

stigmatizes due to lack of special training on handling of adolescents.(Use of contraceptives among adolescents in Kintampo, Ghana: a cross-sectional study by Boamah EA, Asante KP, Mahama E, Manu G, Ayipah EK, Adeniji E, Owusu-Agyei S; DOI<https://dx.doi.org/10.2147/OAJC.S56485>)

Amount of contraceptive education that providers receive appears to be insufficient and they have insufficient opportunities for continuing education on advances in contraceptive methods and changes in contraceptive protocols. Adolescents get little messages and information on the importance of contraception and the methods available. Research suggests that most adolescent girls have a strong desire to become pregnant due to internalized powerful socio-cultural values. Emotional and interpersonal barriers to the uptake of family planning services also stem from the attitudes and desires of partners and other family members regarding girls' fertility. Socio-cultural and religious norms and practices impact the use of contraception in so far as the social value they ascribe to girls versus boys and appropriate gender roles for each. Teens also face important cognitive barriers in that they lack knowledge and understanding of conception and contraception. Geographic barriers are particularly significant for rural teens and those with restricted mobility. The cost of contraception is an economic barrier for adolescents. Administrative barriers can limit the access of unmarried teens. Where teens are stigmatized for their sexuality, barriers relating to quality of care, especially the attitudes of providers are significant. (<https://www.odi.org/projects/2596-barriers-contraceptive-use>)

A cross-sectional study was carried out among 400 senior secondary schools students in Ojo military barracks, Lagos, Western Nigeria. Majority of them 391 (97.8%), were in the adolescent age group (10–19 years). 67.5% of them had correct knowledge of the use of condoms while 31.1% of the sexually active respondents have ever used any form of contraceptive with no statistically significant difference between the male and female respondents ($P = 0.338$). The most common barrier to contraceptive methods as reported by 85.1% of respondents was being too embarrassed to source for the contraceptives.(Contraceptive knowledge and practice among senior secondary schools students in military barracks in Nigeria UC Chimah, TO Lawoyin, AL Ilika, CC Nnebue)

Non-availability of wider choice of methods also reduces the ability to meet the individual needs of contraception. To examine how much contraceptive use increases as additional methods are made available to populations, data estimating contraceptive use from representative national surveys and data estimating method availability from special surveys to make comparisons for 6 modern contraceptive methods, in each of 6 years: 1982, 1989, 1994, 1999, 2004, and 2009 were used. Various method accessibility rules governing different proportions of the total population (ranging from 20% to 80%) that must have access to a method in order for it to qualify as “available” was used to estimate method availability. It was found that contraceptive use is greater when more methods are available to a large portion of the population, both cross-sectionally and over time. Increase in number of methods available by 1 to at least half the population gave an increase of 4–8 percentage points in total use of the 6 modern methods. A consistent pattern emerges for the relationship of contraceptive use and choice among multiple methods. Therefore, contraception use may be increased by extending the availability of current methods, by improving features of current methods, or by introducing new methods (www.ghspjournal.org/content/1/2/203.full)

Methodology

Figure

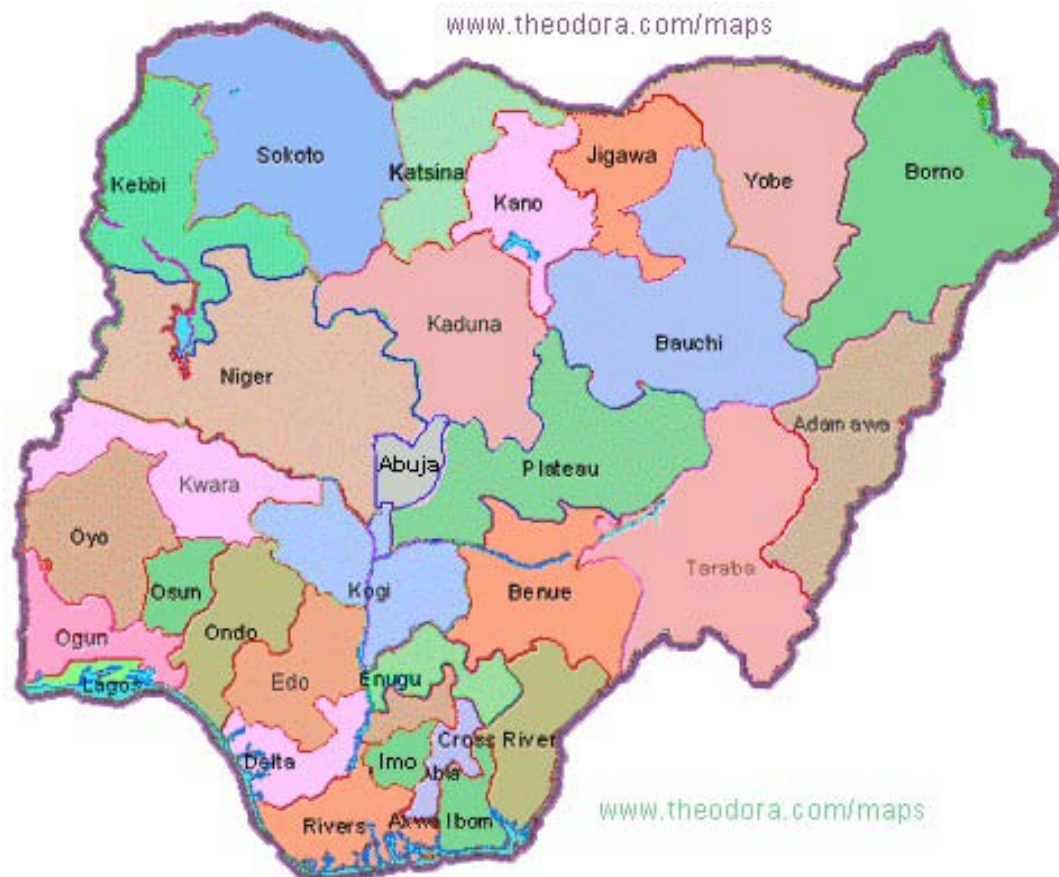


Figure 1. Nigeria lies on the west coast of Africa between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It occupies approximately 923,768 square kilometers of land stretching from the Gulf of Guinea on the Atlantic coast in the south to the fringes of the Sahara Desert in the North. The territorial boundaries are defined by the republics of Niger and Chad in the north, the Republic of Cameroon on the east, and the Republic of Benin on the west. Nigeria is the most populous country in Africa and the 14th largest in land mass. The country's 2006 Population and Housing Census placed the country's population at 140,431,790.

Target and study population

A nationally representative sample of 40,320 households from 904 primary sampling units (PSUs) was selected. People age 15-19 years who were usual members of the selected households or who spent the night before the survey in the selected households was eligible for individual interviews. As with previous NDHS surveys, the main objective of the 2013 NDHS was to provide reliable information on knowledge and use of family planning methods. The survey was designed to produce reliable estimates for key indicators at the national level as well as for urban and rural areas, each of the country's six geographical zones, and each of the 36 states and the Federal Capital Territory (FCT).

Study design

The cross-sectional study design will be adopted and will seek to assess the uptake of contraception among adolescents aged 15 – 19 years.

Sampling

Sampling technique

The sample for the 2013 NDHS was a stratified sample, selected independently in three stages from the sampling frame. Stratification was achieved by separating each state into urban and rural areas. In the first stage, 893 localities were selected with probability proportional to size and with independent selection in each sampling stratum. In the second stage, one EA was randomly selected from most of the selected localities with an equal probability selection. In a few larger localities, more than one EA was selected. In total, 904 EAs were selected. After the selection of the EAs and before the main survey, a household listing operation was carried out in all of the selected EAs. The household listing consisted of visiting each of the 904 selected EAs, drawing a location map and a detailed sketch map, and recording on the household listing forms all occupied residential households found in the EA with the address and the name of the head of the household. If a selected EA included less than 80 households, a neighboring EA from the selected locality was added to the cluster and listed completely. The resulting list of households served as the sampling frame for the selection of households in the third stage. In the third stage of selection, a fixed number of 45 households were selected in every urban and rural cluster through equal probability systematic sampling based on the newly updated household listing

Sample size determination

A nationally representative sample of 40,320 households from 904 primary sampling units (PSUs) was selected. 38,904 were found to be occupied at the time of the fieldwork. Of the occupied households, 38,522 were successfully interviewed, yielding a household response rate of 99 percent. All adolescents age 15-19 years who were usual members of the selected households or who spent the night before the survey in the selected households was eligible for individual interviews.

Sampling procedure

Nigeria is divided into states. In turn, each state is subdivided into local government areas (LGAs) and each LGA into smaller (secondary and tertiary) localities. Nigeria has 36 states and a Federal Capital Territory (FCT). These states are subdivided into 774 LGAs. Furthermore, the states are regrouped by geographical location to form six zones. In addition to these administrative units and geographical zones, each locality was subdivided into convenient areas called census enumeration areas (EAs). The average number of households per EA in the corresponding locality frame was assigned to each EA. The EAs in Nigeria are small in size, with an average of 211 inhabitants (equivalent to 48 households). Since these EAs were too small to be DHS clusters, the 2013 NDHS included several EAs per DHS cluster (with a preferred minimum cluster size of 80 households).

Inclusion criteria

Inclusive criteria are all the adolescents who are within the sexually active age (15 – 19 years) and who will give consent and willing to participate in the study. Adolescents below 15-19 years though sexually active will be excluded from the study.

Data and data collection tools

Both qualitative and quantitative data will be collected during the study using structured questionnaires and interview guides. The questionnaires will consist of three parts. Three questionnaires were used in the 2013 NDHS: the Household Questionnaire, the Woman's Questionnaire, and the Man's Questionnaire. The content of these questionnaires was based on model questionnaires developed by the MEASURE DHS programs. The model questionnaires were modified according to the country's requirements, in consultation with a broad spectrum of government ministries and agencies, nongovernmental organizations, and international donors, to reflect relevant issues such as family planning. The first part will

contain demographic questions, the second part will contain the known and preferred adolescent contraceptive methods and the last will consist of questions relating to barriers to contraceptive uptake. Prior to the start of data collection, the purpose of conducting the study will be explained to the participants for them to express their willingness by granting consent.

Data collection procedures

The Household, female's, and male's Questionnaires were pretested in four locations in Makurdi (northern Nigeria), where the residents are predominantly Hausa, Yoruba, English, and Igbo speaking. The teams were divided according to languages. The supervisors and editors were drawn from among the trainees. The questionnaires were pretested in 120 households. A debriefing session was held at the end of the pretest fieldwork. Based on observations from the field and suggestions made by the pretest teams, revisions were made in the wording and translations of the questionnaires. Logistical arrangements for the survey were also discussed.

Data processing and analysis

After data collection is completed, data entry, cleaning and analysis will be done by using the Statistical Package for Social Sciences (SPSS) software, version 20 Program. In order to describe the descriptive statistic, frequencies and percentages will be computed and represented in bar graphs, pie charts and tables. Qualitative data will be analyzed in relation to the study variables. Chi-square test will be used to measure the strength of associations between the various variables where a p-value of = or < 0.05 will be considered statistically significant.

Expected outcome

The number of adolescents between the ages 15-19 years on contraceptive will be established. Levels of awareness, utilization and barriers to contraceptives' utilization among them will also be established.

Results and discussion

Table 1.0. Exposure to family planning messages among adolescents 15-19 years

	FEMALE (7820)	MALE (3619)
RADIO	24.0	28.9
TV	12.6	14.6
NEWSPAPER/MAGAZINE	4.0	4.4
POSTER/LEAFLET/BROCHURE	9.0	10.8
OTHER	3.4	3.3
NO MEDIA SOURCE	71.2	65.2

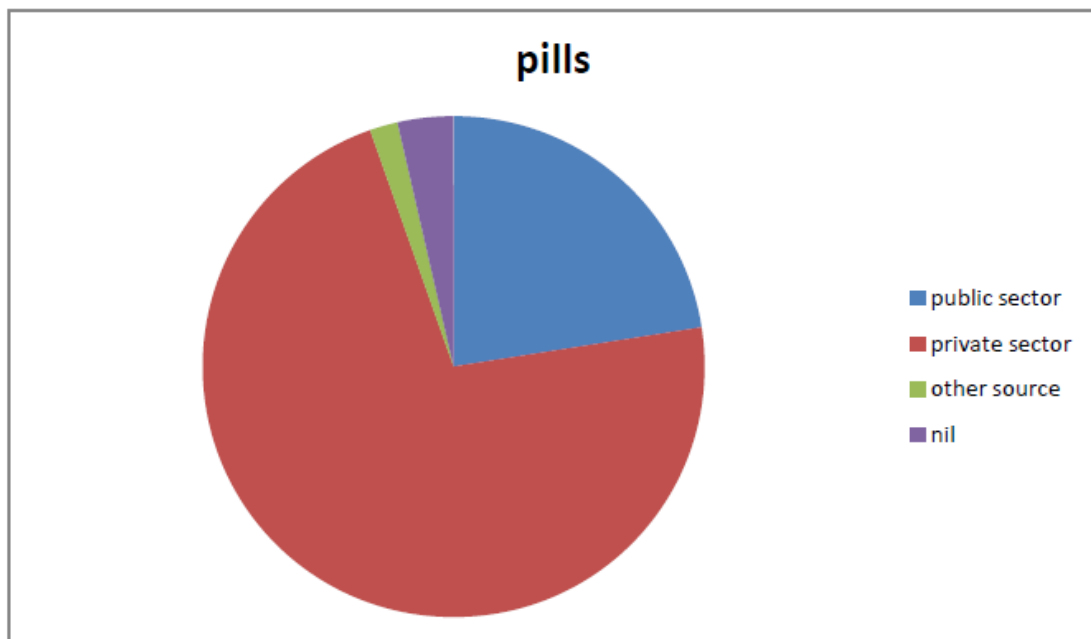
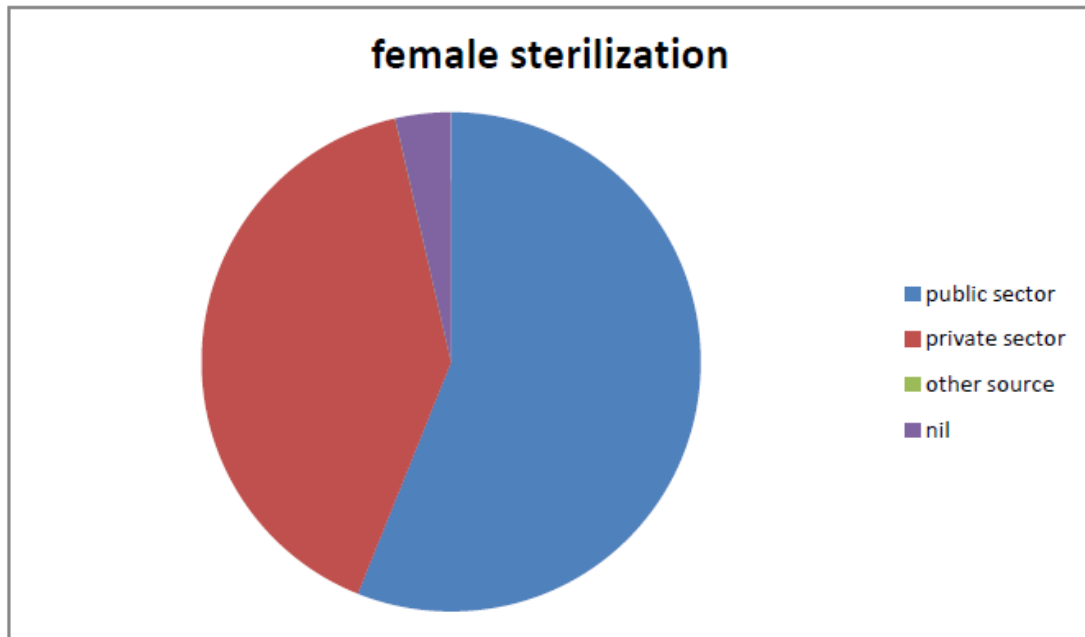
Table 2.0. Knowledge and use of contraceptive methods among adolescents aged 15-19 years

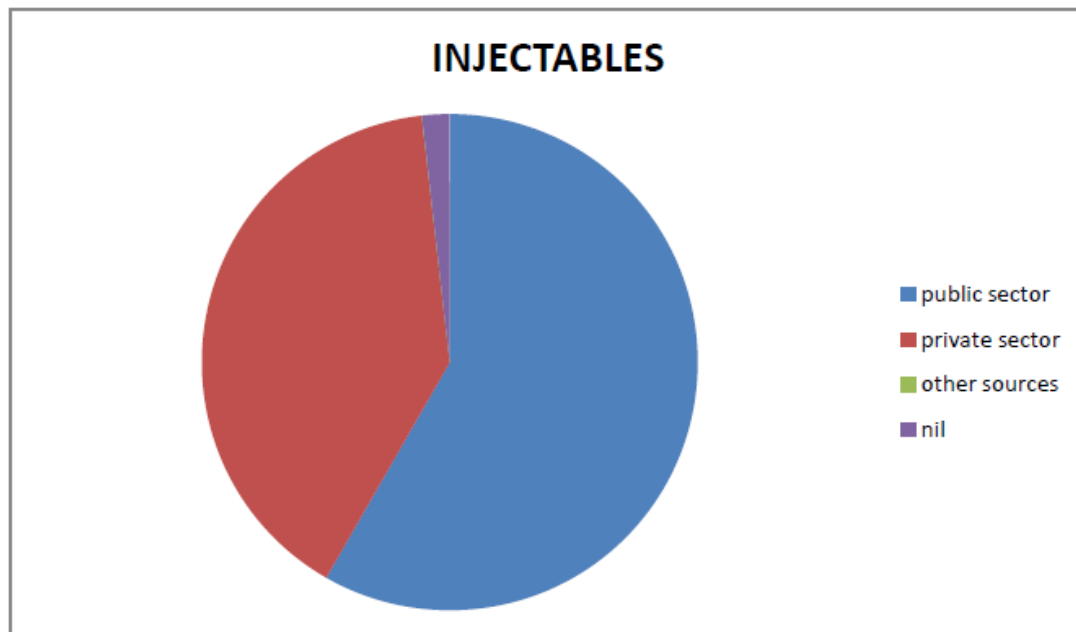
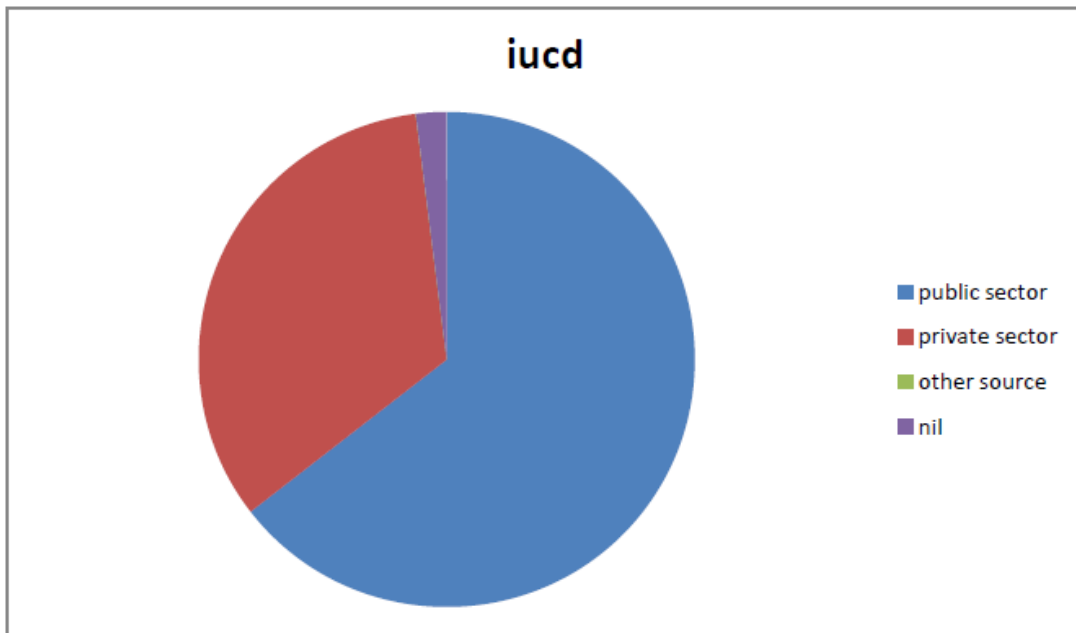
	FEMALE (2251)	MALE (41)
HEARD OF ANY METHOD	67.0	86.7
HEARD OF ANY MODERN METHOD	64.4	85.7

Table 3.0. Source of modern contraceptions among female adolescents aged 15-19 years

SOURCE	FEMALE STERILIZATION	PILL	IUD	INJECTABLES	IMPLANT	CONDOM	TOTAL % OF 3997 FEMALES
PUBLIC SECTOR	56.1	22.5	64.5	58.3	65.4	4.9	28.9
PRIVATE SECTOR	40.3	72.1	33.5	39.9	34.2	73.5	59.9
OTHER SOURCE	0.0	1.8	0.0	0.0	0.0	19.6	9.0
NIL	3.6	3.6	2.0	1.8	0.4	2.0	2.2
NUMBER OF WOMEN	105	724	322	963	112	1771	100.0

Charts representing table 3.0





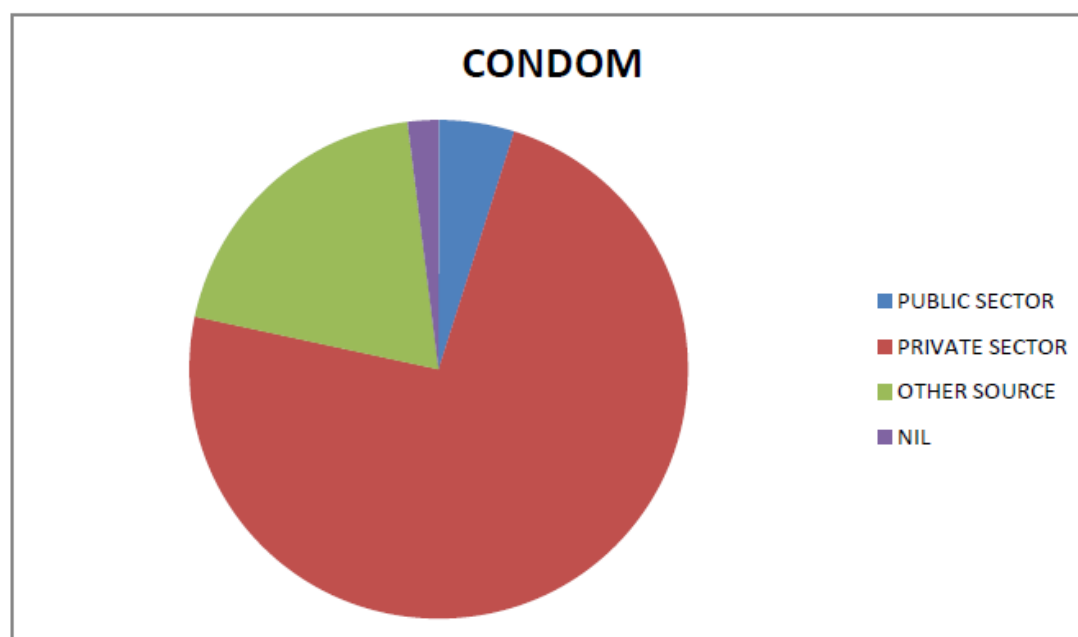
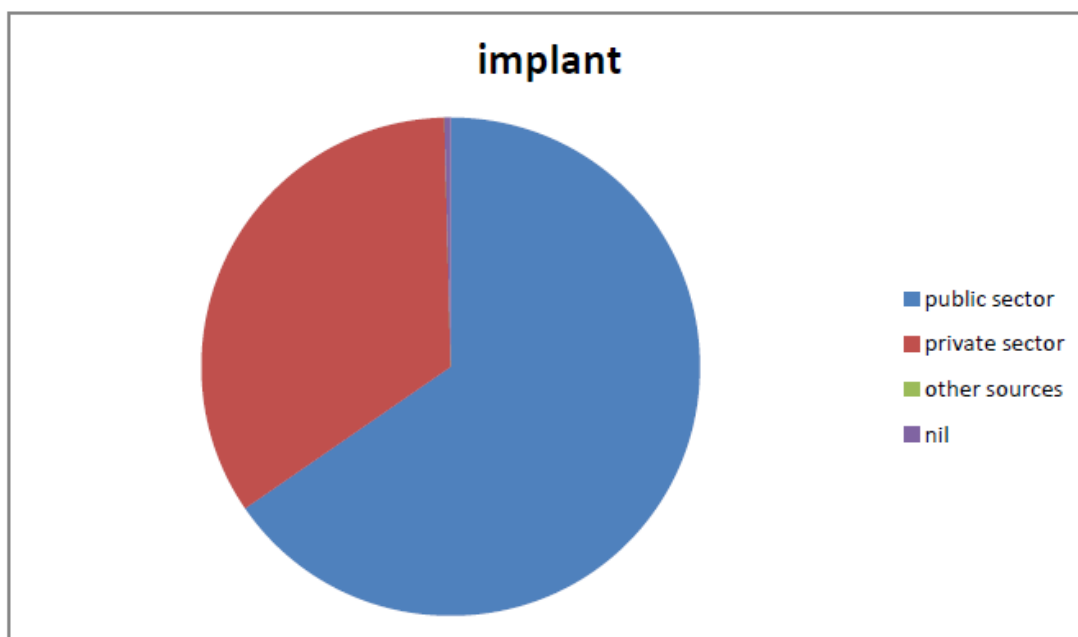


Table 4.0. Need and demand for family planning in females aged 15-19 years

	FOR SPACING	FOR LIMITING	TOTAL
MET NEED	6.1	0.1	6.2
UNMET NEED	6.2	0.0	6.2
TOTAL DEMAND	12.3	0.1	12.4

Table 5.0. Contact of Non-Users with Family Planning Responders Out Of 7340 Adolescents

FIELD WORKER VISITED AND DISCUSSED FP	VISITED HEALTH FACILITY IN PAST 12 MONTHS		NEITHER
	DISCUSSED FP	DID NOT DISCUSS FP	
2.2%	1.6%	8.2%	96.9%

Table 6.0 shows descriptive statistics for selected indicator variables in the logistic regression models Nigeria Demographic and Health survey for females only.

Table 7.0 shows effects of selected explanatory variables on the odds of an adolescent being currently pregnant (Model 1); having borne a child in the five years preceding the survey (model 2) and either of the two models (model 3).

Table 6.0

<i>Selected Variable/Category</i>	<i>Number of Women</i>	<i>Percent of Women in DHS Sample</i>	<i>Percent Ever sexually active</i>	<i>Percent sexually active in last 12months</i>	<i>Percent that had at least a birth</i>	<i>Percent currently pregnant</i>	<i>Percent of women either pregnant or ever had a child</i>
Marital Status							
<i>Never married</i>	4537	68.8	23.2	19.6	3.1	0.8	3.8
<i>Married</i>	1950	29.6	99.2	94.9	53.6	22.7	68.8
<i>Living together</i>	57	0.9	100.0	93.0	64.9	19.3	77.2
<i>Previously married</i>	30	0.5	100.0	60.0	63.3	3.3	66.7
<i>Not Living together</i>	16	0.2	100.0	87.5	68.8	6.2	75.0
<i>Not Stated/Missing</i>	1	0.0	-	-	-	-	-
Wealth Index							
<i>Poorest</i>	1360	20.6	69.9	65.7	34.0	14.3	44.0
<i>Poorer</i>	1352	20.5	56.7	52.4	25.8	10.1	31.9
<i>Middle</i>	1378	20.9	43.2	39.0	16.1	6.2	20.7
<i>Richer</i>	1379	20.9	38.7	33.7	13.3	4.0	16.1
<i>Richest</i>	1122	17.0	21.9	19.6	3.4	1.9	4.9
Educational Attainment							
<i>No education</i>	1792	27.2	83.0	78.7	43.1	17.9	54.7
<i>Incomplete primary</i>	466	7.1	33.7	31.5	14.6	5.6	18.5
<i>Complete primary</i>	554	8.4	49.6	43.5	24.2	9.6	30.3
<i>Incomplete secondary</i>	2933	44.5	28.5	24.8	7.9	2.6	9.9
<i>Complete secondary</i>	773	11.7	40.4	35.4	5.8	2.3	8.2
<i>Higher</i>	73	1.1	34.2	32.9	2.7	0.0	2.7
Place of residence							
<i>Urban</i>	2027	30.8	31.2	28.2	10.2	4.1	13.5
<i>Rural</i>	4564	69.2	53.9	49.3	23.0	8.9	28.9
Geo-Political Zone							
<i>North-Central</i>	1264	19.2	38.5	32.8	16.3	6.8	21.2
<i>North-East</i>	1256	19.1	59.6	56.4	29.9	11.7	37.8
<i>North-West</i>	1245	18.9	70.6	68.9	34.7	15.3	45.0
<i>South-East</i>	774	11.7	24.8	17.8	6.7	2.1	8.4
<i>South-South</i>	1031	15.6	48.5	44.6	11.6	2.6	13.3
<i>South-West</i>	1021	15.5	28.0	24.1	6.8	2.4	8.4
Age							
<i>15</i>	1579	24.0	25.8	24.2	2.8	3.7	6.3
<i>16</i>	1225	18.6	33.2	30.1	9.1	4.9	13.2
<i>17</i>	1151	17.5	50.4	46.5	20.5	8.9	26.8
<i>18</i>	1634	24.8	62.2	56.9	30.6	10.6	37.2
<i>19</i>	1002	15.2	67.9	60.8	36.1	9.7	41.1
Religion							
<i>Catholic</i>	759	11.5	33.5	27.1	9.6	4.0	12.3
<i>Other Christians</i>	2843	43.1	34.9	30.2	10.0	3.0	12.2
<i>Islam</i>	2880	43.7	61.8	59.0	30.0	12.5	38.4
<i>Others</i>	109	1.7	61.5	54.1	33.0	16.5	42.2
TOTAL	6591	100.0	46.9	42.8	19.0	7.5	24.1

Discussion

The above tables and charts are in support of presence of met needs of contraception among adolescents. It shows there is a huge lack of knowledge of contraception, the private sector plays and still has a great role to play in bridging the gap of unmet needs of contraception and this role cannot be undermined. Most adolescents interviewed needed contraception for spacing number of children than for limiting – most adolescent pregnancies take place within the context of marriage in developing countries and is worse among people of low socioeconomic class. 30% of every adolescent is currently married in Nigeria, 19.6% of those who have never been married have been sexually active. Two thirds of those cohabiting, previously married and those not living together are currently pregnant or had borne a child. Those who are not married or previously married are less, significantly so, to be currently pregnant relative to those in marital unions. These show that adolescent marriage is still a threat to the future of our generation. Thus, investing into meeting the contraceptive needs of the adolescent population is a move in the right direction. International data over 27 years show that as each additional contraceptive method became available to most of the population, overall modern contraceptive use rose. But in 2009 only 3.5 methods, on average, were available to at least half the population in surveyed countries.

Conclusion and recommendations

Adolescents have unmet family planning needs. Enough has not been done to reduce this burden especially in rural areas and among those of low socio-economic status. Based on the complications arising from failure to meet the adolescent needs of contraceptives, it is recommended that efforts should be intensified to promote safe sexual practice and contraceptive use in this age group. Five key empowerment dimensions that need to be tackled if adolescents' contraceptive needs are to be given the strategic, multi-pronged policy attention that they merit are: socio cultural, educational, interpersonal relationships, girl child rights and empowerment with practical knowledge. Emphasis is on girls here because they bear the most brunt of problems of unsafe sex.

1. Family planning programs should strive to provide widespread access to a range of methods.
2. It is not the government's duty alone to meet the contraceptive need of the populace; there must be partnership with other stake holders.
3. Policies in support of adolescent contraception need must be encouraged and passed into law.
4. Different channels
5. Adolescent friendly centres should be open in all areas and made accessible to all so adolescents can feel free to walk into anyone at anytime and receive proper counselling.
6. Training and retraining of all family planning workers.
7. Confidentiality of the adolescents who seek to have family planning must not be breached.
8. Parents need to be educated that this transitional stage in the life of a child is very important. Thus, they must give their full support to their wards so they can turn out successful. They are the first contacts of these adolescents and they need to pass the message of sex education across well without being judgmental.
9. Education is key to making informed choices, every child must be educated.
10. Socioeconomic discrepancies should become negligible if meaningful strides are to be recorded nationwide.

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