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SOCIAL BARRIERS THAT AFFECT THE NON-USE OF CONTRACEPTIVES AMONG ADOLESCENTS IN THE GOMOA EAST DISTRICT.

BY

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DECLARATION

I, Crystal Clottey hereby declare that apart from references to other people's works which have been duly acknowledged, this dissertation is as a result of my own independent work under supervision. I further declare that this dissertation has not been submitted for the award of any degree in this institution or in any other universities elsewhere.

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May God richly bless you all.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
COC	Combined Oral Contraceptives
GDHS	Ghana Demographic and Health Survey
GEHD	Gomoa East Health Directorate
GES	Ghana Education Service
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
ICUD	Intrauterine Contraceptive Device
NGO	Non Governmental Organisation
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Emergency Fund

ABSTRACT

The study set out to examine the social barriers that affect contraceptive non-use among adolescents in the Gomoa East district. The Gomoa East district was selected for the study due to its high rate of teenage pregnancies associated with high birth rates, and maternal morbidity. The study was carried out among 238 in-school and out of school adolescent males and females. Two secondary schools were purposively selected (one urban and one rural) and the out of school adolescents from three villages groups at different parts of the district. A systematic sampling technique was used to select the in-school respondents to obtain a representative sample for the study and to ensure valid generalization. Ethical approval was sought from the Ghana Health Service Ethical Review Board and permission from school authorities and parents.

. The findings of the study indicated that more than half (52%) of the respondents had had sex before of which 46% were still sexually active. Majority of respondents have heard of condoms (84.5%), pills and abstinence and sources of knowledge include the media, friends, teachers and health workers. About 42% ever used contraceptives with condom use and pills being the most frequently used. Generally ever use of contraceptive among those who ever had sex was very high (81%). However, discontinuation of use was equally high (40%) among those who ever used a method. Perceive benefits for contraceptives were to delay pregnancy in order to complete school/acquire skills (36%), marry before getting pregnancy (37%), to avoid teenage pregnancy (25%) or 'spoil pregnancy'(2%). Among barriers to non-use by respondents were side effects (34%) opposition from partners/parents (7.3%), infertility (20%) religious influence (24%) attitudes of heath workers (10.6%). Another

obstacle is opposition from partner's most especially male partners. Irrespective of the barriers to contraceptive use, some respondents still used a method of contraception (42%).

The major conclusions that can be drawn from the findings of the study are: the HBM is beneficial in helping to assess motivation among adolescents for either use or non–use of contraceptives. Respondents were able to numerate the negative consequences of non-use of contraceptives like getting pregnant

Contraception knowledge should urgently be improved among adolescents and youth-friendly contraceptive services be provided by both public Ghana Health Service (GHS) and the Ghana Education Service (GES) as well as Non Governmental Organisations (NGOs). Messages should also be tailored to help modify adolescents' perceptions of risk to reduce desire for early childbirth.

CHAPTER ONE

1.0 INTRODUCTION

The reproductive health of the adolescent is very important and the non use of contraceptives among sexually active adolescents could negatively impact their lives and erode the health of our future generation. The use of contraceptives could positively impact on the reproductive health of the adolescent generally with the potential of improving maternal health by reducing birth rates, maternal morbidity and mortality (Williamson et al, 2009). However, the reproductive health of the adolescent in sub Saharan Africa is not as good as expected due to high birth rates among others (WHO 2011). The birth rate of the adolescent in Africa for instance is two times higher than the world's average. The world's average birth rate is 65 per1000 while Africa's is 143 per 1000. (Abdul-Rahman et al, 2011). Aside the high birth rates among adolescents most of the pregnancies are not carried to full term.

According to the United Nations Population fund (UNFPA, 2011) more than one quarter of the world's yearly pregnancies, about 52 million ends up in abortions Many of these abortions are done under unsafe conditions; with 13% of them causing maternal mortalities (UNFPA, 2011). Adolescents contribute 2 to 4.4 million abortions each year and these are mostly done under unsafe conditions (IPAS, 2005; WHO, 2011). Williamson et al, (2009) also estimated that every year, one quarter of 20 million young women goes through unsafe abortions and about 70000 of these abortions are from adolescents age 15-19years.

Infant and child mortality is also highest among children born to adolescent mothers (WHO, 2011). Researchers have found out that contraceptives use in countries with high birth rates could reduce by 32% all maternal deaths and nearly 10% of childhood deaths (UNFPA,

2011). Today, more than 215 million women want to delay or avoid pregnancy but are unable to due to lack of access to contraceptive use (UNFPA, 2011).

Contraceptives are defined as various devices, drugs, agents, sexual practices or surgical procedures to prevent pregnancy. Contraception is practiced for pregnancy planning, limiting the number of children, spacing the time of birth and controlling population (WHO, 2007). Contraceptive can be grouped into five main types; the hormonal, the Intrauterine contraceptive device, the implants, barrier methods and the post coital contraceptives (WHO, 2007).

Modern contraceptive use tended to be low among those who had never been to school, it was only 5%. For those who attended secondary school or attained higher level of education it was 23% (Yoder et al, 2011). Use of contraceptives also was low in the rural areas than in the town or cities. It ranged from 2% in rural Mpoti to 17% in urban Bamako. Also majority of those who use contraceptives use them just for child spacing and not for the limiting of the number of children (Yoder et al, 2011).

1.1 Statement of the problem.

1.2 Meeting the reproductive need of youth today is critical, because the actions of the youth today will shape the size and health of the world's future population. Moreover, improving young people's health is critical with long-term benefits to society as a whole (PRB, 2000).

Young people often have inadequate or misleading information on sexuality and reproductive health and lack access to reproductive health care and contraceptives. Unfortunately, the

increasing sexual activity among the adolescents today places them at greater risk of unintended pregnancies and STIs, including HIV/AIDS (PRB, 2000).

Like most communities in Africa, Gomoa East, which is the study site, is located in a more rural than urban setting has high teenage pregnancy and teenage births rates. In 2010 the number of teenage pregnancies was 589 which formed 12.8% of total pregnancies of the district. Adolescents 'births were 289 which was 13.6% of total deliveries recorded in the Gomoa East District annual report (GEHD, 2010). In 2011 adolescents pregnancies were 587; 13.3% of total pregnancies and deliveries were 343, which was 11.6% of total deliveries. It is recorded that the district had topped the teenage pregnancy ladder of the Central region for some time (GEHD, 2011). As a response to address the issue; the Ghana Health Service has set out outreach clinics in the communities to bring contraceptives to the door step of the people but still adolescentst do not patronize the services and teenage pregnancies are still high (GEHD, 2010; GEHD, 2011). Reasons for the high pregnancies and birth rates among adolescents in the district are not altogether clear. Anecdotal evidence suggests the contribution of some negative societal norms to the non-use of contraceptives among adolescents and the frequent teenage pregnancy experienced in the district. It is not unusual for adolescents to fend for themselves as fathers fail to support or leave the poor mothers who have no work to support the family. This study therefore seek to investigate the social reasons for the non-use of contraceptives by adolescents in the Gomoa East district.

1.2 General objective:

The main objective of this study is to identify the social barriers that affect the non-use of contraceptives among adolescents in the Gomoa East District.

Specific objectives are

- To assess the awareness level of adolescents about contraceptives.
- To identify the reasons for the non-use of contraceptives by adolescents.
- To identify who makes decisions on contraceptives use among adolescents.

1.3 Significance of the Study.

This study will inform policy-makers, program managers and service providers on the factors that affect the non use of contraceptives among adolescents in the Gomoa East District. The more they know about these factors on adolescents contraceptive non-use the more it will influence policy planning and help re-strategize for contraceptives service provision among adolescents.

1.4 Limitation of study

Though respondents were assured of privacy and confidentiality during the survey; the sensitive nature of some of the questions could have had some effect on their level of honesty. It is possible that a few respondents may have under reported about premarital sexual activities, due to the influence of socio-cultural norms. However, this is not expected to influence the overall quality of the findings.

1.5 Conceptual Framework

The study adapts the health belief model which was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The Health Belief Model is a psychological model of theory that attempts to explain and predict the health seeking behavior of individuals by focusing on their attitudes and beliefs. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. The model has since been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS as well as the use of contraceptives in the prevention of unwanted pregnancies.

The Health Belief Model is based on certain core assumptions. For instance, it is based on the understanding that a person will take a health-related action (i.e., use contraceptives) if that person: (1) feels that a negative health condition (i.e. unwanted pregnancy leading to maternal morbidity and mortality) can be avoided, (2) has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using contraceptives will be effective at preventing unwanted pregnancy), and its consequences; and (3) believes that he/she can successfully take a recommended health action (i.e., he/she can use desired contraceptive method of choice comfortably and with confidence).

The key variables of Health Belief Model are based on perceived threat and net benefits and they are: Perceived susceptibility; perceived severity; perceived benefits; perceived barriers; cue for action and self efficacy (Rosenstock et al, 1988). Although the model has six constructs this study would use four: Perceived susceptibility to a disease, perceived severity,

perceived barriers and perceived benefits. The study did not aim at giving information on contraceptive use that will be cue for action nor did it aim at checking the efficacy of respondents using contraceptives.

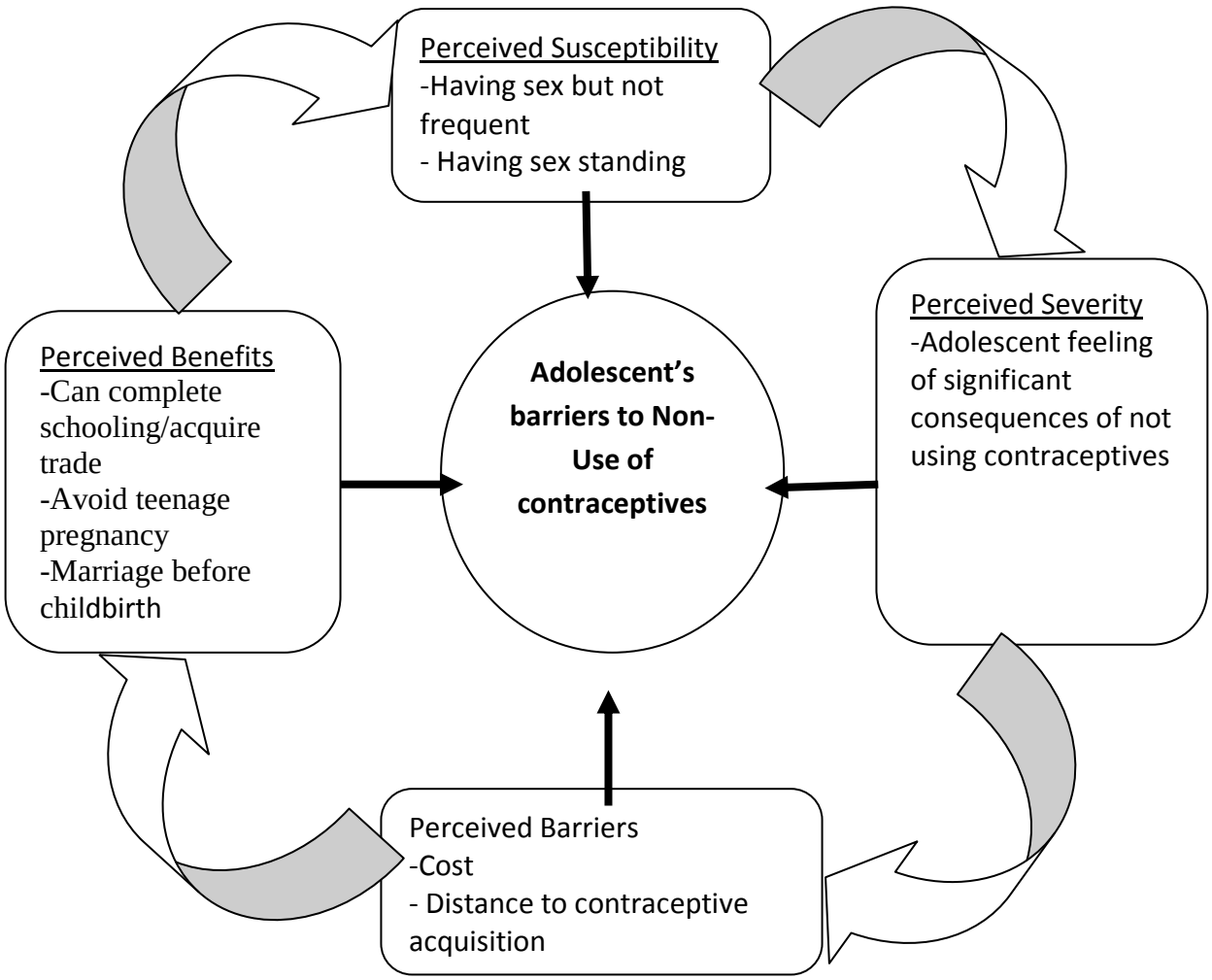
Perceived susceptibility considers whether one is aware or feels at risk of contracting a health condition. For purposes of this study perceived susceptibility refers to the perceived risk of becoming pregnant and is an important factor explaining the use or nonuse of contraception particularly among adolescents. Lack of perceived susceptibility to pregnancy can result in risk taking.

Perceived Severity relates to feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical/ clinical consequences and possible social consequences). For purposes of this study, do adolescents believe that the consequences of not using a contraceptive or getting a pregnancy are significant enough to try to avoid them. For example, the fear of undergoing an unsafe abortion to prevent an unwanted pregnancy, or the fear of dying through childbirth when the body is not fully matured to safely carry a baby to term

Perceived Benefits are the believed effectiveness of strategies designed to reduce the threat of illness. Here, perceived benefits relates to whether adolescents believe that the recommended action of using a contraceptive method would protect them from getting a pregnancy. For instance, do they believe in the effectiveness of the methods? Secondly, whether they believe that the recommended action of using a contraceptive method would benefit them — possibly by allowing them to complete school or acquire employable skills before childbirth, enabling them delay pregnancy and childbirth till after marriage or bringing honour to one's family by avoiding teenage pregnancy.

Perceived Barriers are the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands. In this study, perceived barriers focus on adolescents ability to identify their personal barriers to using contraceptives (i.e., side effects or fear of future infertility due to use) and explore ways to eliminate or reduce these barriers (i.e. teach them about the availability of the varied methods, of the fact that side effects go away after some time or disabuse their minds about contraceptives causing infertility).

conceptual framework: figure 1



2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to the topic 'Social barriers that affect the non-use of contraceptive among adolescents'. This literature is organized thematically covering conceptual framework and topics like; adolescent sexual behavior and their reproductive health, knowledge of contraceptive methods, adolescents contraceptive use and social barriers to contraceptive use.

2.2 Adolescent Sexual Behaviour and Reproductive Health.

The WHO (2009) in the state of the world population report stated that there are about 94 million adolescents in the West and Central African Region, 91 million in Eastern and Southern Africa, 118 million in industrialized countries and 108 million in Latin America and Caribbean Regions (WHO, 2009). The WHO defines adolescent as any person between the ages of 10-19 years. It further stated that about 1.2 billion adolescents aged 10-19 form 18% of the world's population; and that for about every 5 people in the world one is an adolescent (Coskun, 2005). Adolescence is a period of transition from child hood to adult hood. The beginning of adolescence is puberty which is characterized with physical and social changes in the adolescent. The adolescence period can be divided into three. Namely early adolescents which is 10-14 years; late adolescents 15-19 years and youth are 15 -24 year olds (UNFPA, 2003).

The WHO again defines Reproductive health as a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life (UNFPA, 2011). Failure to meet the reproductive health needs of young people is

particularly prevalent among poor adolescents who are often marginalized from interventions located in mass media, schools and clinics (Rani and Lule, 2004). In South Africa for instance, where large numbers of young people live in conditions of poverty, challenges such as lack of access to reproductive health services could translate into increased levels of unwanted pregnancy and diseases (Williamson et al. 2009).It is estimated that 90% of abortions and 20% of pregnancy-related morbidity and mortality, along with 32% of maternal deaths, could be prevented by the effective use of contraception Cleland et al 2006).

According to the state of the World Population Report (2005); every year about 14 million adolescents give birth; many more abandon school and become pregnant or marry and these adolescents are five times likely to die from pregnancy related complications than older woman (WHO, 2005). In a study in Nigeria Ibadan, Abu and Akerele (2002) reiterated that 'adolescence goes with a period of developing behavior patterns including risky sexual behaviours that may have a long–lasting effect on their wellbeing. Risky sexual behaviours are defined as having unprotected sex, having sex with an unfamiliar person or having multiple sexual partners (Grossman and Markowitz, 2005).

In Sub-Sahara Africa women and adolescent girls continue to die due to lack of access to contraceptives; the lack leads to unwanted pregnancies and unsafe abortions (UNFPA, 2011). It is estimated that most of these pregnancies could be averted by the use of contraceptives (UNFPA, 2011). Although Sub-Sahara Africa has 24% unmet need for contraception, the unmet needs vary per region and countries. For example in South Africa 58% of women and adolescents (15-45 years) use contraceptives, but in Sierra Leone only 5% use contraceptives (Guttmacher, 2007).

On the other hand in the United States, it is reported that the percentage of adolescents who had never had sex before had increased from 33% in 1991 to 66% in 2005 (Guttmacher, 2007), 70% of girls who had sex for the first time used condoms that also shows an increase from 46% in 1991 to 63% in 2005. More adolescents in France use birth control pills than those in U.S.A. 59% of adolescents in France and 33% in the U.S.A. Some of the barriers to the use of contraceptives among adolescents in the United States are; pressure from partners and friends, misunderstanding of abstinence (Advocate for Youth, 2007). Lack of knowledge about contraceptive effectiveness, they also assume the pill and condoms are not effective. Also 47% says mandatory notification of parents made them stop using contraceptives (Guttmacher, 2007).

In some countries adolescents take being pregnant as a way to escape parental control or to make money (Marston and King, 2006). The problem of adolescent sexual behavior is a serious one; for example in South Africa where HIV prevalence is high, one study showed that there were schools where 60% to 70% of pupils were pregnant in school. This mirrors the evidence of gang activity or coerced sex in South Africa (Sigsworth1 2008; IRIN ,2012)

A study in George Washington University in the US shows that about 1/3 of all girls in the US become pregnant before age 20, and in 2006 adolescents gave birth to 435,427 infants and 80% of these births are unintended. (GWU,2008). 26% of American adolescents have STDs. The consequences of these teenage pregnancies are complex as they make them socially and economically disadvantaged; they then face poverty and ill health and brings cost to the society (GWU, 2008). The study further revealed that most adolescents in US have Sexually Transmitted Infections especially those from the coloured race like the blacks and the Hispanics. Additionally, it reported that in the Columbia districts adolescents with

Chlamydia infection was 3 times above national average (GWU, 2008). Also the study found out that Gonorrheoa and Syphilis was two times above national average.

Family history, parental education, and care for adolescents have effect on the sexual behavior of adolescents and reproductive health. Abu and Akerele, 2002 found from their study undertaken in Nigeria, Ibadan that adolescents who have parental support and supervision turn to delay early sexual debut. Another study conducted in Los Angeles schools on virgins reported that 65% of adolescents who had never had heterosexual genital activity are those whose parents had graduated from high schools and they also wanted to graduate (Schuster, 2002).

Awusabo Asare et al, (2006) confirmed the median age of sexual debut of adolescents in Ghana at 15.5 for males and 16.2 for females. In another study in 9 senior secondary schools, 50% consider chastity to be ideal and attainable, but 42% of males and 15% of female had had sex (Awusabo Asare et al, 2006). Their reasons for sexual activities were peer pressure, deception from partners, experimental and sexual desire satisfaction. But adolescents in school turn to delay sexual debut.

As regards the type of partners with whom they had sex, 67% males and 55% female had sex with their own age mates. 1% had sex with sugar daddies (an older adult who gives money and gift to the young female). Two percent (2%) of males and 12% of females said their first sex was a forced sex with 0.6 for females, 0.5 males having sex with family member. 8% male and 25% of female also had coerced sex **(**Awusabo Asare et al 2006). Among secondary schools and universities, the study found out that; 13% of adolescents had forced sex. For some this occurred with teachers, or with school mates and at other times with neighbours **(**Awusabo Asare et al, 2006).

In the area of adolescent reproductive health, adolescents have the rights to the following; information about their physical and emotional changes that take place as adolescents proceed through puberty, information, guidance, or counseling about sexual intimacy, planning births, avoiding STDs, and using contraception (Kirby, 1994). They should have access to convenient, confidential, and affordable contraception and reproductive health services, such as gynecological exams, counseling, STD tests, and other tests (Kirby, 1994; ICPD, 1994). But this is not so in many Sub –Sahara Africa countries. Ikamari and Towett, 2007 also recorded that in some three (3) decades ago teaching on sexual reproductive health was done in a gender sensitive way for some activities due to some taboos, but now urbanization has loosened the social practices and in return has made teenage pregnancy and sexual activity of the adolescents more prevalent (Ikamari and Towett, 2007)

2.3 Contraceptive Methods

Contraception is the use of various devices, drugs, agents, sexual practices or surgical procedures to prevent pregnancy. Contraception is practiced for pregnancy planning, limiting the number of children and controlling population (WHO, 2011). There are many contraceptive drugs and devices that can be used for contraception. For better understanding of these contraceptives, they are grouped and discussed under five broad headings namely; hormonal methods, Intrauterine Contraceptive Device (IUCD), barrier methods, natural methods and post-coital contraception.

2.3.1 Hormonal methods

These comprise of Combined Oral Contraceptive (COC) methods, transdermal combined hormonal, transvaginal combined hormonal, Intramuscular combined hormonal injectable and Progestogen-only methods (0bstetricians and Gynaecology, 2004)

According to the society of Obstetricians and Gynaecology (2004), COCs contains synthetic steroid hormones estrogen and progestogen in varying amounts and the mechanism of action is primarily prevention of ovulation. They thicken the endometrial lining making it difficult for the sperm to reach the ovum and make implantation difficult. The COCs can provide virtually100% protection from unwanted pregnancy. Benefits of COCs among others include; effectiveness, convenience, reversibility, reduction of most menstrual cycle and no toxicity in overdose (Obstetricians and Gynaecology, 2004)

However, the most significant unwanted effects are: Irregular or prolonged bleeding, amenorrhea and weight gain (Advocates for youth, 2008).

Progestogen-only method of contraceptives consists of progestogen-only pill, injectable and sub-dermal implants**.** They thicken the cervical mucus to prevent mobility to spermatozoa and also modify the endometrium to prevent implantation**.** It is recommended that the daily tablets should be taken at the same time each day (Obstetricians and GSynaecology, 2004).

Implants are capsules containing progestogen which are inserted sub-dermally into the inner aspect of the upper arm under local anesthetic. The steroid is released into the body at a constant rate (slightly higher during the first year of use). The steady circulating blood level of steroid gives high contraceptive efficacy (Obstetricians and Gynaecology (2004). The main indication for Implants is the woman's desire for a highly effective method without the finality of sterilization (Advocates for youth.2008).

2.3.2 Intrauterine Contraceptives Device (IUCD)

IUCDs are inserted into the uterus at any point of the menstrual cycle as long as the chance of pregnancy has been excluded. Some health practitioners prefer to insert it towards the end of menstruation or just after. The IUCD causes an inflammatory response with the increased number of leucocytes which destroy spermatozoa and ova. Copper affects endometrial enzymes, glycogen metabolism and oestrogen uptake, thus rendering the endometrium hostile to implantation (Advocates for youth.2008). Advantages of copper IUDs include; safety, effectiveness, continuation rates are high and are reversible while the unwanted effect are**;** extrauterine pregnancy**,** expulsion, perforation**,** Pelvic infection, malpositioning, Pain and bleeding (Advocates for youth 2008).

2.3.3 Barrier methods

Barrier methods prevent spermatozoa from coming in contact with the ovum. It comprises of male and female condoms and diaphragms and cervical cap usually used with spermicide. Advantages are: easy availability, protection against sexually transmitted diseases, cheap and safe (Advocates for youth, 2008.)

Vaginal film is a little two inch by two inch thin sheet with a chemical that kills sperm (a chemical called nonoxynol-9). It is placed on or near the cervix (the opening of the womb). It dissolves in seconds (Advocates for youth, 2008). The vaginal sponge is a barrier method of preventing pregnancy. That is, the sponge acts as a barrier to prevent semen from entering the cervix. The sponge is more effective with women who have never given birth than with women who have ever given birth (Advocates for youth, 2008.)

2.3.4 Natural methods

Advocates for youth (2008) stated that natural methods of family planning are based on naturally observing occurring signs and symptoms of fertile and infertile phases of menstrual cycle with abstention from intercourse during fertile phase. Major advantages of this method are the absence of physical side effects and freedom from dependence on medical personnel. The method requires some level of discipline and daily recordings. Natural methods include; observation of cervical mucus, observation of body temperature, calendar or rhythm method and coitus interrupts or withdrawal (Advocates for youth, 2008).

2.3.5 Post-coital contraception

This is also called emergency contraception. Advocates for youth, described the three methods of emergency contraception as; combined oral emergency contraceptives, Progestogen-only emergency contraceptives and Insertion of a copper IUD. Advocates for youth (2008) concluded that insertion of a copper IUD before implantation is extremely effective when it is done up to 5 days after the first sexual exposure (Advocates for youth, 2008). Speaking of variety to enhance choice, the vaginal ring, the contraceptive sponge and the transdermal patch is not available in Ghana.

2.4. Contraceptive use among adolescents

Despite the progress of international family planning programs, the world's population is expected to approach or exceed 10 billion within the next 100 years. Globally, there are about 76 million pregnancies each year which are mostly from the developing world, and about half of these pregnancies end in induced abortions, which are either illegal or unsafe .The other half ends as unwanted or mistimed births.(Guttmarcher,2007). Two-thirds of all unintended pregnancies in developing countries occur among women and adolescents who do not use

contraceptives. As the demand for contraceptive increases and unmet need decreases worldwide, Sub-Sahara Africa's unmet need is not decreasing because of the growing population numbers that may also need contraceptives (Guttmarcher, 2007**).** A study done in some developing countries revealed that the continuation of contraceptive use by adolescents is not assured, because most adolescents are not consistent in the use of contraceptives. The reasons given for that were; due to side effects, convenience of use, change of needs, and switch to other methods. The knowledge of this is very important because adolescents more often have unplanned and irregular sexual activity (Blanc et al., 2009).

A study conducted by the Guttmacher institute (2007) stated that out of 62 million women in child bearing age in United States, 7 out of 10 aged 14-49 years use contraceptives. Meaning they start using contraceptives from adolescent age. A typical U.S woman want two children and to achieve that she must use contraceptive for three decades. Sixty-six percent (66%) of those who practice contraceptive use non permanent methods and adolescents use pills (Guttmacher, 2007). About 23% of teens who use contraceptives use condoms. Out of the 2.9 million adolescents using contraceptives, 54% (about 1.5 million) use pills. More than 20 million women including 1.8 million teens receive the contraceptives from public funded family planning clinics in the U.S.

Studies in Nigeria stated that adolescents in the middle level of their studies use condom and 77% thinks condoms are more reliable (Ojikutu and Adeleke, 2009). All over the world most unintended pregnancies occur among adolescents who do not use any contraceptive. In Ojikuto and Adeleke, 2009 study in Nigeria they found out that adolescent who had sexual debut are less likely to use contraceptive than older women. And that 77% of adolescents

knew about some type of contraceptive but they did not use them (Ojikutu and Adeleke, 2009).

Agyei et al, 1997 in a study on sexual behaviour, reproductive health and contraceptives use among adolescents indicated that some reasons for non- use of contraceptives in Uganda were poor knowledge of about contraceptives, non availability and beliefs. In Ghana, the reasons documented by the GDHS, 2008 for non use of contraceptives are; fear of side effect, not intended to use modern contraceptive and some women themselves oppose contraceptive use (GDHS, 2008). Guttmacher Institute also noted that in Ghana, about half of adolescents lived in the rural areas and condom is the most used contraceptive. Close to 4 in every 10 sexually active females use condom and 5 in every 10 male adolescents use condom. (Guttmacher, 2007). The institute also stated partner refusal and the fact that some adolescents feel they are not susceptible to pregnancy thus they do not use contraceptives. (Guttmacher, 2007). In some developing countries, even among married adolescent women who have an interest in spacing or limiting their births sometimes 20% to 40% are not using contraception (Population Reference, 1994)

2.5. Social Barriers to contraceptive use.

Many studies in Sub-Sahara Africa show that there are many barriers that inhibit the use of contraceptives among adolescents. These barriers include; poor knowledge of contraceptive, fears and rumours about side effect, influences partners and family member (Williamson, et al, 2009). Ladipo and Konje, in their 1999 study confirmed this and added that; poverty, illiteracy, preferred family size, the use of family size as security and safety and sex preferences constitute barriers to contraceptive use (Ladipo and Konje,1999). For instance

family members put pressure on adolescents to give birth because they are not sure whether she would be fertile after using contraceptives. Others also reject contraceptives for religious reasons (Williamson et al, 2009).

Studies in the Philippines show poverty, lack of knowledge on contraceptives, having infrequent sex and the practice of lactational Amenorrhea method as reasons for contraceptive non –use (Guttmacher Institute, 2007; and Likhaan, 2010). They found that respondents who had not used a contraceptive at first sex considered that "Infrequent intercourse cannot cause a girl to get pregnant even she has experienced her menstruation". They noted that the cut in contraceptive funding in the country is also a key reason (Likhaan, 2010). The study indicated that meeting the unmet need for contraceptive would be very beneficial in reducing 4,700 maternal deaths, 1.6 million fewer pregnancies, abortion would decline by 500,000, 200 miscarriages and 2,100 maternal mortality (Likhaan, 2010).

In Sub-Sahara Africa 20% to 30% of partners and significant others oppose contraceptives use. In that case they do not encourage their adolescents to use contraceptives (Williamson, et al, 2009). In communities where spouses do not discuss contraceptives, usage is also low. In Ghana it is a taboo for adolescents to talk about sexual issues let alone contraceptives this is not a bother to adolescents in Mali (Yoder et al, 2011). It is estimated that over 50% women in Africa are poor and illiterates, thus not knowledgeable in the correct use of contraceptives hence the low use. Women in Africa are not just poor but powerless and always pregnant (Ladipo and Konje, 1999; Lakhaan, 2001). Some single women and adolescents may be barred from using contraceptives (UNFPA, 2011). Religion has also been a barrier for contraceptive use for decades where children are regarded as gifts or blessings from God. This is found mostly among the Catholics and Muslims who sees contraceptive use as a

license or moral degraded action for illicit extra marital sexual behavior or indiscriminate sexual behavior (Ladipo and Konje, 1999).

Furthermore, societies that put high premium on the number of children as a source of security and safety of lineage and man power on farms would desire high numbers of children. This ideology prevents women and adolescent girls in such societies from using contraceptives to limit the number of children. Also couples would not use contraceptives if the couple has preference for a particular sex; for instance, where they have only females as children. They would continue having children with the hope of having a male child till the woman gets to menopause (Ladipo and Konje, 1999). In societies where contraceptives are perceived as a means to eliminate a race or tribe, that community would not use contraceptives (Ladipo and Konje 1999).

Although the international community recognizes the rights of persons to healthy and reproductive life this is not fully practiced in many developing countries. Socio-cultural based gender inequalities put young women and adolescents into positions that make it difficult for women and adolescents to control and protect their reproductive health (UNFPA, 2011). Also, social determinants like marriage patterns, decision making modalities, puberty rites and inability to control resources puts young women especially adolescents into the need for contraceptives because they cannot have easy access to contraceptives.About 16 million adolescents give birth each year. Some communities practice child marriage which jeopardizes the health and opportunities of the adolescents. It disrupts their schooling and employment opportunities (UNFPA, 201I). Early child birth can lead to obstetric fistula social isolation could and neglect of the girl child. These issues make it difficult for the adolescent to access contraceptives (UNFPA, 2011).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology employed in this study. Issues covered in this chapter include the research design, study area, study population, sample, sampling techniques, data collection and data analysis.

3.2 Research Design

It is across-sectional/ quantitative study. Choice of this design is due to its advantage to facilitate the collection of original data necessary to address the research objectives. It is useful in collecting data that can be quantified for reporting the true picture of the situation at the district.

3.3 Study Area.

The Gomoa East District is one of the newly created districts which was carved from the former Gomoa district. The district was split into two; Gomoa East and Gomoa West districts. The Gomoa East district is bounded on the North by the Agona district, in the south by the Effutu district and the Atlantic Ocean, in the East by Senya Breku district and the west by Gomoa west district. The district is made up of 95 communities. The community members I the district has three main occupations namely; farmers, fisher folks and traders. The district health service has grouped the communities into eleven zones namely: Obuasi, Buduatta ,Ojobi . Nyanyanu, Bududuram ,Postin, Dasum, Okyereku, Fetteh, Abasa and Ekwamkrom This groupings turns the communities into three farming communities, three fishing communities and five trading communities.

3.4 Study population.

Although WHO defines adolescents as persons between the ages of 10 -19 years the study was conducted among adolescents 12-19 year olds. This is because they are the age group normally found at the health institutions with teenage pregnancies. The adolescents in Gomoa East are usually found at funerals, festivals and youth group meetings. Some of them abandon their schooling for their festival which they normally call "Gomoa two weeks"

For easy access two old secondary schools in the district namely Okyeedom Secondary school in the urban side of the district and Ahmadiya Secondary school in one of the villages were purposively selected. These schools have students from many parts of the district. The out of school participants were selected from three villages from different locations and these are Dasum in the eastern part of the district, Okyereko in the middle and Manso in the western part.

3.5 Sample Size determination

A purposive sampling technique was used for this study. The population of the district according to 2010 census was 142,854; In Ghana, the adolescent population is 22% of the total population (UNICEF 2011). Applying the national proportion, the estimated adolescent population in the district is 31427. Considering the largeness of the district adolescent population size, a sample was drawn that would enable the study to reach adequate number of adolescents as well as help draw relevant conclusion. In determining the sample size, a 95% confidence interval and a 5% margin of error were applied. Based on the proportion of the population of 22%, the calculation of the sample size for the study using the formula that follows:

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

Where= d is margin of error, p = population proportion, q= (1-p), n is sample size $n = \frac{1.96^2 * (0.22)(0.88)}{(0.05)^2}$ n =298.

The number is round –up to 300. $n \sim 300$ Sample size is therefore 300.

3.6 Sampling method.

Out of the 300 questionnaires 60 were administered to three of the out of school groups in different communities and 240 among the in school group (100 to the Okyeedom Secondary School and the remaining 140 to the Ahmadiya Secondary School). The estimated student population at Okyeedom is 800 and the Ahmadiya's is 1100. Ahmadiya has nine classes while Okyeedom has six classes. Each class has an average of 45 students. Fifteen questionnaires were given to each class. The class registers were used to select every 3rd person in the register for the sample in order to arrive at 15 questionnaires for each class. The decision to chose 60 out of the 300 questinaires for out of school adolescents is for convenience sake because it is difficult getting them as compare to the in school adolescents.

3.7 Validity and Reliability

The questionnaire was piloted among in school and out of school adolescents at Nyanyanu which is one of the towns in the district. The questionnaires were fine-tuned based on the responses from the pilot prior to the main data collection.

3.8 Data Collection

Structured questionnaires were designed and used to collect data from 240 respondents from Secondary schools and 60 out of school adolescents. The questionnaires were designed in English, but the questions were asked in the local dialect which is Fante for better understanding of respondents who are out of school or those who did not attend any school. Four Senior High graduates were trained in the data collection. Emphasis was placed on techniques of data collection, rapport creation, assurance of privacy and confidentiality, the meaning of the items and correct ticking of responses provided. Attention was also given to skip patterns used in the questionnaire.

Informed consent was sought at different levels. For instance among in-schools adolescents, consent was sought from the school as well as from their parents. Adolescents in school sent their consent forms home prior to the study to be signed by their parents. Among the out-of school adolescents, permission was sought from community leaders and from their parents.

3.9 Data Analysis

The data gathered were screened and edited for completeness. The completed questionnaires were then coded and entered. Descriptive statistics were generated; analyses were drawn from background statistics. .Means ages for use/nonuse were conducted. Also Statistical Package for Social Science (SPSS version 16) was employed in analyzing data and for highlighting significant characteristics associated with the social factors that influence the use or non-use of contraceptives.

3.10Ethical clearance

Approval was sought from the Ethical Review Board of the Ghana Health Service. Permission was sought from the Ghana Education Service and head masters of the schools before the study commenced.

3.11 Quality Control

Supervision was carried out by the principal investigator while research assistants undertook field work. Completed questionnaires were checked for correctness and completeness. Two independent people entered the data with the help of the principal investigator and the output was checked to ensure accuracy. Daily review of work was done and emerging problems immediately addressed.

CHAPTER FOUR

4.O RESULTS

4.1 Introduction

This chapter focuses on the presentation of the findings of the research concerning the Social barriers that affect the non-use of contraceptives among adolescents in the Gomoa East district. This is guided by the objectives of the study.

4.2 Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics of the survey respondents provide a clear idea of who the respondents of the study are. Table 1 presents information on the socio-demographic characteristics. A total of 238 adolescents between the ages 12 to 19 years participated in the study. Of the total number of respondents the majority (77.8%) fell within the age group of 16 – 19 years and the remaining 22.3% were between 12 – 15 years. In terms of formal education attained, 70.6% were Senior High School (SHS) students, 24% had finished Junior High School (JHS) and 2.5% had completed primary school. However, 2.9% never went to school. Majority of respondents were Christians (71%). The rest were Muslims (19%) and adherents to traditional African beliefs (8.4%). With respect to who they stayed with, 64.7% of respondents said they stayed with their parents, 22.5% with guardians who are not relatives and 8.9% stayed on their own while 4.2% stayed with their friends.

The study also sought information on the parental level of formal education and responses show that 26% and 15% of respondents' mothers and fathers respectively had no formal education. The proportion of mothers and fathers who had basic level of education (JHS

level) was 24.8% and 20.2% respectively, while 37.4% and 58.4% of respondents mothers and fathers respectively achieved at least secondary (SHS) level of formal education. The education of parents do not have any significance on the non-use of contraceptive behaviours of adolescents in Gomoa East.

Table 1. Socio-demographic characteristics of respondents

Socio Demographic Variables	Frequency (N=238)	Percentage (%)
Sex		
Male	94	39.5
Female	144	60.5
Age		
12-15 years	53	*22.3*
16-19 years	185	*77.7*
Educational level of Respondent		
Primary	5	*2.5*
Junior High School	57	*23.9*
Senior High School	168	*70.6*
No Schooling	7	*2.9*
Educational level of Mothers		
Primary	26	*10.9*
Junior High School	59	*24.8*
Senior High School	66	*27.7*
Tertiary	23	*9.7*
No Schooling	62	*26.1*
Don't know	2	*0.8*
Educational level of Fathers		
Primary	15	*6.3*
Junior High School	48	*20.2*

Senior High School	93	*39.1*
Tertiary	46	*19.3*
No Schooling	36	*15.1*
Religious Affiliation		
Christian	168	*70.6*
Moslem	45	*18.9*
Traditional	20	*8.4*
Other	5	*2.1*
Who do you live with?		
Parents	154	64.7
Guardian	53	22.5
Partner/friend	10	4.2
Myself/on my own	21	8.9

4.3 Sexual Behaviour

About 52% (123 people) of the adolescent respondents said they have ever had sexual intercourse. Of the total that ever had sex 43.5% were males and 56.5% were females. The age at first sexual intercourse ranged between ages 10 and 19 years. A total of 5% of respondents had their first sex by age 12. Close to 30% adolescents, had their first sex between the ages 13 and 15 while the greater majority were 16 years or more when they had their first sexual encounter. The mean age at first sexual intercourse was 15.57 and 16.58 for males and females respectively. While the median age at first sex for males was 16.0 and females 17.0.

On the question of adolescents currently having sex, about a quarter of the respondents said Yes, 58 (46.3%) and the rest 66 (53.7%) said No. Close to 37.9% of males and 62.1% of females were still sexually active at the time of the survey.

On the question of whom do you have sex with among those who have ever had sexual intercourse, 93% of respondents said they have sex with their boy/girlfriends. The rest (7%) said they had sex with casual friends (Table 2).

Table 2: Sexual Behaviour of respondents

Sexual Behaviour	Frequency	percentage
Ever had sex (n=124)		
Male	54	43.5
Female	70	56.5
Total	*124*	*100.0*
Currently sexually active (n=58)		
Male	22	37.9
Female	36	62.1
Total	*58*	*100.0*
Sexual Partner (n=58)		
Boyfriend/ Girl Friend	54	93.1
Casual Friend	4	6.9
Total	*58*	*100.0*
Mean/Median age at 1st sex		
Male	15.57/16.0	
Female	16.58/17.0	

4.4 Awareness of contraceptives among Adolescents

Regarding respondents awareness of contraceptives, 201 (84.5%) said they had heard of contraceptives. Table 3 shows types of methods respondents have heard of. Out of the 201 who had heard of contraceptives, the majority (82%) said they had heard of condoms, followed by the pills (49%) and injectables (25.4%). More permanent methods were hardly known among the respondents. For instance, only 9.1% had ever heard of the implant, 9.1% had heard about the IUD. Only 7.2% and 4.3% respectively had heard of the female sterilization and the male sterilization methods.

Of those who were aware, 74.6% said they heard of contraceptives from the radio, 55% from friends, 53.2% from their teachers, 17% from family members and 14% from partners. Only a few respondents (6%) mentioned the print media as their source of contraceptive information.

Table 3: Knowledge of Contraceptive Methods and Source of Knowledge

	Frequency	Percentage (%)
***Method**		
Abstinence	43	20.6
Condom	171	81.8
Pills	103	49.3
Lactational amenorrheoa	10	4.8
Female sterilization	15	7.2
Male sterilization	9	4.3
Implants	19	9.1
Injectables	53	25.4
IUCD	19	9.1
Spermicides	9	4.3
Rhythm	7	3.3
Diaphragm	1	0.5
***Source**		
Radio	153	74.6
Friend	113	55.1
Teacher	109	53.2
Family member	34	16.6
Health worker	29	14.1
Partner	28	13.7
Print media	13	6.3
Others	10	4.9

*multiple responses given

4.5 Contraceptive use

Asked whether they had ever used a method of contraceptive, 37% (representing 89 people) of all the respondents responded in the affirmative (Table 4).

Among respondents who ever had sex the greater majority (71.8%) used a method of contraception. However, close to three out of every ten sexually active respondents used no method at all. Among those who ever used a method 30% did not use any at last sexual intercourse

Regarding the type of contraceptives used, Table 3 shows that majority of the adolescents who ever used contraceptives used condoms (72%). Others used the pills (37%) and injectable (6.4%). Those reported under 'other' include spermicides, rhythm, withdrawal and enema (13.7%).

Out of the 89 respondents who ever used a method of contraception, only 69.7% of them used a contraceptive during their last sexual activity. Thus a little over three in ten did not use any contraceptive during their last sexual intercourse. About 67% of those who used a contraceptive during their last sexual activity had used condoms and 30% used pill and 3% used injectables.

dTable4: Use of Contraceptive Method

Ever Use	Ever Use Frequency (%)	Used at last Sex Frequency (%)
All respondents (n=238)		
Yes	89 (37.4)	
Of respondents who ever had sex (n=124)		
Yes	89 (71.8)	
Contraceptive use at last sex (n=89)		
Yes		62 (69.7)
***Method**		
Condom	60 (69.0)	46 (66.7)
Pills	33 (37.9)	21 (30.4)
Injectables	6 (6.9)	2 (2.9)
Others	12 (13.7)	0 (0.0)

* multiple responses given for methods

4. 6 Perceived Benefits of Contraceptive Use

Respondents who had ever used a contraceptive method were asked to provide reasons for use. Their reasons for the use of contraceptives were similar for both male and female adolescents. About 36% adolescents said they used contraceptives to delay childbirth in order to complete school /acquire a trade. In the same vein 35% said they used contraceptives to avoid teenage pregnancy. A total of 28% respondents said they used contraceptives because they desire to be married before starting child birth. The remaining 2% used it to terminate pregnancy (Table 4).

4.7 Reasons for Non use (general perception of adolescents)

All respondents were asked to provide reasons why adolescents do not use contraceptive methods. These responses are general perceptions of adolescents and may not necessarily be the perceptions held by the respondents but may have a potential of influencing their own beliefs. For reasons why adolescents in general do not use contraceptives, respondents gave reasons such as opposition from partners 41.6 %, opposition by parents 22% and lack of knowledge as to where to obtain the method (29%). A little over 6% of respondents mentioned cost of contraceptives while the rest categorized under 'other' cited religious belief, fear of side effects, attitude of providers, fear of becoming infertile and infrequent sex as reasons for non-use (Table 4).

Table 5: Reasons for use and non use of contraceptive methods among respondents

	Frequency	Percent
Reasons for use (n=87)*		
Delay pregnancy to complete school/acquire trade	31	35.6
Avoid teen pregnancy	30	34.5
Want to marry before pregnancy	24	27.6
Terminate pregnancy	2	2.4
Reasons for non-use (n=214)*		
Opposition from partner	89	41.6
Opposition from parents	46	21.5
Do not know where to get	61	28.5
Cost of contraceptives/no money	13	6.1

Others	5	2.3

*Some did not answer

4.7.1 Reasons for non use (Respondents own perception)

Table 5 provides respondents own reasons for non-use of methods. Reasons given among those who ever had sex was cross tabulated by whether or not they used a contraceptive method. Side effect was the most important reason mentioned for contraceptive non-use. Among those who ever used a method 38% mentioned side effects while 37.5% of those who never used mentioned same. Religious belief was mentioned as a reason for non-use among 30% who ever used a method and 25% among those who never used any contraceptive method. Again about 23% and 22% respectively of respondents who ever used and those who never used a method of contraception mentioned fear of infertility/difficulty to get pregnant in future as a reason for non-use. Close to 21% mentioned infrequent sex (21.5% by ever users and 19% by never users) as a reason for non use of contraceptives. Issues of accessibility (distance to acquisition of contraceptives, too costly, hard to get preferred method and attitude of service providers) also featured well.

Table 6: Reasons for Non-use of methods among Respondents who ever had sex by Ever use of a Contraceptive Method

Reasons	Have you ever used a contraceptive method ?		Total
	Yes	No	
	Freq (%)	Freq (%)	Freq (%)
Side effects	30 (38.0)	12 (37.5)	42 (37.8)
Religious belief	24 (30.4)	7 (24.9)	31 (27.9)
Difficult to get pregnant/infertility in future	18 (22.8)	7 (21.7)	25 (22.5)
Infrequent sex	17 (21.5)	6 (18.8)	23 (20.7)
Distance to acquisition of contraceptive	11 (13.9)	5 (15.6)	16 (14.4)
Attitude of service providers	12 (15.2)	1 (3.1)	13 (11.7)
Want children	8 (10.1)	3 (9.4)	11 (9.9)
Partner or family member oppose to using	4 (5.1)	5 (15.6)	9 (8.1)
Hard to get preferred method	7 (8.9)	2 (6.3)	9 (8.1)
Too costly	5 (6.3)	1 (3.1)	6 (5.4)

4.7.2 Reasons for non use by age and sex

Respondents' personal or own reasons for non use of methods by age and by sex are given in Table 7. Side effect was the most important reason for contraceptive non-use among females while for the males it was religious beliefs. On the whole therefore, side effects of methods and religious form the main reason for non use of contraceptives among both sexes. Distance to acquisition of contraceptive was more of an important reason to non use among males as compared to females since about twice the proportion of males than females cited it. Again, more females than males

were likely to mention infrequent sex (20% versus 15%) and attitudes of service providers (12% versus 9%) as reasons for contraceptive non use.

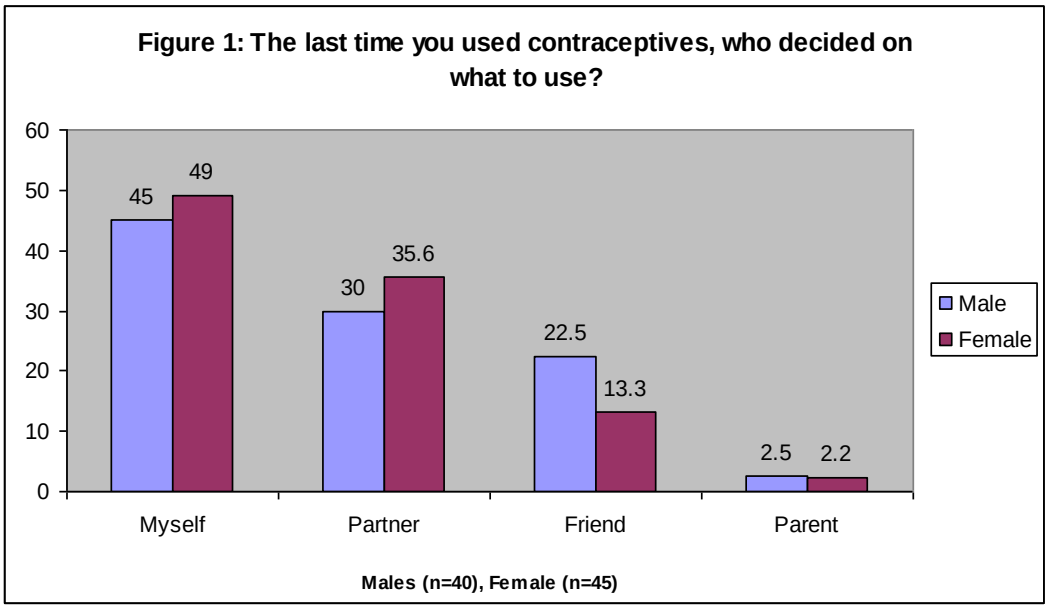
With respect age, side effects and religious beliefs were the key reasons for respondents who fell between both the 12-15 year as well as the 16-19 year old groups – with similar proportions of respondents in each age group providing those two reasons (37% and 35% mentioned side effects and 30% and 32% cited religious beliefs respectively). Difficult to get pregnant/infertility in future was more frequently cited among the higher age group 16-19 years (21%) than the lower age group 12-15 years (15%). A higher proportion of youth aged 12 – 15 years than their older counterparts in the 16-19 years age bracket said they want children (17% versus 7%), a likely reference to their desire to have children in the future. Attitude of service provider (15% versus 9%) and cost of method (13% versus 6%) were more important reasons for the younger age group respondents. Reasons of Infrequent sex, Distance to acquisition of contraceptive and Partner or family member oppose to using did not differ in proportion among the age groups.

Table 7: Reasons for Non-use of Methods among Respondents by Sex and Age

Reasons	Sex (%)		Age Group (%)	
	Male	Female	12-15 yrs	16-19 yrs
Side effects	31.8	38.3	37.0	35.3
Religious belief	37.5	27.3	30.4	31.8
Difficult to get pregnant/infertility in future	18.2	21.1	15.2	21.2
Infrequent sex	14.8	19.5	17.4	17.6
Distance to acquisition of contraceptive	17.0	8.6	10.9	12.4
Attitude of service providers	9.1	11.7	15.2	9.4
Want children	10.2	8.6	17.4	7.1
Partner or family member oppose to using	10.2	8.6	8.7	9.4
Hard to get preferred method	3.4	7.0	.0	7.1
Too costly	8.0	7.0	13.0	5.9

4.8 Decision to use contraceptives

When asked who decided on whether or not to use contraceptive the last time the respondents had sex the following responses emerged. Responses show that the majority took the decision themselves (45% males and 49% females). This was followed by their partners (30% males and 36% females) and friends (22% males and 2.2% females) (Figure 1).



CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

The study sought to investigate the social barriers that affect the non-use of contraceptives among adolescents in the Gomoa East District using the health belief model, and guided by the constructs of perceived threats (susceptibility and severity) and benefits of the Health Belief Model (HBM).

5.2 The Health Belief Model

Perceived susceptibility relates to the respondents subjective perception of risk of an unwanted pregnancy. Where respondents feel that they are very much at risk of getting an unwanted pregnancy, then they are likely to take an action to prevent it. Where the perception of risk is low, the likelihood of taking an action to avoid the undesirable threat will also be low. Reasons for non-use of methods at last sex by respondents who ever used a method and those who never used a method of contraception were sought. Nineteen percent of study participants (17.0% ever used and 26% never used) mentioned infrequent sex as the reason for not using a contraceptive method at last sex. Guttmacher Institute (2007) and Likhaan (2010) reported similar findings of low perception of susceptibility to becoming pregnant due to having infrequent sex among adolescents in the Philippines. This perception warrants consideration in view of consequences of an unplanned and an unwanted pregnancy. The low perception of risk among those who fail to protect themselves from pregnancies due to infrequent sex is purely based on ignorance and gives the indication that they do not appreciate how pregnancies occur. Support from another study showed that respondents who

had not used a contraceptive at first sex considered that "Infrequent intercourse cannot cause a girl to get pregnant even she has experienced her menstruation" Likhaan, 2010).

Close to 9% of the adolescents said they did not use contraceptives because they want children (8% had ever used and 13% had never used a method). While it remains their choice to desire childbirth it is also possible that these respondents are oblivious to the consequences of an adolescent pregnancy. Although the reason for early pregnancy among this category of people were not fully explored, it is obvious that the benefit of childbirth for them outweighs their perception of risk of adolescent pregnancy. Indeed studies from other countries show that adolescents sometimes seek pregnancy as a way to escape from parental control or to make money (Marston and King, 2006). Some families, particularly very poor ones, may marry their children off early in order to reduce the financial burden on the family income while some adolescents would want to use pregnancy to tie down their partners (Ladipo and Konje, 1999). Anecdotal evidence from the Gomoa East district shows that poverty and lack of parental support constitute push factors towards early childbirth among the youth. Some insight on this could be gleaned from the background information of respondents of this study which shows that over 13% of adolescents lived on their own or with partners/friends. Promoting parental support and supervision for adolescents could reduce their desire for early births and even early sexual debut among those who never had sex (Abu and Akerele, 2002).

The HBM assumes that the more serious a health problem is viewed (perceived severity), the more likely one will take preventive action against it. For example if adolescents feel getting pregnant may negatively impact their reproductive health they would likely use a contraceptive method. Again if they believe that not taking any action could hinder their desire for high educational and career goals then they would be more likely to practice

effective contraception According to the model, before taking preventive health actions, people weigh the perceived benefits of the health action against the cost of taking the proposed actions. On benefits 36% of adolescents who used contraceptives said they use contraceptive to delay pregnancy in order to complete school or acquire skills, (37%) to avoid teenage pregnancy and (25%) to pursue childbirth after wedlock.

Perceived barriers to non use are discussed under physical, financial and psychosocial. *Physical barriers to* use of contraceptives mentioned by those who had ever used a method of contraceptives as well as those who never used showed that perceived physical barriers were important. Overall 38% of respondents mentioned side effects as a reason for non use. About 38% of those who ever used a method and 38% among those who had never used mentioned side effects. Whereas it is definite that non users were expressing their perception, one may not be so sure whether the ever users reported actual side effects they experienced or anticipated fear of side effects in continuous use. This finding agrees with several other study results within Ghana (GDHS, 2008) and outside (Blanc et al 2009). In Ghana, one of the key reasons documented by the GDHS, 2008 for non use of contraceptives is fear of side effect. Despite mentioning side effects as reason for non use, this study also highlights that 38% of respondents used a contraceptive method.

Further analyses by sex and by age group (12 -15 years and 16-19 years) in the Gomoa study, showed that while side effects remained the most significant reason for non-use irrespective of age or sex, more females than men (38% females versus 32% males) mentioned side effects as their reason for non-use of contraceptives. This may not be surprising as most methods of contraceptives, particularly the hormonals, with contra-indications tend to be designed for use only by females. Knowledge and attitudes of adolescent female regarding

the side effect of Combined Oral Contraceptives (COCs) were investigated among 486 single females in counselling centres in Ontario, Canada (Blanc et al 2009). The study showed that 91% planned to use COC after their clinic visit in spite of the fact that they had heard about side effects of COCs with weight gain as the best known side effect. Despite knowledge regarding side effects, most of the subjects had positive attitudes toward COCs with 59% believing that the advantages outweighed any disadvantages .

Fear of infertility/difficulty to get pregnant in future came up as the third most important reason for non-use after side effects and religion. This was mentioned by 23% overall, 23% among ever used and 22% of those who never used a method of contraceptive. This results is not surprising considering the social context within which the study was conducted-semi rural, and African where one's inability to have a child ultimately defines his manhood or womanhood. This situation for instance leads family members to put pressure on adolescents to give birth because they are not sure whether or not she would be fertile after using contraceptives (Ladipo and Konje, 1999).

Financial or economic barriers: Financial barrier relating to non-use in this study centres on issues of accessibility (distance to acquisition of contraceptives, too costly, hard to get preferred method). Too costly was mentioned by 5% overall (6% had ever used and 3% had never used), distance to acquisition of contraceptive 14% (14% had ever used and 16% had never used) and hard to get preferred method 8% (9% had ever used and 6% had never used**).** Distance to acquisition of contraceptive was more of an important reason to non use among males as compared to females since about twice the proportion of males than females (17% versus 8.6%) cited it. In Ghana the supply of most contraceptives are facility based- either provided in the health facility or in the pharmacy shops. Due to the better health seeking

behaviour of females, who tend to seek medical help when sick, they may not perceive distance to such facilities for services as the strongest source of barrier to them. Males are supposed to be strong thus not visiting the health facility often so they` find going to the health facility as burdensome. This notwithstanding, UNFPA (2011) reports lack of access to contraceptives as a major factor leading to continuing deaths, unwanted pregnancies and unsafe abortions among Sub-Sahara Africa women and adolescent girls. The issue of cost is further substantiated by Ladipo and Konje (1999) who reported poverty among other things as constituting a barrier to contraceptive use. Where poverty is an issue, it is likely that adolescents would be much more affected such that even condom which is inexpensive may be prohibitively costly for many impoverished adolescents. Some countries have put in place measures to remove the financial barrier to use. In the United States for example most of the adolescents benefit from public funded contraceptives and that caused the rise in the use of contraceptive in the US. Similarly, in the Philippines cuts in public funding of contraceptives brought down the rate of contraceptive use in the country (Guttmacher, 2010 and Likhaan, 2010)

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Perceived Social and Psychological barriers: Religious beliefs was the second most important barrier to contraceptive use among this study population with 24% of respondents mentioning it with no difference among those who ever used and those who never used contraceptives**.** Again in terms of males and females, as well as among the age group 12-15 years and 16-18 years, religion stands out as the second most important reason for non use after side effects. Whereas more males than females held religious reasons as reason for non-use there was no difference in this regards with respect to age group. Religion has been a

barrier to contraceptive use for decades where children are regarded as gifts or blessings from God. This situation is found mostly among the Catholics and Muslims who see contraceptive use as a license or moral degraded action for illicit extra marital sexual behaviour or indiscriminate sexual behaviour (Ladipo and Konje, 1999). While religion as background information was sought, Christianity was not categorized into the various denominations to provide further insight into this finding. Attitude of service providers as a reason for non use was also noted (10.6%) with more females than males mentioning the negative attitudes of service providers (12% versus 9%) as reasons for contraceptive non use. This may be so in light of the fact that more females than males tend to interact with service providers at the health facilities and again society tends to be more liberal with y adolescent males who are sexually active than their female counterparts.

Partner or family member's opposition to use accounted for non-use among 10% of respondents. Advocate for Youth (2007) reports pressure from partners and friends as barriers to the use of contraceptives among adolescents in the United States. While Williamson et al (2009) in their study in Sub-Sahara Africa report that 20% to 30% of partners and significant others respectively oppose contraceptives use. About 22% of study participants from Gomoa district indicated their parents' opposition to contraceptive use. This opposition by parents is likely to be influenced by the social norm that frowns on pre-marital sexual activities despite the fact that it is no longer news in this period of time even in Ghanaian rural communities that adolescents are sexually active. Although this did not come up in the findings of this study perceived barriers to condom use (the most accessible method available to adolescents), have been reported in many other studies to include inconvenience, reduced sexual pleasure, or embarrassing to use (Zhonghua, 2006). This may need to be further explored in order to

provide a comprehensive approach to removing the barriers to contraception among the adolescents within the Gomoa East District.

5.3 Adolescent Sexual Behaviour and Reproductive Health

There are some negative societal norms that contribute to the non-use of contraceptives among adolescents and the frequent teenage pregnancy experienced in the Gomoa East district. It is not unusual for adolescents to fend for themselves under the condition of fathers leaving and mothers being poor or having no work to support the family which possibly explains why 13% of adolescents live by themselves or with friends. Living on one's own at an early age increases one's vulnerability to all sorts of vices and challenges including risky (RAND, 2002). Although it is a taboo in most cultures in Ghana to have pre-marital sex, the findings from this study show that sexual debut for some adolescents is 10 years while the mean age was 15 for males and 16 for females. This clearly indicates the need for adequate information to change their perception of the risk of unprotected sex. For many adolescents the benefits tend to be pleasure without any opportunity for assessing the real benefit over the risks particularly as first sex is mostly unplanned (Awusabo Asare et al, 2006).

5.4 Knowledge on contraceptives.

Knowledge on contraceptives was collected from all adolescents that took part in the study. It is believed that knowledge on contraceptives would translate into use. A total of 84.5% have heard about contraceptives with the condoms and pills being the most widely known methods. Knowledge of condom is not surprising in the wake of its promotion as a dual protection method against pregnancy and HIV and AIDS. Ongoing radio and television campaigns 'it's your life, its your choice' emphasize on these methods. Respondents sources

of knowledge about the methods of contraceptives were mainly radio (75%) their teachers (53%) and friends (55%). The radio constitute a key information source and its use should be explored in widely disseminating information to adolescents to enable them make well informed risk assessments in order to prevent early pregnancies and their associated consequences. Again, the fact that they ever heard about methods of contraception does not mean they would use as found by Ojikuto and Adeleke (2009) in their study in Nigeria where adolescents who had sexual debut are less likely to use contraceptive than older people and that while 77% of adolescents knew about some type of contraceptive they did not use them (Ojikutu and Adeleke, 2009).

5.5 Contraceptive use among adolescents

Low contraceptive use was reported among study participants who were sexually active; only 31.1% of them used contraceptive during their last sexual activity. This corroborates with similar studies in Kenya and in Ghana. For instance in Kenya less than 20% of sexually active adolescents use contraceptives and less than 15% use modern contraceptives (USAID/APHIA11, 2011). In Ghana also 17% of nulliparous women including adolescents used a method (GDHS, 2008). On methods mainly used in this current study, about 70.8% of those who used contraceptive during their last sexual activity used condom, 29% used pill and 3.4% used the injectable. About 8% used spermicides, rhythm and withdrawal methods which some consider as effective ways of preventing pregnancy as substantiated by Zhonghua (2006) For instance, among 113 students who had experienced sex, 68.4% of respondents thought withdrawal and rhythm were effective methods Zhonghua (2006). These methods tend not to be used effectively among adolescents. For instance it has been observed that most adolescents do not have the patience or time during sex especially as they do not

want to be seen as sexually active. Most often also sex is unplanned (Zhonghua (2006)) and these definitely are recipe for the non effectiveness of these methods, particularly the rhythm and the withdrawal methods.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 CONCLUSION

The study set out to examine the social barriers that affect contraceptive non-use among adolescents in the Gomoa East district due to high rate of teenage pregnancies. The objectives were to assess the awareness level of adolescents about contraceptives, identify the reasons for the non-use of contraceptives by adolescents and to identify who makes decisions on contraceptives use among adolescents. The study was guided by the Health Belief Model (HBM) which assumes that persons weigh the perceived benefits of a health action against the cost of taking the proposed actions.

Regarding respondents awareness of contraceptive methods, the findings showed that the majority of respondents have heard condoms (82%) and pills (49%). Sources of contraceptive knowledge include the media, friends, teachers and health workers. About 42% ever used contraceptives with condom use and pills being the most frequently used. Generally ever use of contraceptive among the study participants was very high (81%) although discontinuation also remained equally high (30%) among those who ever used a method. Decisions to use a method mainly by respondents themselves (46%), followed by partners (37%).

Main social barriers include opposition from partners/parents (9.3%), religious influence (24.4%) and attitudes of heath workers (10.6%). Side effects and possible infertility were also mentioned. Irrespective of these barriers to contraceptive use, some respondents still used a method of contraception (37%), an indication that the perceive benefits such as desire to

delay pregnancy in order to complete school/acquire skills (36%) or marry before pregnancy (37%) outweighed these barriers.

The major conclusions that can be drawn from the findings of the study are: the HBM is beneficial in helping to assess motivation among adolescents for either use or non –use of contraceptives.

6.2 RECOMMENDATIONS

1. Tailored message should be developed to help modify adolescents' perceptions of risk to reduce desire for early childbirth.The radio and friends are major sources of contraceptive knowledge among adolescents. It is therefore important to promote benefits and dispel barriers to contraceptive use among adolescents through the media and trained peer promoters.

2. There is the need to help adolescents define actions to take; how, where, when and clarify the positive effects to be expected, programs should be implemented that devise ways to provide adolescents with greater awareness of the risk of unsafe sexual practices which include acquiring STIs or HIV/AIDS and to enable them take control over their sexual lives in a responsible manner.
3. Attitude of service providers came up as a reason to non- use of contraceptive among adolescents. It is important therefore to ensure that all reproductive health service providers in the Gomoa East district are trained in the provision of youth friendly services to enable them provide friendly services adolescents.

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APPENDICES
INTRODUCTION OF STUDY

The main investigator is Crystal Clottey, a student at the School of Public Health, Legon and conducting a study on. 'Social barriers that affect the non-use of contraceptives among adolescents in the Gomoa East District' This study is for academic purposes and a requirement for the award of Master of Science Degree in Applied Health Social Science Degree and supervised by Dr. Phyllis Dako-Gyeke a lecturer of School of Public Health, University of Ghana, Legon.

Procedure:

Structured questionnaires will be used to conduct the interview. The questions would be posed either English or Twi as the choice of respondents. There would be no recording of names and everything we say should remain here. There is no right or wrong answer everybody is free to share his/her mind. You are at liberty to object to participation at any time but if you accept to start I will encourage you to stay on till we finish. It would take about 15minutes of your time.

CONSENT FORM FOR RESPONDENTS

General Information

This study seeks to know the about Social barriers that affect the non- use of contraceptives among adolescents in the Gomoa East district. The study is quantitative one. The study participants will include adolescent both in school and out of school. ‘

Possible Risk and Discomfort

Some questions related to sex life and making decision for contraceptive use may possibly seem sensitive and uncomfortable to some respondents.

Description on measures to minimized risk. The risk involved would be explained to everybody before consenting to participate. Any person who feels uncomfortable to any question may decline to answer that question. However participants would be encouraged to speak their minds. Participants would be admonished not to discuss anything said during the interview out of the premises.

Data Security: All data collected would be under the supervision of the main investigator under lock and key. Data would be accessible to only the research team. Data would be entered in SPSS software by research team.

Participation in this study is entirely voluntary and declining to answer any question or terminate the interview has no negative consequences on the respondents.

Social Barriers that affect Contraceptive non-use among Adolescents in the Gomoa East District

ADDRESS BOX LG 13 SOBS DEPARTMENT

School Of Public Health.

College Of Health Sciences

University Of Ghana, Legon.

TEL: 0244 920154 Email: cryclo@yahoo.com

I ……have been thoroughly briefed on the entire methodology and process of this research being conducted by Crystal Clottey a student of the School of Public Health, Legon.

And on my own free will, consented to participate in the study based of my understanding of what it entails.

I am doing this on condition that, under no circumstance should reference be made to my actual identity, my name or what I said personally at the interview.

Researcher signature……. **Respondent Signature:……**

Date:…….. **Date……**

Thumb Print

PARENTAL CONSENT FORM FOR MINORS

Your child has been invited to participate in a study on social factors that affect the non-use of contraceptives among adolescents. The study is done among students in Okyeedom Senior High school at Afransi and Ahmadiya Secondary School at Postin.

> *Any information collected from your child will be treated as confidential and not disclosed to anybody outside the research team. No responses would be linked to their name or person. There would be no name or address written on the questionnaire.*

The study would help health providers to plan how to curb the incidence of teenage pregnancy in the district.

The process is answering a number of questions on paper questionnaires.

Your signing the form or thumb printing means acceptance of your child to participate in the research. In case you decide to withdraw your child/ children, please call and they would not be penalized in any way.

In case of anything, call Crystal Clottey on- 0244920154 OR SUPERVISOR

Name of Parent/ Guardian **Signature of investigator**

…….. **……..**

Sign…… **Date……..**

Date:……

or Thumb print .

QUESTIONNAIRES FOR SOCIAL BARRIERS THAT AFFECT CONTRACEPTIVE NON-USE AMONG ADOLESCENTS IN THE GOMOA EAST DISTRICT.

Demographic Characteristics

Circle appropriate answer:

1) What is your age? [a]12-15 years [b]16-19 years

2) What is your highest level of schooling?

[a] Primary [b] JHS [c]Secondary [d] No schooling

3) What is the highest level of schooling of your mother?

[a] Primary [b] JHS [c]Secondary [d] No schooling e)Tertiary

4) What is the highest level of schooling of your father?

[a] Primary [b] JHS [c]Secondary [d] No schooling e)Tertiary

5) What is your religious affiliation?

Religious Affiliation	Tick
Christianity	
Moslem	
Traditional	
Others specify	

6) Sex of respondent [a] Male [b]female

7) Who do you stay with?

[A] Parents [b] guardian [c] partner [d] By myself

Contraceptive Awareness

8) Have you ever heard of any contraceptive before?

[a]Yes [b] If No skip to question 11

9) If yes which type? Tick as appropriate.

Contraceptive methods	**Tick**	**Contraceptive methods**	**Tick**
abstinence		implants	
condom		Injectables	
pills		IUCD	
lactational amenorrheoa		Spermicides	
female sterilization		Rhythm	
male sterilization		Diaphragm	
Others specify			

10) Where did you hear of this contraceptive(s) you have mentioned? Tick appropriate.

Source	tick	Source	tick	Source	Tick	Source	tick
Radio		teacher		Family member		Friends	
Print media		Health worker		partner			
Others specify							

Contraceptive use

11) Have you used any contraceptive before? [a] Yes [b] No

If no skip to question number 14

12) If yes which type? Tick as appropriate.

Methods	Tick	Methods	Tick
Abstinence		Implants	
condom		Injectables	
pills		IUCD	
spermicides		Diaphram	
lactational amenorrheoa		Rhythm	
female sterilization		withdrawal	
male sterilization			
Others specify			

13) What are the reasons for using contraceptives?

a) to delay pregnancy in complete school/acquire trade b) to avoid teenage pregnancy

c) to be married before childbirth d)other specify

Sexual activity and contraceptive use

14) Have you ever had sex before? [a]Yes [b] No.

15) How old were you when you first had sexual encounter? Age…….

16) The last time you had sex did you or your partner use any contraceptive? a) Yes b) No

17) Which type of contraceptive did you use? Which type? Tick as appropriate.

Methods	**Tick**	**Methods**	**Tick**
abstinence		implants	
condom		Injectables	
pills		IUCD	
spermicides		Diaphragm	
lactational amenorrheoa		abstinence	
female sterilization		rhythm	
male sterilization		others	

18) The last time you used a contraceptive who decided on what to use?

Methods	**Tick**
You	
Friend	
Partner	
Parent	
Others specify	

19)Are you currently having sex? [a] Yes [b]No.

If no skip to number 21.

20) With whom do you have sex?.....

21) What will you say are the reasons why adolescents do not use contraceptives?

Barriers	**Tick**
opposition from partner	
opposition from parents	
do not know where to get	
cost of methods/no money to buy	
Others specify	

22) Why are you not using contraceptive (can tick more than one)

Religious belief	
Distance to acquisition of contraceptives	
Partner or family members opposed to using Side effects	
Difficult to get pregnant/infertility	
Infrequent sex	
Hard to get preferred methods	
Too costly	
Want children	
Attitude of service providers	
Other, specify	

THANK YOU.