Archives of Sexual Behavior (2021) 50:2411–2421
https://doi.org/10.1007/s10508-021-01914-z

ORIGINAL PAPER

Exploring Adolescents' (Non-)Use of Modern Contraceptives in Ghana Through the Lens of the Theory of Gender and Power

Sylvia Esther Gyan[1] · **Stephanie Marhefka-Day**[2]

Received: 6 December 2018 / Revised: 8 January 2021 / Accepted: 12 January 2021 / Published online: 19 July 2021

Abstract

Despite the benefits of modern contraceptives, its usage is low among adolescents in sub-Saharan Africa. Based on the theory of gender and power, this study explored adolescents' (non-)use of contraceptives in the context of their sexual and reproductive health. Data were collected from adolescents (15–19 years) through focus group discussions as well as through interviews with five key informants. The collected data were investigated through thematic analysis. The study revealed that gender and power influenced adolescents sexual behavior. Both young men and young women engaged in risky sexual behavior, which exposed them to unintended pregnancy. Whereas some young women engaged in risky sexual behaviors due to financial reasons, young men engaged in such behaviors for pleasure. Lack of knowledge about the correct use of modern contraceptives, type of sexual relationship, and cultural norms of adolescent girls' appropriate sexual behavior influenced the use of contraceptives by adolescent girls. Avoiding pregnancy could be easier for adolescent girls if only they could have easy access to more long-term and reliable contraceptive methods. Education on the need to use condoms during sexual intercourse should be intensified to create awareness about using condoms to avoid sexually transmitted infections in addition to unwanted pregnancy.

Keywords Unintended pregnancy · Adolescents · Contraceptives · Gender · Ghana

Introduction

Globally, adolescents are increasingly becoming sexually active at earlier ages, which often expose them to sexual and reproductive health risks such as unintended pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). Approximately 25% of adolescents aged 15–19 years in sub-Saharan Africa engage in sex before the age of 15 years (Doyle, Mavedzenge, Plummer, & Ross, 2012). Early marriage is identified as one of the factors for early sexual initiation among adolescent girls in most developing countries (Wodon, Nguyen, & Tsimpo, 2016). Most adolescents who engage in risky sexual behavior tend to use little or no protection when engaging in sexual activities (Doyle et al., 2012; Kalamar, Tunçalp, & Hindin, 2018; Radovich et al., 2018).

Unmarried adolescents have a larger unmet demand for contraceptives than married women of their age (Blanc, Tsui, Croft, & Trevitt, 2009), because most of them do not use contraception methods due to barriers to obtaining contraceptives (Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014). This issue persists despite the consequences such as unintended pregnancy, unsafe abortion, maternal and child mortality, and reduced earning potential and educational achievements being more serious for them (Hindin, McGough, & Adanu, 2014; Santhya & Jejeebhoy, 2015). Using protection during sexual activity has the potential to reduce sexual and reproductive health risks, the negative consequences for adolescents (Bongaarts, Cleland, Townsend, Bertrand, & Gupta, 2012; Sánchez-Páez & Ortega, 2018). Despite the benefits of contraceptives, their use continues to be low among adolescents in sub-Saharan Africa (Doyle et al., 2012; Kalamar et al., 2018; Radovich et al., 2018).

Although adolescents' knowledge of contraceptives is high, contraceptive use in Ghana is low (Awusabo-Asare, Abane, & Kumi-Kyereme, 2004; Ghana Statistical Service [GSS],

✉ Sylvia Esther Gyan
sgyan@ug.edu.gh

[1] Department of Sociology, School of Social Sciences, University of Ghana, Accra, Ghana

[2] Department of Community and Family Planning, College of Public Health, University of South Florida, Tampa, FL, USA

Ghana Health Service, & ICF International, 2015). The 2014 Ghana Demographic Health Survey (GDHS) indicates that approximately 6% of adolescent girls (15–19 years) use a modern contraception method, and approximately 2% use traditional contraception methods (withdrawal method and rhythm method) (GSS et al., 2015; Hindin et al., 2014). Poor access, fear of side effects, misinformation, and misconceptions have been identified as factors that limit adolescents' use of modern contraception.

While several studies have investigated adolescent sexual and reproductive health risks in sub-Saharan Africa, studies focusing on how the gendered relationship between young men and young women in society influences adolescents' sexual and reproductive health behavior within the Ghanaian social context are limited. Contraceptive needs may vary between adolescent boys and girls. These variations may stem from social structures, which, according to Connell (1987), characterize the gendered relationships between men and women. These are embedded in the cultural norms that define the roles of men and women both within society and in the family (Ampofo, 2001).

In her theory of gender and power, Connell (1987) identified three major structures that characterize the gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis. The sexual division of labor at the societal level refers to the allocation of men and women to certain occupations. Adolescents are expected to be unemployed; however, adolescent girls may be more vulnerable compared to boys when seeking access to financial resources. The inequalities in power between the sexes form the basis for the sexual division of power. In patriarchal societies, the increase in the power inequity between men and women favors the former, thus increasing the likelihood of women experiencing adverse health outcomes (Wingood & DiClemente, 2000). For instance, men's preference for not using condoms may result in women being exposed to health risks. The structure of cathexis is also referred to as the structure of affective attachments and social norms, which according to Wingood and DiClemente (2000), "dictates appropriate sexual behavior for women and is characterized by the emotional and sexual attachments that women have with men" (p. 544). According to Connell (1987), these three structures are dependent on and influence each other.

The power relations between the sexes have an impact on the outcome of sexual negotiations. Affective relationships result from societal expectations, and these are imbibed through socialization. The presence of these gendered relationships and social structures constrains women's daily lifestyle practices, which may expose them to sexual and reproductive health risks (Wingood & DiClemente, 2000).

The theory of gender and power is utilized as a framework for data analysis, as many of the reasons for low contraception use seemed to be nested within the social structures identified by the theory (structure of labor, structure of power, and structure of cathexis). We explored adolescents' perceptions about contraceptive use/nonuse and how they influence their contraceptive use behaviors based on the structures of labor, power, and cathexis from the modified theory of gender and power by Wingood and DiClemente (2000). The present study aimed to answer the following question: How do the structures of labor, power, and cathexis influence adolescents' (non-) use of modern contraceptives? The findings of the study are expected to provide information for interventions and policies aiming to address adolescents' sexual health needs and prevent unintended pregnancy and STIs.

Method

Participants

The present study was conducted in the Greater Accra Region of Ghana. According to the 2014 GDHS, this region had the lowest adolescent fertility rate of 2.6 births per woman (GSS, 2015). Since most studies conducted in the Greater Accra Region have focused on adolescents in urban areas (Awusabo-Asare et al., 2004; Aziato et al., 2016), our study focused on adolescents from two peri-urban districts in the region. Communities within urban centers have close proximity to clinics, poly-clinics, and hospitals in Accra, unlike in peri-urban districts (Adanu, Ntumy, & Tweneboah, 2005; Biney, 2011; Hindin et al., 2014). Peri-urban communities within the Ga South and Ga West districts were selected for the present study. Since most peri-urban areas are transitioning from rural to urban areas, adolescents in these social environments grapple with different value systems and norms pertaining to sex, getting married, and having children (Ahlberg, 1994). The communities in these areas tend to have communal relationships; thus, any behavior that flouts social norms and values becomes known to other community members and is seen as a deviation from the norm, unlike in the case of adolescents in urban communities. These tensions in the value systems and socioeconomic factors could influence adolescents' sexual and reproductive health behaviors in such communities.

This study is part of a larger study aiming to understand adolescents' contraceptive needs in Ghana. The analysis in the present study is based on qualitative data collected from four communities in the Ga West and Ga South Districts in the Greater Accra Region of Ghana in August 2018. Eight focus group discussions (FGDs) with adolescents (15–19 years) along with five key informant interviews were conducted to understand the current use or nonuse of contraceptives by adolescents. These key informants included a healthcare worker, an opinion leader, a religious leader, a teacher, and a traditional leader. The FGDs were used to collect data from the adolescents since the research sought to explore the diverse perceptions of adolescents on contraception

and unintended pregnancy (Krueger, 1994). Using this data collection method encouraged the participants to discuss their own or peers' experiences as well as the perceptions of adolescents in the community on modern contraceptive use behaviors.

Procedure

Morgan and Krueger (1997) recommend a homogenous group for FGDs in order to encourage participants to feel comfortable sharing a common experience or belief. The purposive sampling technique, which involves selecting individuals who are knowledgeable about sexual and reproductive health matters in the community, was used to select the participants for the FGDs. Similarly, the five key informants were purposively selected to offer community and institutional views on the topic. The inclusion criteria for the FGDs were age (15–19 years), ability to communicate in either Ga or English language, being a permanent resident of the community, and verbal confirmation of having knowledge about sexual and reproductive health matters pertinent to the community. The FGD participants were selected and grouped based on age and the ability to communicate in one common language, which, according to Morgan and Krueger, encourages members to actively participate in the discussion.

The FGD participants were recruited with the help of the Ghana Health Service focal person in the community. The focal person was briefed about the study and assisted in participant recruitment. Eight FGDs (four groups of young men and four groups of young women) were held with adolescents aged 15–19 years across four communities in the Ga South and Ga West Districts in Greater Accra Region (Bebianiha, Obom, Kwarteman, and Dome Sampaman). Ten participants were contacted for each group in the community, with the assumption that some of them might not attend the discussion (Krueger, 1994). However, almost all the recruited participants attended the discussion. Thus, all the groups comprised ten adolescents, except for one group with only nine young men (Morgan & Krueger, 1997). All the in-depth interviews and seven of the FGDs were held in Ga, which is the local language of the community. The discussions in one of the focus groups with young men were held in English because it was the preferred language of the participants. All the FGD sessions were audio recorded.

The eight FGDs were moderated by the researcher. Separate discussions were held with young men and young women in each community. Participants sat in circle so that all of them could see each other and the moderator (Finch, Lewis & Turley, 2003). The moderator introduced herself and explained the purpose and process of the FGDs, including guidelines for confidentiality. Four key questions informed the discussions and interviews: Are adolescents concerned about their fertility, and if so, why? What factors contribute to adolescents' exposure to risky sexual behaviors and unintended pregnancy? What are adolescents' perceptions on the use of modern contraceptives? What are the factors inhibiting adolescents' contraceptive use in the community? Using the FGD technique enriched the quality of the collected data because it allowed adolescents to share their experiences in the presence of their peers, who periodically encouraged each other to talk during the discussions.

Five key informants were contacted and interviewed to provide insights into the broader social context influencing the adolescents' sexual and reproductive health behaviors. The key informants were selected from the four communities based on their positions in the society. Key informants were contacted in their homes or at their workplaces. The interviews were conducted after obtaining their permissions. The key informants were asked about factors that contributed to adolescents' exposure to risky sexual behaviors and unintended pregnancy, society's perceptions on adolescents use of modern contraceptives as well as the factors inhibiting adolescents' contraceptive use in the community. The views of key informants provided insight into the contexts of the adolescents sexual and reproductive health.

Ethical Considerations

This study was approved by an institutional review board. Parental/guardian consent was received for all participants below the age of 18 years. The researcher also obtained informed consent from the minors. The study participants and their parents/guardians were informed about the study and were informed about their right to withdraw from the study at any point. The participants were also assured that their data would remain anonymous.

Data Analysis

The audio recordings of discussions held in English were transcribed, and recordings in Ga (local language of participants) were translated and transcribed simultaneously. Thematic analysis was used to analyze the data (Attride-Stirling, 2001; Braun & Clarke, 2006). As suggested by Braun and Clarke's six-step model, the analysis started with data familiarization. After transcribing the data, the researcher attentively read through the transcripts to fully understand the content of each transcript. During this phase, ideas for coding were noted down on each transcript, which helped organize the data according to the broad topics explored in the study, such as "perceptions about modern contraceptives" and "challenges with accessing modern contraceptives." In the second phase of the analysis, codes were identified from the data extracts. For instance, when a participant indicated that her parents did not provide her basic needs or that she relied on men for financial support, lack of financial support

and lack of parental support were identified as the codes. All the data extracts were organized under the relevant codes. The codes were generated by highlighting interesting and recurrent features from the data in a systematic manner.

The third phase of the analysis involved collating the codes into themes. The researcher identified themes by combining different codes, which focused on a common subject. For example, the codes "lack of financial support" and "cost of contraceptives" were merged under the theme "causes of risky sexual behavior." After organizing the codes into themes, the initial themes were further reviewed and refined, thereby generating main themes and sub-themes. The final main themes were selected by utilizing the two levels suggested by Braun and Clarke (2006), where on level one, the "candidate themes formed a coherent pattern," and on the second level, the candidate themes reflected "the meanings evident in the data set as a whole" (p. 91). To avoid any overlap of codes, the themes were defined and refined to ensure that each theme was distinct in the story it told. The themes were either revised or merged with other themes, and in some cases, sub-themes were created. For instance, the main theme, "Influence of the structure of labor on adolescents' use of contraceptives" emerged after further review of the initial theme. The final stage of the analysis was report writing. The report highlights three main themes built around the three social structures of the theory of gender and power. The findings are discussed under the sub-themes that emerged under the main themes.

Table 1 Sociodemographic background of participants

Sociodemographic characteristics	Young men $N=39$ (%)	Young women $N=40$ (%)
Age		
15	7 (18.0)	18 (45.0)
16	19 (48. 7)	7 (17.5)
17	3 (7.7)	7 (17.5)
18	5 (12.8)	4 (10.0)
19	5 (12.8)	4 (10.0)
Highest level of education completed		
Senior high school	2 (5.2)	–
Junior high school	13 (33.3)	7 (17.5)
Upper primary (Class 4–6)	24 (61.5)	31 (77.5)
Lower primary (Class 1–3)	-	1 (2.5)
None	-	1 (2.5)
Relation status		
In a relationship	10 (25.6)	9 (22.5)
Not in a relationship	29 (74.4)	31 (77.5)
Religious background		
Christian	39 (100)	38 (95.0)
Muslim	–	2 (5.0)
African traditional religions	–	–
None	–	–
Occupation		
Student	35 (89.7)	35 (87.5)
Unemployed	1 (2.5)	3 (7.5)
Employed	3 (7.7)	2 (5.0)

Results

Sociodemographic Characteristics of Participants

The sociodemographic characteristics of the study participants are described in Table 1. The majority of the participants were aged between 15–16 years. The participants comprised 18 young women (all of them were 15 years old) and 19 young men (all of them were 16 years old). Most participants were Christian; however, two young women were Muslim. The highest level of education of the young men who participated in the study was senior high school (SHS; i.e., 12 years of education). Of the young men, 2 had completed SHS, whereas 13 had completed junior high school [JHS] (9 years of education) and 24 had completed 6 years of basic education. None of the young women who participated in the study had completed SHS; the highest level of education was six years of basic education, with seven participants having completed JHS. The majority of the participants, both young men ($n=29$) and young women ($n=31$), were not in any sexual relationship at the time of the interview. The study participants were mainly students; only three of the young men and two of the young women indicated being employed in the informal sector, and they worked as commercial motor riders, petty traders, or bar attendants (Table 1).

To analyze the data, the researchers applied the theory of gender and power, as many of the reasons for low contraception use seemed to be nested within the three social structures identified by this theory. Table 2 provides a summary of the major themes, sub-themes and sample quotes.

Influence of the Structure of Labor on Adolescents' (Non-)Use of Contraception

Lack of Financial Support

Most adolescents attend school; they are thus unemployed and are financially dependent on their parents. Both the key informants and the FGD participants talked about poverty as a factor influencing adolescent girls' sexual behavior. Lack of financial support from parents compelled girls to turn to adult men for financial support in exchange of sexual favors. When asked why girls engage in risky sexual behavior, one of the key informants (traditional leader) recalled:

Table 2 Summary of the key findings

Main themes	Sub-themes	Comments/Quotes
Influence of the structure of labor on adolescents' (non-)use of contraception	Lack of financial support	Due to financial difficulties, the ladies get boyfriends, and the boyfriends give them money in exchange for sex. (FGD, Bebianiha, young woman)
	Financial cost of contraceptives	I do not use the condom all the time. I buy them when I have money (FGD, Bebianiha young man)
Influence of the structure of power on adolescents' (non-)use of contraception	Sexual pleasure among boys and limited self-efficacy in negotiating and using condoms among girls	Someone told me that when he uses the condom, he does not feel satisfied. He had unprotected sex, and he was so satisfied that since then, he always has unprotected sex. (FGD, Dome Sampaman young man)
	Lack of knowledge about the proper use of modern contraceptives	Some people do not know how to use the contraceptives. They sometimes take the emergency contraceptive pills two weeks after having sex, and before they know it, they are already pregnant (FGD, Bebianiha young woman)
Influence of the structure of cathexis on adolescents' (non-)use of contraception	Adolescents sexual relationship	When you have two boyfriends but love one more than the other, you use contraceptives when you have sex with the one you do not love much. (FGD, Bebianiha, young woman)
	Social and cultural norms proscribing adolescent premarital sex	When you go to a shop to buy condoms, the news will spread in the community … the whole community will know that you went to buy a condom. (FGD, Obom, young woman)

> Just like the elders say, not all fingers are equal. Some parents are not financially sound enough to cater to the needs of their children and their education. Therefore, if young men decide to give these girls money for themselves, parents only witness the consequences of their lack of financial support for their daughters only when they become pregnant. (Key Informant, Traditional Leader, Bebianiha)

This quote shows that for some girls, risky sexual behavior is a consequence of poverty, which is consistent with the structure of division of labor. It was perceived that the poverty experienced by some adolescent girls pushed them to engage in risky sexual behaviors—yet, at the same time, their economic status might have limited their access to family planning programs. The key informant noted that parents are often unable to meet the basic needs of their children, and thus, girls in particular are forced to engage in risky sexual behaviors. The informant also noted that all girls did not engage in sexual activity due to financial constraints.

To meet their basic needs, some girls relied on men and sometimes sought multiple partners. A young woman provided the following response when asked why adolescents are susceptible to unintended pregnancy.

> Another reason why some of us get boyfriends is because of our parents. This is because if I have a friend who has a boyfriend or has been sleeping with men for money, when I ask my parents for money, they—especially my mother—will compare me to that friend of mine who is sleeping around for money. Therefore, I will have no option other than to go and see that friend of mine and ask her to introduce me to that kind of lifestyle that gives her money, and if I am not lucky, I may get pregnant. (FGD, Bebianiha, young woman)

In his response to why some adolescent girls could be vulnerable to unintended pregnancy in the community, a key informant who was a religious leader noted the practice of having multiple sex partners as a survival strategy adopted by some girls.

> Some time ago, I was teaching catechism when five condoms dropped from a lady who got up, so I picked them up. She realized what had happened and came to see me after the session. It was then that she told me that she finances her own education and has five boyfriends and that as school is closed on Wednesday, she does not go home. … She goes to each of the boyfriends for money in exchange for sex, so that's how she provides for herself. (Key Informant, Religious leader, Obom)

The above quote is an extreme example but highlights the reality of multiple partnerships in the communities under

study. Some of the young women believed it to be necessary to put themselves at such risk to obtain small amounts of money or goods to meet their basic needs.

Financial Cost of Contraceptives

Using contraceptives is costly, and adolescents may not be able to consistently use contraceptives to control their fertility. The financial costs of accessing contraceptives tend to limit adolescents' access to using "reliable" methods of protection in their sexual activities. Both the young men and the young women explained that the financial cost of accessing contraceptives influenced the latter's contraceptive use. They explained that most adolescent girls do not have the financial means to consistently access contraceptives when they need them, and this may increase their risk of getting pregnant or contracting an STI including HIV/AIDS. One participant explained why girls do not use modern contraceptives or enroll in family planning programs.

> Most girls turn to the rhythm method because they do not have money to buy the pills (birth control pills). Today, you may have some money to buy it, but next month you may not have any. (FGD, Bebianiha, young woman)

> They [girls] do family planning, but it [family planning] is not common here; most of them do not have money to go to the hospital for it. It expires after some time, so you must go and renew it. Most of them do not have the money to do that. (FGD, Bebianiha, young man)

The participant is referring to the amount of money that the girls are required to pay for family planning. Yet, given the sexual division of labor, adolescent girls may have constrained choices due to the lack of financial resources to support family planning.

Influence of the Structure of Power on Adolescents' (Non-)Use of Contraception

Sexual Pleasure Among Boys and Limited Self-Efficacy Among Girls

While some young women realized that they had the power to insist on condom use even when engaging in sexual encounters for financial assistance, others did not. In the latter case, the young women were at risk of unintended pregnancy or STIs.

> If a woman goes to borrow money from a man, the man may try to take advantage of her and have sex with her. Although the woman may not want to get pregnant, she cannot insist that the man should use a condom because she might be afraid to do so or she may be too embarrassed to bring up the topic. (FGD, Bebianiha, young woman)

In a cultural context where girls are socialized to perceive themselves as inferior to men (Ampofo, 2001), having a partner who disapproves of practicing safe sex may influence adolescent girls' use of contraceptives. Adolescent boys expressed reduced pleasure as the reason for not using condoms. One young man explained:

> Someone told me that when he uses the condom, he does not feel satisfied. He had unprotected sex, and he was so satisfied that since then, he always has unprotected sex. (FGD, Dome Sampaman young man)

The young men mentioned pleasure as the reason for not using condoms, but the young women did not do so. The reason why girls did not cite pleasure as a reason could be because this was not an important preference for them. However, it could also be a result of how social norms are structured; similar to many societies, Ghana's conservative culture does not socially sanction sexual pleasure for young women (Ampofo, 2001). The effect of such perceptions is experienced more drastically by adolescent girls because they are at a high risk of becoming pregnant from unprotected sex.

Lack of Knowledge About the Proper use of Modern Contraceptives

Some of the participants note that limited or low education among adolescent girls negatively influenced their use of modern contraceptives. One participant explained:

> Some people [girls] have not been to school, so when you give them the pills (contraceptive pills), they do not know how to use it, and before they (girls) know it, they are already pregnant. (FGD, Bebianiha young woman)

Most of the participants noted that lack of knowledge about the proper use of modern contraceptives was a major factor in the unintended pregnancies of adolescent girls. Less education may cause them to not use contraceptives or not using contraceptives appropriately to achieve the best results.

Adolescents' reliance on unreliable methods of preventing pregnancy also increases their risk of unintended pregnancy. For instance, adolescents' perception of a "safe period" (following the menstrual cycle), based on the lower probability of getting pregnant on certain days, makes girls susceptible to unintended pregnancy. In response to the question of why adolescents are likely to have unintended pregnancies, a young woman mentioned:

> …if a woman is with a man and they both want to have sex, but the woman lies about the fact that she is in

her safe period. (FGD, Bebianiha young woman).…if a woman is with a man and they both want to have sex, but the woman lies about the fact that she is in her safe period. (FGD, Bebianiha young woman)

Although adolescents may be aware about the days in their menstrual cycles where the probability of getting pregnant is lower, this is known to be an ineffective contraceptive method (Gangestad, Thornhill, & Garver, 2002).

Influence of the Structure of Cathexis on Adolescents' (Non-)Use of Contraception

Adolescents' Sexual Relationships

Adolescent girls' sexual relationships with either adult men or young men influenced their chosen mode of contraception. Young women who were in multiple sexual relationships had a tendency not to use contraceptives consistently. When asked whether they used protection during sex, one participant explained:

When you have more than one sexual partner and have unprotected sex [with one partner], you must wear a condom when having sex with another partner to prevent pregnancy and STIs (FGD, Bebianiha, young woman)

Young women practiced differential condom use with sexual partners based on emotional attachments. Adolescent girls who practiced this pattern of contraceptive use preferred having sex without contraceptives with partners they are emotionally attached to while they used contraceptives in casual sexual relationships. Some young women explained:

When you have two boyfriends but love one more than the other, you use contraceptives when you have sex with the one you do not love much. (FGD, Bebianiha, young woman)

On being accused by your parents of being in a sexual relationship, you deny it…Because you love your boyfriend, you would not want to break up with him, so you have to ensure that you do not get pregnant…You must always remember to take the pills [emergency contraceptive pills] to cover your tracks anytime you have sex (FGD, Bebianiha, young woman)

Being in love played a role in young women's contraceptive use. Young women tend to engage in unprotected sex with multiple partners when they are in love with them; however, there are also instances where they used contraceptives to preserve their relationship.

Another type of sexual relationship that influenced adolescent girls' contraceptive use on the bases of emotional attachment and social norms is being in a sexual relationship with an adult man. Some young women engaged in sex for money and material goods from adult men; however, they are not able to influence the men's decision on using protection during sex. Elaborating on such situations, a young woman explained:

Sometimes, as a young woman, due to peer pressure, you have sexual relationships with adult men to obtain small amounts of money or goods…Since you [young woman] do not want to get pregnant, you may initiate the use of a contraceptive and if he [adult man] refuses, you must take the contraceptive pill after sex to avoid pregnancy. (FGD, Dome Sampaman, young woman)

Adolescent women's engagement in sexual relationships with adult men for money and material goods is a common phenomenon in most sub-Saharan African countries. Young women's dependence on adult men for money and gifts as well as gendered norms that support men's dominance over women limit their ability to convince their sexual partners to use protection. Luke (2005) noted that young women lack the power to persuade condom use due to gender norms.

Social and Cultural Norms Proscribing Adolescent Premarital Sex

Social norms that proscribe premarital sex among young men and women prevented adolescents from accessing modern contraceptives. Although both young men and women were apprehensive about purchasing modern contraceptives, women were the most tensed. When asked to explain this, they stated:

I cannot go and buy condoms, I am shy…I cannot go and stand in front of the man (chemist) and say, "Please, I want to buy a condom." He will ask why I need a condom, and I would be too embarrassed to tell him; I am young. (FGD, Obom, young woman)

For me, when I go to buy the condom, the chemist or salesperson will question me as follows: "[Name of girl], who sent you? or "What are you going to use the condom for?" The chemist will not sell anything to me and will instead come and report me to my mother. (FGD, Obom, young woman)

The views of the few young men who also expressed worry about accessing modern contraceptives are adequately represented in this quote:

Sometimes you may want to use contraceptives; however, getting access to it may be difficult, as they (chemists) will ask you so many questions. At times, the drugstore may be crowded, and you do not want people to know you are having sex. (FGD, Obom, young man)

The participants explained the difficulties they faced in accessing contraceptives from pharmacies/drugstores. In communities where condoms are frequently purchased from non-health professionals, the confidentiality of adolescents is not maintained when it comes to condom use. The community uses social control mechanisms and social norms to discourage adolescents from being sexually active.

Some participants perceived having protected sex as worse than having unprotected sex. Unfortunately, nonuse of contraceptives may lead to unintended pregnancy, which often becomes a burden on young women. The following quote by a young man on why girls do not use contraceptives indicates the participant's perception that having sex is a sin that is worsened by using protection:

> Most of them, especially girls, think that using protection [the use of contraceptives] is a sin. People equate the use of protection with aborting a pregnancy. This mindset prevents them from using modern contraceptives. They would rather have sex without protection or use the traditional method. They use the rhythm method, and when it fails, they either go ahead with the pregnancy or abort it…(FGD, Bebianiha, young man)

Here, the young man's use of "them" when equating contraceptives with sin is noteworthy. He also goes on to discuss how "they study the calendar," thus appearing to again suggest that girls are responsible for preventing pregnancy and that they are the ones who feel guilty for committing the "sin" of contraceptive use. It is found that social norms impose more burden on women (Ampofo, 2001), because they are generally in charge of family planning, presumably because they can become pregnant.

Discussion

This study aimed to explore adolescents' perceptions of factors influencing the nonuse of modern contraceptives in Ghana within a specific social context. The structural drivers of adolescents' engagement in risky sexual behaviors could be largely attributed to the structure of labor and power as well as the structure of affective attachments and social norms (Wingood & DiClemente, 2000). Adolescents' risky sexual behavior such as not using modern contraceptives during sexual intercourse, lack of knowledge about the appropriate use of modern contraceptives, as well as having multiple sexual partners were some of the main factors that resulted in unintended pregnancies. Some adolescent girls engaged in risky sexual behaviors in exchange for economic gains, whereas adolescent boys engaged in such risky sexual behaviors mainly for pleasure (Amo-Adjei, Kumi-Kyereme, & Tuoyire, 2014; Awusabo-Asare et al., 2004).

Poverty influenced adolescent girls' attitude and behavior in sexual relationships. Some adolescent girls relied on men for financial support to meet basic needs that could not be met by their parents, reinforcing the sexual division of labor. Financial cost has been identified as one of the barriers to adolescent contraceptive use in Burkina-Faso, Uganda, Malawi, as well as Ghana (Biddlecom, Munthali, Singh, & Woog, 2007). Accessing modern contraceptives is costly, which most adolescents could not afford on their own, leading to limited access to modern contraceptives. Most adolescents found it challenging to consistently have money to access contraceptives to prevent unintended pregnancy. This suggests that lack of financial resources makes adolescents rely on short-term contraceptive methods that are cheaper instead of on long-term contraceptive methods that ensure consistency. Findings by Do and Kurimoto (2010) on women's use of contraceptives in Ghana resulted in similar observations, suggesting that contraceptive use was associated with economic empowerment. Being economically empowered as a young woman will not only translate into contraceptive use, but also result in girls making decisions about their own health with or without the support of their sexual partners.

In addition to poverty, lack of knowledge about contraceptives played a role in some adolescents engaging in unprotected sex that could lead to unintended pregnancy. When adolescents had knowledge about contraceptives, such knowledge tended to be superficial. Lack of sufficient knowledge may lead to contraceptive failure, which has been identified as one of the leading causes of unintended pregnancy among adolescents in sub-Saharan Africa (Biney, 2011; Hindin et al., 2014). Contraceptive failure could be due to adolescents' poor or inappropriate use of contraceptives, such as wrong timing of using contraceptive pills and wearing condoms incorrectly (Bajos, Leridon, Goulard, Oustry, & Job-Spira, 2003).

Adolescent boys' perceptions about contraceptives prevented them from using modern contraceptives. Some boys perceived condoms as a reason for reduced sexual pleasure. With the structure of power and the sexual division of labor limiting adolescent girls' ability to negotiate for safe sex and boys' prioritization of pleasure over safe sex, girls are exposed to unintended pregnancies and its consequences. This corroborates what Doyle et al. (2012) found in their studies on adolescents' sexual behaviors in sub-Saharan Africa. Engaging in sexual activities without using modern contraceptives increases teenage pregnancy and STIs, including HIV/AIDS, although the latter was not frequently mentioned as a possible risk by most participants. Similar findings were noted in a recent study on adolescents' contraceptive use in 46 developing countries (Kalamar et al., 2018). In their analysis, Kalamar et al. observed that the majority of adolescent girls never used a contraceptive for their sexual

activities. Although studies on sub-Saharan Africa identify adolescents' unmet contraceptive needs as the main contributing factor to most unintended pregnancies (Chandra-Mouli et al., 2014; Envuladu, Van de Kwaak, Zwanikken, & Zoakah, 2017; Sánchez-Páez & Ortega, 2018), this study identifies additional factors such as lack of financial resources to consistently access and use modern contraceptives and boys' preference for "raw" sex factors.

The affective attachments between men and women and the social norms that proscribe premarital sex for adolescent girls limit young women's contraceptive use. Contraceptive use among young women is influenced by the type of sexual relationship. Young women in multiple relationships used contraceptives based on their emotional attachment to their sexual partner. In most cases, women who were in love with their sexual partners did not always use protection. According to Luke (2005), young women's engagement in sex for financial rewards takes precedence over fears of pregnancy or STIs including HIV. However, this study observed that some young women were assertive by using contraceptives after sex when their partners refused to use protection. A few young women engaging in such sexual relationships were proactive in preventing unwanted pregnancy.

Adolescents' fear of being labeled as "bad girls" in their community for buying condoms (an act that suggest their engagement in premarital sex) affected their sexual behavior. This corroborates Wingood and DiClemte's (2000) explanation of how the structure of affective attachment and social norms may influence health behavior, because "women who are more accepting of conventional social norms and beliefs will be more likely to experience adverse health outcomes." From a sociocultural perspective, adolescents' fear of being stigmatized by society for accessing modern contraceptives prevented them from attempting to access them. This is common among unmarried adolescents in low- and middle-income countries, where adolescents face many challenges in accessing contraceptives as well as using them correctly and consistently (Chandra-Mouli et al., 2014; Gyan, 2018).

Limitations

The findings of this study must be seen in light of some limitations. As the sole facilitator of the focus groups and interviews, the researcher's biases were likely to influence the interpretation and analysis of the data. However, this bias was minimized using the theory of gender and power to guide the data analysis. As a qualitative study, the small sample size makes the findings difficult to generalize. The sample comprises adolescents who resided in a peri-urban community in the Greater Accra Region. Therefore, it may not provide insight into the perceptions of adolescents from other areas about the influence of gender and power on the use or nonuse of modern contraceptives. However, the strength of this study is that it provides insight for interventions and programs that seek to target communities that are in transition and grappling with sociocultural norms inhibiting adolescent sexual and reproductive health. Future studies can focus on rural and urban communities in the 16 regions of Ghana and across the sub region to better understand the gender dynamics of adolescents' contraceptive use. Given the social norms of the Ghanaian community, it is not acceptable for unmarried adolescent girls to initiate sex or to openly discuss or demonstrate knowledge on sex and sexuality. This resulted in most participants being comfortable in sharing the experiences of their friends instead of their own experiences. Although the quotes may seem to be adolescents' perceptions on the topic, it could also be their own experiences to some extent. This study would have gained better insights on the topic had it collected the data using a different approach. Future studies on such sensitive topics should use in-depth interviews for data collection to encourage participants to share their own experiences.

Conclusion

Adolescents face several barriers that prevent them from using modern contraceptives. At the individual level, lack of knowledge about the correct use of modern contraceptives, type of sexual relationship, fear of stigma about having sex as well as accessing modern contraceptives, and the cost of accessing contraceptives tend to prevent adolescents from using modern contraceptives. At the family and community level, the fear of being stigmatized by both parents and community members for having premarital sex or accessing modern contraceptives also prevents adolescent girls from using contraceptives. At the institutional level, adolescents are concerned about anonymity, confidentiality, and effectiveness when they access reproductive health services from the health institution. Additionally, adolescents also worry about how health professionals would treat them when they seek their services. Avoiding pregnancy could be much easier for adolescent girls if only they could have easy access to contraceptives or use more long-term and reliable contraceptive methods. Adolescent boys need to be educated on the need to use condoms not only to prevent unintended pregnancy, but also to avoid STIs and adolescent girls must be educated on using contraceptives consistently with their partners.

This study recommends that all barriers hindering adolescents from fulfilling their contraceptive needs should be addressed so that their fertility rate will be reduced through safe and reliable contraceptive use. To attain the full potential of modern contraceptives, healthcare providers should ensure that they are guided by their professional work ethics when attending to adolescents' contraceptive needs, rather than by their own personal values and norms. Furthermore, parents should be encouraged to talk to their children on both abstinence and the use of modern contraceptives to reduce

the fear and stigma that adolescents associate with accessing and using modern contraceptives.

Furthermore, health service providers and health clerks (chemists) should be educated on providing adolescent-friendly services to improve adolescents' access to modern contraceptives. With regard to contraceptive failure, adolescents should be educated on the effective use of various contraceptive methods in both school and during community gatherings. Since the majority of the participants were Christians, churches should also initiate programs to encourage adolescents through religious activities to avoid risky sexual and reproductive health behaviors.

Authors' Contributions SEG was involved in conceptualization, funding, writing, reviewing, and editing. SM helped in conceptualization, reviewing, and supervision.

Funding This study was funded by the Carnegie Corporation of New York under the "Building A New Generation of Academics in Africa (BANGA-Africa)" project at the University of Ghana.

Data Availability The participants were assured of confidentiality and anonymity; therefore, the data are not available to the public.

Compliance with Ethical Standards

Conflict of interest Not Applicable.

Code Availability Not Applicable.

References

Adanu, R. M. K., Ntumy, M. N., & Tweneboah, E. (2005). Profile of women with abortion complications in Ghana. *Tropical Doctor, 35,* 139–142. https://doi.org/10.1258/0049475054620725.

Ahlberg, B. M. (1994). Is there a distinct African sexuality? A critical response to Caldwell. *African, 64*(2), 220–242.

Amo-Adjei, J., Kumi-Kyereme, A., & Anamaale Tuoyire, D. (2014). Transactional sex among female university students in Ghana: Implications for HIV education. *Health Education, 114,* 473–486. https://doi.org/10.1108/HE-02-2014-0013.

Ampofo, A. A. (2001). When men speak women listen: Gender socialisation and young adolescents' attitudes to sexual and reproductive issues. *African Journal of Reproductive Health, 5*(3), 196–212.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1,* 385–405. https://doi.org/10.1177/146879410100100307.

Awusabo-Asare, K., Abane, A. M., & Kumi-Kyereme, A. (2004). *Adolescent sexual and reproductive health in Ghana: A synthesis of research evidence*. New York: Alan Guttmacher Institute.

Aziato, L., Hindin, M. J., Maya, E. T., Manu, A., Amuasi, S. A., Lawerh, R. M., & Ankomah, A. (2016). Adolescents' responses to an unintended pregnancy in Ghana: A qualitative study. *Journal of Pediatric and Adolescent Gynecology, 29,* 653–658. https://doi.org/10.1016/j.jpag.2016.06.005.

Bajos, N., Leridon, H., Goulard, H., Oustry, P., & Job-Spira, N. (2003). Contraception: From accessibility to efficiency. *Human Reproduction, 18,* 994–999. https://doi.org/10.1093/humrep/deg215.

Biddlecom, A. E., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health, 11,* 99–110. https://doi.org/10.2307/25549734.

Biney, A. A. (2011). Exploring contraceptive knowledge and use among women experiencing induced abortion in the Greater Accra Region Ghana. *African Journal of Reproductive Health, 15*(1), 37–46.

Blanc, A. K., Tsui, A. O., Croft, T. N., & Trevitt, J. L. (2009). Patterns and trends in adolescents' contraceptive use and discontinuation in developing countries and comparisons with adult women. *International Perspectives on Sexual and Reproductive Health, 35*(2), 63–71.

Bongaarts, J., Cleland, J., Townsend, J. W., Bertrand, J. T., & Gupta, M. D. (2012). *Family planning programs for the 21st century*. New York: The Population Council Inc.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Chandra-Mouli, V., McCarraher, D. R., Phillips, S. J., Williamson, N. E., & Hainsworth, G. (2014). Contraception for adolescents in low and middle income countries: needs, barriers, and access. *Reproductive Health, 11*(1), 1–8.

Chernick, L. S., Schnall, R., Higgins, T., Stockwell, M. S., Castaño, P. M., Santelli, J., & Dayan, P. S. (2015). Barriers to and enablers of contraceptive use among adolescent females and their interest in an emergency department based intervention. *Contraception, 91*(3), 217–225. https://doi.org/10.1016/j.contraception.2014.12.003.

Connell, R. W. (1987). *Gender and power*. Stanford, CA: Stanford University Press.

Do, M., & Kurimoto, N. (2012). Womens empowerment and choice of family planning methods. *International Perspectives on Sexual and Reproductive Health, 38,* 23–33.

Doyle, A. M., Mavedzenge, S. N., Plummer, M. L., & Ross, D. A. (2012). The sexual behaviour of adolescents in sub-Saharan Africa: Patterns and trends from national surveys. *Tropical Medicine International Health, 17,* 796–807. https://doi.org/10.1111/j.1365-3156.2012.03005.x.

Envuladu, E. A., Van de Kwaak, A., Zwanikken, P., & Zoakah, A. I. (2017). Exploring the factors influencing adolescent sexual behavior in plateau state Nigeria. *American Journal of Medicine Medical Sciences, 7,* 1–6. https://doi.org/10.5923/j.ajmms.20170701.01.

Finch, H., Lewis, J., & Turley, C. (2003). Focus groups. In J. Ritchie, J. Lewis, N. C. MaNaugthon, & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 211–239). London: Sage Publications.

Gangestad, S. W., Thornhill, R., & Garver, C. E. (2002). Changes in women's sexual interests and their partner's mate–retention tactics across the menstrual cycle: Evidence for shifting conflicts of interest. *Proceedings of the Royal Society of London B Biological Sciences, 269,* 975–982. https://doi.org/10.1098/rspb.2001.1952.

Ghana Statistical Service, Ghana Health Service, & ICF International. (2015). *Ghana demographic and health survey 2014*. Rockville, MD: GSS, GHS, and ICF International.

Gyan, S. E. (2018). Passing as "normal": Adolescent girls' strategies for escaping stigma of premarital sex and childbearing in Ghana. *Sage Open, 8,* 1–8. https://doi.org/10.1177/2158244018801421.

Hindin, M. J., McGough, L. J., & Adanu, R. M. (2014). Misperceptions, misinformation and myths about modern contraceptive use in Ghana. *Journal of Family Planning and Reproductive Health Care, 40,* 30–35. https://doi.org/10.1136/jfprhc-2012-100464.

Kalamar, A. M., Tunçalp, Ö., & Hindin, M. J. (2018). Developing strategies to address contraceptive needs of adolescents: Exploring patterns of use among sexually active adolescents in 46 low-and

middle-income countries. *Contraception, 98,* 36–40. https://doi.org/10.1016/j.contraception.2018.03.016.

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage Publications.

Luke, N. (2005). Confronting the'sugar daddy'stereotype: age and economic asymmetries and risky sexual behavior in urban Kenya. *International Family Planning Perspectives, 31*(1), 6–14.

Morgan, D. L., & Krueger, R. A. (1997). *Focus group kit* (Vol. 1–6). Thousand Oaks, CA: Sage Publications.

Radovich, E., Dennis, M. L., Wong, K. L., Ali, M., Lynch, C. A., Cleland, J., & Benova, L. (2018). Who meets the contraceptive needs of young women in sub-Saharan Africa? *Journal of Adolescent Health, 62,* 273–280. https://doi.org/10.1016/j.jadohealth.2017.09.013.

Sánchez-Páez, D. A., & Ortega, J. A. (2018). Adolescent contraceptive use and its effects on fertility. *Demographic Research, 38,* 1359–1388. https://doi.org/10.4054/DemRes.2018.38.45.

Santhya, K. G., & Jejeebhoy, S. J. (2015). Sexual and reproductive health and rights of adolescent girls: Evidence from low-and middle-income countries. *Global Public Health, 10,* 189–221. https://doi.org/10.1080/17441692.2014.986169.

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior, 27,* 539–565. https://doi.org/10.1177/109019810002700502.

Wodon, Q., Nguyen, M. C., & Tsimpo, C. (2016). Child marriage, education, and agency in Uganda. *Feminist Economics, 22,* 54–79. https://doi.org/10.1080/13545701.2015.1102020.