
| 3. Newspaper [ ] | 4. Friends [ ]    |
| 5. Teachers [ ]  | 6. Parents [ ]    |





32. Have you ever used contraceptives? 1. Yes [ ] 2. No [ ]

If “No” move to Q 36

33. If “Yes” which one/ones have you used before? N/A [ ]

- |                               |                                    |
|-------------------------------|------------------------------------|
| 1. Pill [ ]                   | 2. Male condom [ ]                 |
| 3. Female condom [ ]          | 4. IUCD [ ]                        |
| 5. Injectable [ ]             | 6. Implant [ ]                     |
| 7. Diaphragm/Cervical cap [ ] | 8. Vaginal foaming tablets/gel [ ] |
| 9. Vaginal ring [ ]           | 10. Patch [ ]                      |
| 11. Abstinence [ ]            | 12. Withdrawal [ ]                 |
| 13. Natural/Calendar          | 14. Others (specify) [ ]           |

34. Have you had any side effect from using a contraceptive before? N/A [ ]

- |            |           |
|------------|-----------|
| 1. Yes [ ] | 2. No [ ] |
|------------|-----------|

If “No” move to Q 36

35. If “Yes” what was it? N/A [ ]

Contraceptive	Side effect

36. Are you sexually active?

1. Yes [ ]                      2. No [ ]

37. Do you have a friend/know of anyone who is about your age in your community who is sexually active? 1. Yes [ ]    2. No [ ]

38a. (For those on contraception) what do you think your father/male guardian will do if he should find out, assuming he is not aware you are on contraception? N/A [ ]

1. Can't tell his reaction [ ]                      2. Will be angry with me [ ]  
3. Will not say anything [ ]                      4. Will ask me to stop [ ]  
5. Will sack me from the house [ ]                      6. Will disown me [ ]  
7. Will kill me [ ]                      8. Will punish me [ ]  
9. Others (specify) [ ]

38b. (For those not on contraception) Assuming you are on contraception without the knowledge of your father/male guardian, what do you think he will do if he should find out? N/A [ ]

1. Can't tell his reaction [ ]                      2. Will be angry with me [ ]  
3. Will not say anything [ ]                      4. Will ask me to stop [ ]  
5. Will sack me from the house [ ]                      6. Will disown me [ ]  
7. Will kill me [ ]                      8. Will punish me [ ]  
9. Others (specify) [ ]

39a. (For those on contraception) what do you think your mother/ female guardian will do if she should find out assuming she is not aware you are on contraception? N/A [ ]

1. Can't tell his reaction [ ]                      2. Will be angry with me [ ]  
3. Will not say anything [ ]                      4. Will ask me to stop [ ]  
5. Will sack me from the house [ ]                      6. Will disown me [ ]  
7. Will kill me [ ]                      8. Will punish me [ ]

9. Others (specify) [ ]

39b. (For those not on contraception) Assuming you are on contraception without the knowledge of your mother/female guardian, what do you think she will do if she should find out? N/A [ ]

- |                                    |                              |
|------------------------------------|------------------------------|
| 1. Can't tell his reaction [ ]     | 2. Will be angry with me [ ] |
| 3. Will not say anything [ ]       | 4. Will ask me to stop [ ]   |
| 5. Will sack me from the house [ ] | 6. Will disown me [ ]        |
| 7. Will kill me [ ]                | 8. Will punish me [ ]        |

9. Others (specify) [ ]

40a. in your opinion should sexually active adolescents use contraceptives?

- |                          |                       |                |
|--------------------------|-----------------------|----------------|
| 1. Strongly disagree [ ] | 2. Disagree [ ]       | 3. Neutral [ ] |
| 4. Agree [ ]             | 5. Strongly Agree [ ] |                |

40b. Please give reasons for your response.

### COMMUNICATION ABOUT CONTRACEPTIVES

41. Have you ever initiated a discussion with your father/ male guardian that involved talking about contraceptives? N/A [ ]

- |            |           |
|------------|-----------|
| 1. Yes [ ] | 2. No [ ] |
|------------|-----------|

If "No" move to Q 46

42. If "Yes" at what age did this first occur? [ ] yrs [ ] mths N/A [ ]

43. What brought about this discussion? N/A [ ]

44. Summary of discussion N/A [ ]

- |   |  |
|---|--|
| 1. Encouraged me to abstain from sex [ ]        | 2. Encouraged me to use contraceptives [ ] |
| 3. Discouraged me from using contraceptives [ ] |  |



54. Summary of discussion N/A [ ]

1. Encouraged me to abstain from sex [ ]
2. Encouraged me to use contraceptives [ ]
3. Discouraged me from using contraceptive [ ]
4. Other (Specify)

55. How often do you do so? N/A [ ]

1. Rarely [ ]
2. Often [ ]
3. Very often [ ]

56. Has your mother/ female guardian ever initiated a discussion with you that involved talking about contraceptives? N/A [ ]

1. Yes [ ]
2. No [ ]

If “No” move to Q 61

57. If “Yes” at what age did this first occur? [ ] yrs [ ] mths N/A [ ]

58. What brought about this discussion? N/A [ ]

59. Summary of discussion N/A [ ]

1. Encouraged me to abstain from sex [ ]
2. Encouraged me to use contraceptives [ ]
3. Discouraged me from using contraceptive [ ]
4. Other (Specify)

60. How often do you do so? N/A [ ]

1. Rarely [ ]
2. Often [ ]
3. Very often [ ]

61. Do you/will you feel comfortable discussing contraception with your father/male guardian? N/A [ ]

1. Yes [ ]
2. No [ ]

If “Yes” move to Q 63

62. If “No” what are your reasons? N/A [ ]

63. Do you/will you feel comfortable discussing contraception with your mother/female guardian? N/A [ ] 1. Yes [ ] 2. No [ ]

If “Yes” move to Q 65

64. If “No” what are your reasons? N/A [ ]

65. Have you ever discussed contraceptives with any of your friends before?

1. Yes [ ] 2. No [ ]

66. Do you/will you feel comfortable discussing contraception with your male friend?

1. Yes [ ] 2. No [ ]

If “Yes” move to Q 67

67. If “No” what are your reasons? N/A [ ]

68. Do you/will you feel comfortable discussing contraception with your female friend?

1. Yes [ ] 2. No [ ]

If “No” what are your reasons?

69. Now tell me the type of issues/other issues that you discuss freely with your mother/female guardian?

70. Now tell me the type of issues/other issues that you discuss freely with your father/male guardian?

Interviewer. \_\_\_\_\_

THANK YOU

## Appendix B: Parent questionnaire

Attitude of Parents and Adolescents towards Contraceptive use by Adolescents in  
Alajo, Ayawaso Central Submetro of Accra

### PARENT QUESTIONNAIRE

Study ID \_\_\_\_\_ Date of interview \_\_\_\_\_

Respondent's ID: \_\_\_\_\_

#### BACKGROUND CHARACTERISTICS

1. Age of respondent: [ ] yrs [ ] mths      Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
2. Sex: 1. Male [ ]      2. Female [ ]
3. Marital Status:
  1. Never married [ ]      2. Married [ ]
  3. Divorced [ ]      4. Separated [ ]
  5. Widowed [ ]      6. Cohabiting [ ]
4. Religion:
  1. Catholic [ ]      2. Protestant [ ]
  3. Charismatic/Pentecostal [ ]      4. Moslem [ ]
  5. Traditionalist [ ]      6. No religion [ ]
  7. Others (Specify) [ ]

5. Ethnicity:

- |                   |                        |
|-------------------|------------------------|
| 1. Ga/Adangme [ ] | 2. Akan [ ]            |
| 3. Ewe [ ]        | 4. Mole-Dagbani [ ]    |
| 5. Grushi [ ]     | 6. Gruma [ ]           |
| 7. Dagarti [ ]    | 8. Hausa [ ]           |
| 9. Guan [ ]       | 10. Others (state) [ ] |

6. Highest education attained

- |                      |                          |
|----------------------|--------------------------|
| 1. No education [ ]  | 2. Primary education [ ] |
| 3. Middle school [ ] | 4. JSS [ ]               |
| 5. Technical [ ]     | 6. Commercial [ ]        |
| 7. Vocational [ ]    | 8. SSS [ ]               |
| 9. Polytechnic [ ]   | 10. University [ ]       |

7. Occupation

- |                          |                            |
|--------------------------|----------------------------|
| 1. Clerical [ ]          | 2. Managerial [ ]          |
| 3. Professional [ ]      | 4. Owner of a business [ ] |
| 5. Trader [ ]            | 6. Artisan [ ]             |
| 7. Housework [ ]         | 8. Apprentice [ ]          |
| 9. Unemployed [ ]        | 10. Farmer [ ]             |
| 11. Security [ ]         | 12. Labourer/cleaner [ ]   |
| 13. Others (Specify) [ ] |                            |

8. How many children do you have? [ ]

9. Do you currently have an adolescent under your care?

1. Yes [ ] 2. No [ ]

If “No” move to Q 11

10. If “Yes” state whether male or female N/A [ ]

1. Male [ ] 2. Female [ ] 3. Both [ ]

11. Have you taken care of an adolescent before?

1. Yes [ ]      2. No [ ]

12. If “Yes” state whether male or female      N/A [ ]

1. Male [ ]      2. Female [ ]      3. Both [ ]

### **KNOWLEDGE ABOUT CONTRACEPTIVES (FAMILY PLANNING)**

13. Do you know/heard of any method/way to prevent pregnancy?

1. Yes [ ]      2. No [ ]

If “No” move to Q15

14. If “Yes” name it/them      N/A [ ]

- |                               |                                    |
|-------------------------------|------------------------------------|
| 1. Pill [ ]                   | 2. Male condom [ ]                 |
| 3. Female condom [ ]          | 4. IUCD [ ]                        |
| 5. Injectable [ ]             | 6. Implant [ ]                     |
| 7. Diaphragm/Cervical cap [ ] | 8. Vaginal foaming tablets/gel [ ] |
| 9. Vaginal ring [ ]           | 10. Patch [ ]                      |
| 11. Abstinence [ ]            | 12. Withdrawal [ ]                 |
| 13. Natural/Calendar [ ]      | 14. Others (specify) [ ]           |

15. Do you know/heard of any method/way to prevent sexually transmitted infections?

1. Yes [ ]      2. No [ ]

If “No” move to Q 17

16. If “Yes” name it/them      N/A [ ]

- |                                |                      |
|--------------------------------|----------------------|
| 1. Male condom [ ]             | 2. Female condom [ ] |
| 3. Vaginal foaming tablets [ ] | 4. Abstinence [ ]    |
| 5. Others (Specify) [ ]        |                      |

17. Have you heard about contraceptives (family planning methods)? :

1. Yes [ ] No [ ]

If answer is “No” end interview

18. If “Yes” where did you hear it from?

- |                           |                        |
|---------------------------|------------------------|
| 1. Radio [ ]              | 2. Television [ ]      |
| 3. Newspaper [ ]          | 4. Friends [ ]         |
| 5. Siblings [ ]           | 6. Health worker [ ]   |
| 7. Reading from books [ ] | 8. Other (specify) [ ] |

#### **ATTITUDE TOWARDS CONTRACEPTIVE USE**

19. Have you ever used contraceptives? 1. Yes [ ] 2. No [ ]

If “No” move to Q 25

20. If “Yes” which one/ones have you used before? N/A [ ]

- |                               |                                    |
|-------------------------------|------------------------------------|
| 1. Pill [ ]                   | 2. Male condom [ ]                 |
| 3. Female condom [ ]          | 4. IUCD [ ]                        |
| 5. Injectable [ ]             | 6. Implant [ ]                     |
| 7. Diaphragm/Cervical cap [ ] | 8. Vaginal foaming tablets/gel [ ] |
| 9. Vaginal ring [ ]           | 10. Patch [ ]                      |
| 11. Abstinence [ ]            | 12. Withdrawal [ ]                 |
| 13. Natural/Calendar          | 14. Others (specify) [ ]           |

21. Are you currently on contraception? N/A [ ]

1. Yes [ ] 2. No [ ]

If “No” move to Q 25

22. If “Yes” which one/ones are you using? N/A [  ]

- |  |   |
|--|---|
| 1. Pill [ <input type="checkbox"/> ]                   | 2. Male condom [ <input type="checkbox"/> ]                 |
| 3. Female condom [ <input type="checkbox"/> ]          | 4. IUCD [ <input type="checkbox"/> ]                        |
| 5. Injectable [ <input type="checkbox"/> ]             | 6. Implant [ <input type="checkbox"/> ]                     |
| 7. Diaphragm/Cervical cap [ <input type="checkbox"/> ] | 8. Vaginal foaming tablets/gel [ <input type="checkbox"/> ] |
| 9. Vaginal ring [ <input type="checkbox"/> ]           | 10. Patch [ <input type="checkbox"/> ]                      |
| 11. Abstinence [ <input type="checkbox"/> ]            | 12. Withdrawal [ <input type="checkbox"/> ]                 |
| 13. Natural/Calendar                                   | 14. Others (specify) [ <input type="checkbox"/> ]           |

23. Have you had any side effect from using a contraceptive before? N/A [  ]

1. Yes [  ]                      2. No [  ]

If “No” move Q 25

24. If “Yes” what was it? N/A [  ]

Contraceptive	Side effect



4. Don't know what I will do [ ]      5. Ask him to abstain from sex [ ]
6. Others (specify) [ ]

32. Assuming you have a female adolescent who is using contraceptives without your knowledge, what will you do if you find out?

1. Ask her to stop [ ]      2. Punish her [ ]
3. Will not say anything [ ]      4. Encourage her [ ]
4. Don't know what I will do [ ]      5. Ask her to abstain from sex [ ]
6. Others (specify) [ ]

### **COMMUNICATION WITH ADOLESCENTS ABOUT CONTRACEPTIVES**

33. Have you ever discussed contraceptives with another adult before?

1. Yes [ ]      2. No [ ]

If "No" move to Q 35

34. If "Yes" who was this? N/A [ ]

1. Spouse [ ]      2. Female friend [ ]
3. Sibling [ ]      4. Co-worker [ ]
5. Health worker [ ]      6. Others (specify) [ ]

35. Should we talk to female adolescents about contraceptives at all?

1. Yes [ ] 2. No [ ]

36. Reasons for your answer

37. Should we talk to male adolescents about contraceptives at all? 1. Yes [ ] 2. No [ ]

38. Reasons for your answer

39. Have you ever initiated a discussion about contraceptives with a female adolescent under your care? N/A [ ]

1. Yes [ ]                      2. No [ ]

If "No" move to Q 44

40. If "Yes" at what age did this first occur? [ ] yrs [ ] mths N/A [ ]

41. What brought about this discussion? N/A [ ]

42. Summary of discussion N/A [ ]

1. Encouraged her to abstain from sex [ ]    2. Encouraged her to use contraceptives [ ]  
3. Discouraged her from using contraceptives [ ]  
4. Other (Specify)

43. How often do you do so? N/A [ ]

1. Rarely [ ]                      2. Often [ ]                      3. Very often [ ]

44. Have you ever initiated a discussion about contraceptives with a male adolescent under your care? N/A [ ]

1. Yes [ ]                      2. No [ ]

If "No" move to Q 49

45. If "Yes" at what age did this first occur? [ ] yrs [ ] mths N/A [ ]

46. What brought about this discussion? N/A [ ]

47. Summary of discussion N/A [ ]

1. Encouraged him to abstain from sex [ ]
2. Encouraged him to use contraceptives [ ]
3. Discouraged him from using contraceptives [ ]
4. Other (Specify)

48. How often do you do so? N/A [ ]

1. Rarely [ ]
2. Often [ ]
3. Very often [ ]

49. At what age do you think girls are old enough to be told about contraceptives? [ ]  
years

50. At what age do you think boys are old enough to be told about contraceptives? [ ]  
years

51. Do you/will you feel comfortable discussing contraception with a female adolescent  
under your care? 1. Yes [ ] 2. No [ ]

If "Yes" move to Q 53

52. If "No" what is/are your reasons? N/A [ ]

53. Do you/will you feel comfortable discussing contraception with other female  
adolescents?

1. Yes [ ]
2. No [ ]

If "Yes" move to Q 55

54. If "No" what is/are your reasons? N/A [ ]

55. Do you/will you feel comfortable discussing contraception with a male adolescent  
under your care?

1. Yes [  ]

2. No [  ]

If “Yes” move to Q57

56. If “No” what are your reasons N/A [  ]

57. Do you/will you feel comfortable discussing contraception with other male adolescents?

1. Yes [  ]

2. No [  ]

If “Yes” move to Q 59

58. If “No” what is/are your reasons?

59. (For all those who have never discussed contraceptives with any adolescent before)

If you should have the opportunity to talk to an adolescent about contraceptives, what will you tell the person?

Interviewer. \_\_\_\_\_

**THANK YOU**

## Appendix C: Focus Group discussion guide

### FOCUS GROUP DISCUSSION GUIDE

Good morning, my name is Ernest Tei Maya and I am from the School of Public Health, University of Ghana. I am conducting a survey in this community about what parents and adolescents think about the use of contraceptives (family planning) by people who are between 10 and 19 years old.

This survey is part of the requirements for my postgraduate programme in public health. The information gathered however may be of help to the health authorities in planning for adolescent reproductive health programmes in this community which will benefit society at large.

I would therefore implore your indulgence to discuss the above topic. The discussion will last for about 45 minutes and it will be audio recorded. I have an assistant (**name of assistant**) to assist me with the recording and also taking of notes. I have no answers to the questions I am about to ask and that should tell you that there are no right and wrong answers. So please feel free to express your views.

Could you please introduce yourselves by just mentioning your ages and occupation and whether you have a male or female adolescent or both?

Now let us start:

1. What do people do to prevent themselves from getting pregnant?
2. Have you heard about modern contraceptives?

Prove for different types of contraceptives, advantages and disadvantages.

3. How did you know about these contraceptives?
4. What is your opinion about adolescents who are using contraceptives?
5. what is your opinion about adolescents discussing contraceptives with
  - (i) parents/guardians
  - (ii) their peers

Prove where discussion should take place

6. Do people in your community discuss contraceptives with their adolescents?

Prove: have any of you done it before?

What brought about the discussion?

What did you tell him/her?

7. How do parents react if they find out that their adolescent children are using contraception in this community?
8. Under what circumstances would you allow your adolescent children to use contraceptives

**Thank you for being part of this discussion.**

## **Appendix D: Consent form: Parents with adolescents below 18 years**

### **CONSENT FROM PARENTS WITH ADOLESCENTS BELOW 18 YEARS**

Hello, my name is \_\_\_\_\_ and I am working with Ernest Tei Maya of the School of Public Health, University of Ghana. We are conducting a survey in this community about what parents and adolescents think about the use of contraceptives (family planning) by people who are between 10 and 19 years old.

We shall be grateful if you will allow your adolescent be one of the participants. Because he/she is below 18 years of age, we need your consent first before we can take a personal consent from him/her to take part in the survey.

The survey involves a one-time answering of questions only. The questions that will be asked involve questions about him/herself and his/her opinion on contraceptive (family planning) use by adolescents and communication about contraceptives (family planning) between adolescents and their parents. It usually takes between 20 to 30 minutes to answer the questions. He/she will be interviewed alone and whatever information he/she gives will be kept strictly confidential and will not be disclosed to any other person.

The survey is part of the requirements for Ernest Tei Maya's postgraduate programme in public health. However, the information gathered may be of help to the health authorities in planning for adolescent reproductive health programmes in this community which will benefit society at large.

Your adolescent's participation in this survey is voluntary and there is no direct monetary or other benefits attached. There is also no penalty if you decide not to allow him/her to take part in this survey. We however hope that you will allow him/her to take part in this survey as his/her views are very important. If you decide to allow him/her to participate in this survey, he/she is not obliged to answer all the questions if he/she finds some too

sensitive to answer. At the end of the survey the findings will be communicated back to the people in the community

If there are any questions or clarifications about the survey you require to know, you are free to do so now. You can also contact Ernest Tei Maya on telephone number 020-8131270 for further clarification.

## **DECLARATION BY PARENT OF ADOLESCENT BELOW 18 YEARS OF AGE**

I \_\_\_\_\_ have read the above information/it has been read to me. I have had the opportunity to ask questions about it and any question I have asked has been satisfactorily answered. I agree to allow my adolescent to take part in the survey. I also understand that he/she has the right not to answer question he/she does not feel comfortable to answer and doing so will not affect him/her in any way.

Signature/ thumbprint of participant \_\_\_\_\_ Date:

Signature of interviewer \_\_\_\_\_ Date:

If permission is not given what is the reason?

## **Appendix E: Consent form: Participants for focus group discussion interview**

### **CONSENT FROM PARTICIPANTS TAKING PART IN FOCUS GROUP DISCUSSION**

Hello. My name is Ernest Tei Maya and I am from the School of Public Health, University of Ghana. I am conducting a survey in this community about what parents and adolescents think about the use of contraceptives (family planning) by people who are between 10 and 19 years old.

The survey is part of the requirements for my postgraduate programme in public health. However, the information gathered may be of help to the health authorities in planning for adolescent reproductive health programmes in this community which will benefit society at large.

We would like to have a discussion with you and 6 or 7 other people on the above subject matter. The discussion will center on what methods of family planning you know of, and your opinion on contraceptive (family planning) use by adolescents and communication about contraceptives (family planning) between adolescents and their parents. The discussion will last for about 45 minutes. It will be audio recorded and so there will be another person with me to assist with the recording.

You will not be required to mention your name during the discussion and you are not obliged to make contribution towards every single point if you do not want to do so. You are also at liberty to leave the discussion at anytime before it ends if you so wish. Whatever information we get from the discussion will be kept strictly confidential and will not be disclosed to any other person. The audio tapes will be kept with me until such a time that I have finished presenting my findings to the school and the community which I hope will take place by the end of August 2009.

Your participation in the discussion is voluntary and there is no direct monetary or other benefit to you. There is also no penalty if you decide not to take part. I however, hope that you will take part as your views are very important.

If there are any questions or clarifications about the discussion you require to know, you are free to do so now. You can also contact me on telephone number 020-8131270 for further clarification.

## DECLARATION BY PARTICIPANT

I \_\_\_\_\_ have read the above information/it has been read to me. I have had the opportunity to ask questions about it and any question I have asked has been satisfactorily answered. I agree to take part in the discussion voluntarily. I also understand that in addition to having the right not to contribute towards every topic under discussion if I so wish I can also leave the discussion before it ends and doing so will not affect me in any way.

Signature/ thumbprint of participant \_\_\_\_\_ Date:

Signature of interviewer \_\_\_\_\_ Date:

## **Appendix F Consent form: Participants in interview**

### **CONSENT FROM PARTICIPANTS TAKING PART IN INTERVIEW**

Hello. My name is \_\_\_\_\_ and I am working with Ernest Tei Maya of the School of Public Health, University of Ghana. We are conducting a survey in this community about what parents and adolescents think about the use of contraceptives (family planning) by people who are between 10 and 19 years old.

The survey involves a one-time answering of some questions. I would like to ask you some questions about yourself and your opinion on contraceptive (family planning) use by adolescents and communication about contraceptives (family planning) between adolescents and their parents. It usually takes between 20 to 30 minutes to answer the questions. You will be interviewed alone and whatever information you give will be kept strictly confidential and will not be disclosed to any other person.

The survey is part of the requirements for Ernest Tei Maya's postgraduate programme in public health. However, the information gathered may be of help to the health authorities in planning for adolescent reproductive health programmes in this community which will benefit society at large.

Your participation in this survey is voluntary and there is no direct monetary or other benefit to you. There is also no penalty if you decide not to take part in this survey. We

however, hope that you will take part as your views are very important. If you decide to participate in this survey, you are not obliged to answer all the questions if you find some too sensitive to answer. At the end of the survey the findings will be communicated back to the people in the community

If there are any questions or clarifications about the survey you require to know, you are free to do so now. You can also contact Ernest Tei Maya on telephone number 020-8131270 for further clarification.

## **DECLARATION BY PARTICIPANT**

I \_\_\_\_\_ have read the above information/it has been read to me. I have had the opportunity to ask questions about it and any question I have asked has been satisfactorily answered. I agree to take part in the survey voluntarily. I also understand that I have the right not to answer any question if I so wish and doing so will not affect me in any way.

Signature/ thumbprint of participant\_\_\_\_\_ Date:

Signature of interviewer\_\_\_\_\_ Date:

If Not participating; what is your reason?

**THANK YOU**