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FACTORS INFLUENCING ACCESS TO INFORMATION AND UTILIZATION OF CONTRACEPTIVES AMONG FEMALE ADOLESCENTS IN SOME SELECTED SECONDARY SCHOOLS AT SAMARU COMMUNITY, ZARIA, NIGERIA

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ABSTRACT:

Contraceptives are drugs used in preventing a woman from becoming pregnant. Man's desire to control his reproductive potential is as old as humanity. Hence, attempt to dominate reproduction human among adolescents is not exclusively a contemporary phenomenon. Approximately, 16 million adolescents give birth yearly, 95% developing countries including Nigeria. Complications from pregnancy including childbirth are highest in these age groups, and are the foremost cause of demise for women. This study intends to bridge the knowledge gap that makes adolescents prone to negative health consequences of early high fertility, high unintended pregnancy, unsafe abortion and sexually transmitted diseases in the study area. A cross-sectional descriptive study was adopted in which 281 female secondary school students were selected using a multi-stage cluster sampling technique. Data collection was through questionnaire, featuring questions in line with the study objectives. Data collected was analyzed using the Statistical Package for Social Sciences (SPSS) for windows version 23.0. Most of the respondents about 40.2% of the respondents believed it was wise for them to use contraceptives while 49.1% believed that, modern contraceptives prevent the ability to become pregnant in later life. Only 21% have used contraceptives prior to the study of which, oral pills (11%), condom (9.3%), traditional method (7.8) and emergency contraceptives (6.4%) were mentioned. About 30.2% mentioned prevention of unwanted pregnancy as one of the factors that influenced their use of contraceptives while 42.7% of respondents mentioned limited knowledge on contraceptive options as their major barrier to the use of contraceptives. Major barrier to access of information and use of contraceptives among the respondents. Thus, it was recommended that health talk on contraceptive should be organized as a routine to increase awareness and correct misinformation about contraceptives and the health.

Key Words: *Adolescents, Contraceptives, Female students, Information, Problems, Samaru community, Secondary schools, Utilization.*

1. Introduction

Globally, contraceptives are utilized by the greater portion of married or in-union women in roughly all area of the world. In 2015, 64 per cent of in-union women or married of reproductive age worldwide had used some form of contraceptives (figure 3, dark bars)[1]. However, access to information to contraceptive usage was to a large extent lesser in the least developed countries (40 per cent) and was predominantly low in Africa (33 per cent). Amongst the other key geographic areas, contraceptive usage was to a large extent higher in 2015, between 59 per cent in Oceania to 75 per cent in Northern America Kantorová, Biddlecom and Newby (2014);[2]. and stability. Within the realm of health, sexual and reproductive health is a key component in the determination of future outcomes. [3] posit that adolescents are children aged 10-19 year olds (early adolescence 10-14; late adolescence 15-19) Similarly, WHO (2015) in [4] sees adolescent as a psychological, physical and social transformation from childhood to adulthood and falls within 10 – 19 years of age.

At 576 maternal deaths per 100,000 live births, Nigeria accounts for approximately 14 percent of the universal liability of maternal mortality [5]. WHO (2014) in [6]. A worldwide fact shows that young girls bear a high affliction of maternal mortality and morbidity. Just over 30 percent of deaths among female adolescents aged 15-19 years old are related to pregnancy and child birth [5]. It is estimated that 2.6 million persons in Nigeria are infected with HIV and a wide knowledge-behaviour gap exists, particularly amongst adolescents [7]. More worrisome, is a wide knowledge-behaviour gap concerning condom use for HIV prevention. Although about 50 percent of young women are conscious that the use a condom in each intercourse prevents HIV, only 7 percent of them reported having used condom at their previous intercourse. Barriers to adolescents' contraceptive use include inadequate knowledge of their contraceptive alternatives, myths and misconceptions, biasness from the providers, short of family partner, and society support, pessimistic social norms, and an nonexistence of elongated acting reversible contraceptives(LARCs) services in the areas where several adolescents and youth access contraceptives. All of these chip in to uncertain atmosphere for adolescents and youth, mainly in their capacity to access LARCs. However, of the unusual reproductive health related problems of adolescents in Africa, the girl-child is mainly likely to be in danger. In Nigeria, like in numerous African countries, the young girl is obviously and generally disadvantaged to bargain safer sex. This circumstance is still not as good as for the girl-child who survives in a cultural setting, where gender inequity is an established way of life, similar in Northern Nigeria. The 2008 NDHS showed that 23percent of women 15-19 years in Nigeria and 45percent in the North-Western zone are presently mothers or pregnant [8]. In fact, adolescent marriage and parenthood are a familiar sight equally in urban and rural families in Northern part of Nigeria [9].

In Nigeria, the use of contraceptive among female adolescents is very low. According to the three waves of National Demographic Health Survey (NDHS): 1.1% in 2003; 4.14% in 2008; and 5.18% in 2013. A study conducted in two South Eastern Nigerian states (Anambra and Enugu) showed that only 17% of sexually active

students had ever used contraceptive method other than abstinence [10]. A study among married adolescent conducted in1992 showed that contraceptives pill were the most used by female adolescents than injectables. It further showed that in 2000 – 2004, the study participant used more of injectables contraceptives as they are perceived to be used easily and are more effective since they do not require any adherence [11]. Another related study conducted in Porthacourt Nigeria showed that 78.8% of the study participant admitted using contraceptives during sex. The mean age of the respondent was 15.04 while modal age was 12 years. The study further revealed that 51% of the study participants have been exposed to multiple sexual partners. The study concluded by suggesting active effort to support sexual education and contraceptive usage should be strengthen amid Nigerian adolescents [12]. According to a in rural community, 227(69.7%) reacted that the services of family planning are accessible in the community and majority of the adolescents 31.25% patronize chemist as their sources of services. The study also confirmed most of the adolescents (33.25%) received information on how to use contraceptives through radio, schools 19%, peer 12.75%, churches 8.5%, and parents 65%. The study bring to a close that the services of family planning were obtainable but not properly utilized, due to unplanned pregnancy and it sequel [13]. Kapiga *et al.,* (1992) in [14] reported that while 60.9% of the pupils in secondary school at Bagamoyo district, Tanzania were sexually energetic, contraceptive information and usage was very small mainly amongst females, with only 15.4% of the pupils reported to have for one's ever used contraceptive method. In a related study in Kaduna Nigeria, it was revealed that contraceptive use among adolescents' hawkers 15-19 years is relatively low, due to lack of knowledge of the foundation of family planning information, cost of contraception, social barriers and quality of services available [15]. Another study by Mbunda (2000) in Mung'ong'o (2010) showed that the general level of contraceptive usage was established to be very small (11.8 %) among sexually active teenagers (15-19 years). According to a study conducted in Ghana, 97% of the adolescents used contraceptives and were had information about family planning method and that of traditional or local method was low with 74.3%. Majority of the male respondents 92.4% also revealed that they have used contraceptives before and are also aware of male condom, injectables 88.3% female sterilization (83.2%), pills (81.6%). Diaphragm had the lowest respondents with 19.1%. For the traditional family planning methods, rhythm 67.2% was the most used traditional method and the least was lactational amenorrhoea method. The findings further revealed that 28.4% male sterilization with 15% among the female respondents. One third of respondents revealed that they had used and known about emergency contraceptives. Three fourth of the study participants amounting to 77.3% had also used and known about female condom with males showing higher level of awareness 83.3% than the females 74.6% [16]. A study conducted in Edo Nigeria showed that majority of the respondents' 120 (60%) used pills as their most preferred family planning method than condom 50 (20%) and others 30 (15%). It recommended that adequate health education programme on family planning should be properly organized so that birth control are not one size fits all [17]. Related study by Lugoe *et al.,* (1996) in [14] amongst secondary school students at Arusha, Tanzania established that only 26.8 % of sexually energetic students reported having used a condom. A study carried out in Niger-Delta territory Nigeria, showed a wide difference in some of the report on adolescent reproductive health. Briggs confirmed that no more than 12% of mothers of pregnant adolescents may possibly talk without restraint about sex with

their offspring particularly females. In another study, it showed a slight difference higher than the previous one with 67% of mothers discussing sexual issues with their daughter at adolescent stage. The study made some recommendations for involving adolescents and stakeholders in planning, implementing, monitoring and establishment of functional youth friendly services, support and society mobilization [18]. According to a study conducted in University of Maiduguri Teaching Hospital, the survey revealed that Muslim clients acceptance and usage of contraceptives was (58%) while in Sokoto State the contraceptives prevalence was (78%) which is also a northern and Islamic State. Reasons found for the drastic difference between both States was that, there was prevalence of other tribes and region present in Maiduguri, that is Yoruba's and Igbo's who are economically stable and have high literacy levels. The presence of other tribes increased the population of the family planning attendance in Maiduguri. These proved that high literacy level, economic stability and education improve contraception positive ECA (1999).

2. Materials And Methods

2.1 Study setting

This study was carried out at Samaru Zaria, Sabongari Local government area, Kaduna State, Nigeria. It is a community situated adjacent to Ahmadu Bello University, Zaria Nigeria and it encompasses multi-ethnic groups primarily Fulani and Hausa which are either Muslims or Christians.

2.2 *Study Design*

Cross Sectional Descriptive Survey method was used for this study. The design was adopted for this study because the researcher has no cannot manipulate the variables, research population and environment of the study but only reports what happened.

2.3 Study Population

The study population consisted of only 2,800 female adolescents in the selected Secondary Schools in Samaru Community, Sabongari Local Government Area, Kaduna State. Nigeria

2.4. Sample Size

A multistage Cluster Random Sampling technique was used for this study. The sampling techniques was used because; it has high precision, sampling frame is less cumbersome and all the groups under study were well represented in the final selection. The schools were first multi stage and then a sample of Five (5) schools namely; Demonstration Secondary School A.B.U Zaria, Knowledge is Power Secondary School Samaru, Government Secondary School Bomo, Government Girls Secondary School Samaru, and Model Learning Centre School Samaru were randomly selected from ten (10) schools in Samaru, to serve as the population of the study using multistage cluster random sampling techniques.

Sample size was determined using the formula

;Therefore n: $= \frac{Z^2pq}{e^2}$ (1)

$$= \frac{1.96^2 \text{x } 0.15 \text{x } 0.85}{0.05^2}$$

n =195.92

10% of the sample size (195.92) would be added for non-respondents= 19.59

Sample size 195.92 + 19.59

= 215.51

Note that if the entire population is fewer than 10,000, then the requisite sample size will be smaller the final sample estimate (nf) is calculated using the formula below;
nf = n/{1+(n)/N}

N = the estimated number of female adolescents in Samaru secondary schools, 2,800
Where nf= the desired sample size when the when the population is less than 10,000.
nf= 215.51/ { 1+ 215.51/2,800}
= 215.51/1.077 = 200
The minimum sample size for the study was estimated to be **200** but was further increased by one to 281 to make up for cases of attrition [19].

2.5 Data Collection

The researcher and her research assistants personally collected the data from the five study areas.

2.6 Pilot Study and reliability

A pre-tested was conducted at Demonstration Secondary School, Ahmadu Bello University, Kongo Campus Zaria.

2.7 Statistical Analysis

The data was analyzed using Statistical Package for Social Sciences (SPSS) version 23.0 and was presented in form of constructed tables and charts for easy comprehension.

2.8 Inclusion Criteria

Female adolescents in some selected secondary schools in Samaru Community, Kaduna state Nigeria.

2.9 Exclusion Criteria:

Female adolescents who do not approve to take part in the study.

Female adolescents not schooling in Samaru Community, Kaduna State Nigeria.

3. Results

Table 1: Socio-Demographic Characteristics of Respondents n=281

Variables	Frequency	Percentage
Age (years)		
12-13	2	0.7
14-15	81	28.8
16-17	161	57.3
18-19	28	10.0
>19	9	3.2
Total	281	100.0
Religion		

Islam	237	84.3
Christianity	44	15.7
Total	281	100.0
Tribe		
Hausa	200	71.2
Yoruba	12	4.2
Igbo	6	2.2
Northern minority	58	20.6
Southern minority	5	1.8
Total	281	100.0
Marital status		
Single	274	97.5
Married	5	1.8
Separated	2	0.7
Total	281	100.0
Living with family members		
Yes	234	83.3
No	47	16.7
Total	281	100.0
Living with family members		
Yes	234	83.3
No	47	16.7
Total	281	100.0
Class		
SS1	190	67.6
SS2	91	32.4
Total	281	100.0

TABLE 1 shows a greater number of the respondents are within ages of 16 to 17 (57.35%) and in SS1 class (67.6%). The respondents are predominantly Muslims (84.3%) of Hausa ethnicity (71.2%) and are majorly single (97.5%) living with their family members (83.3%). Other minor tribes include Igbira, Tiv, Kanikon, Obudu among others.

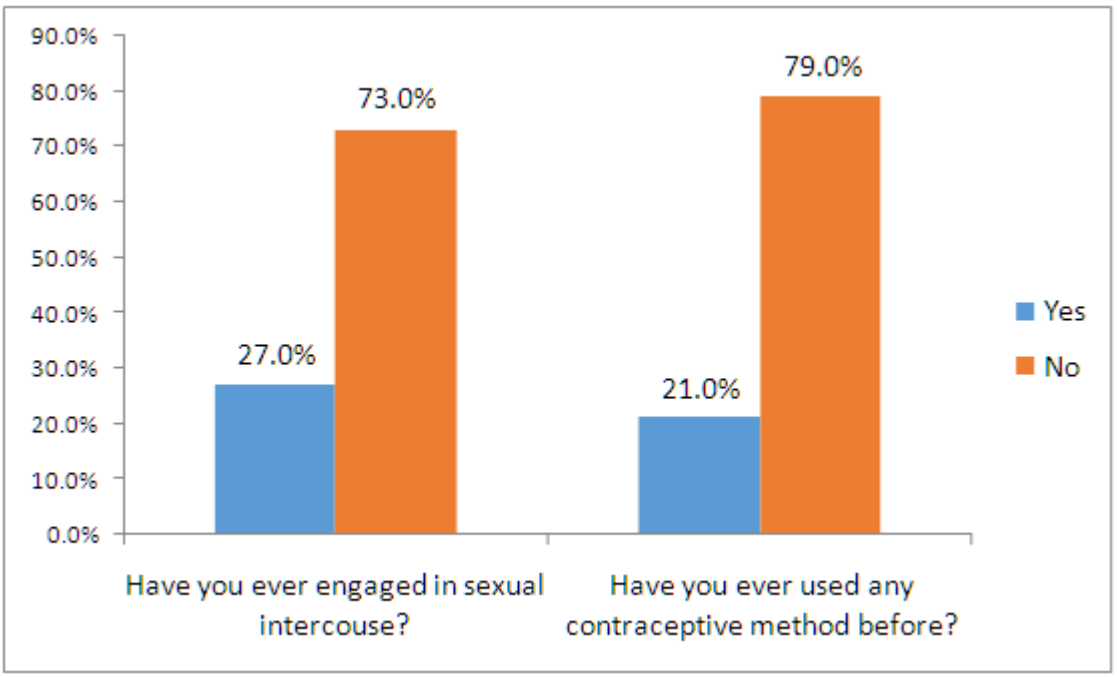


Figure 1: Respondents sexual engagement and utilization of contraceptives.

Only about one third and one fifth of the respondents had respectively engaged in sexual intercourse (27.0%) and used contraceptive (21.0%) prior to this study, the mean age at sexual debut was 16.3± 1.8years.

Table 2: Types Of Contraceptive Used And Reasons For Not Using Contraceptives

*Category	Frequency	Percentage
Type of Contraceptive Used		
Oral pill	31	11.0
Condom	26	9.3
Traditional method	22	7.8
Emergency contraceptive (Postinor)	18	6.4
Implant	2	0.7
IUCD	1	0.4
Reasons for not using Contraceptive		
My religious belief does not accept its use	76	27.0
Not sexually active	68	24.2

Don't know that I can get pregnant	65	23.5
Have only one single sexual partner	39	13.9
Lack of adolescent h health friendly services	31	11.0
Inadequate financial support	28	10.0
It has side effect	18	6.4
Unavailability of contraceptives	5	1.8

*Multiple responses

Most commonly used contraceptives are oral pills (11.0%), condom (9.3%) among others. Some of the respondents mentioned religious belief (27.0%), not sexually active (24.2%) and they are not aware if they can get pregnant as a few reason for not using contraceptives.

Table 3: Respondents Opinion on Contraceptive Methods

Category	**Frequency**	**Percentage**
Modern contraceptive method		
Prevent pregnancy in later life	138	49.1
They are not readily available	24	8.5
Make you have heavy menstrual flow	23	8.2
They are not 100% effective	22	7.8
They prevent contacting sexually transmitted disease	20	7.1
They are very expensive	12	4.3
They may cause stoppage of menses	8	2.8
Some of the procedures are painful	6	2.1
Makes you gain more weight	-	-
Predispose you to frequent headache	-	-
They interrupt foreplay e.g. condom	-	-
Natural Method		

It is meant for married women	115	40.9
It is difficult to practices e.g. withdrawal	47	16.7
They are very cheap	37	13.2
They can cause unwanted pregnancy	30	10.7
They are not very effective/can fail	7	2.5
Traditional Methods of Contraceptives		
They involve super natural believers	64	22.8
The herbs can be dangerous to the liver	54	19.2
Most of them are irreversible	39	13.9

*Multiple responses

TABLE 3 above revealed that almost half of the respondents (49.1%) believed that modern contraceptives prevent pregnancy in later life while 40.9% also believed natural contraceptive method is meant for married women. About one fifth (22.8%) of the respondents have the opinion that practice of traditional methods of contraceptives involve super natural believers.

Table 4: Factors influencing respondents' access to information and use of Contraceptives

Variable	**Frequency**	**Percentage**
What are the factors that prevent you from using contraceptive methods (family planning)?		
Lack of counselling services in the school	83	29.5
Lack of adolescent health friendly services/centres	76	27.0
Negative believe about family planning e.g. family planning is only for married adult	66	23.5
Poor attitude of health worker	47	16.7
Adolescent who use family planning are sex workers	28	10.0
Peer pressure	25	8.9
What are the factors that make you use contraceptive method (family planning)?		

It prevents unwanted pregnancy	85	30.2
I have multiple sexual partner	38	13.5
It is protective against sexually transmitted disease	32	11.4
I am sexually active	24	8.5
It reduces the incidence of unsafe abortion	9	3.2
It reduce rate of drop out from school	7	2.5

The majority of the commonly revealed factors preventing respondents from using contraception are; lack of counselling services in the school (29.5%), lack of adolescent health friendly services/centres (27.0%) among others. While about one third of the respondents (30.2%) mentioned prevention of unwanted pregnancy as one of the factors that make them use contraceptives.

Table 5: Barriers to access to Information and Use of Contraceptive Methods

Barriers	**Frequency**	**Percentage**
Limited knowledge of their contraceptive option	120	42.7
Societal rules and regulation	88	31.3
Family planning centres are located in the hospitals	87	31.0
Lack of parent, partner and community support	59	21.0
Lack of money to purchase contraceptive option	42	14.9
Negative social norms e.g. contraceptive not meant for adolescent	17	6.0
Inadequate family planning centres	9	3.2
Negligence from parent/school management to educate student	8	2.8
Provider bias	8	2.8

Most commonly mentioned barrier to the use of contraceptive method is the limited knowledge of the contraceptive options (42.7%).

4. Discussion

4.1 Socio-Demographic features of Respondents

The study was conducted by administering 281 questionnaires giving 100% responses. Majority of the respondents (99.3%) were within 14-20 years of age with mean age being 16.3 ± 1.3years. Most of the respondents were predominantly Muslims (84.3%) of Hausa ethnicity (71.2%) living with their parents (83.3%). This socio demographic finding are similar to those found in Niger State, North Central part of Nigeria, where 85% of the respondents were aged 14-20 years, although a greater portion of the respondents were Hausa (21%) and Gwari (44%), to some extent, higher proportion were also Muslims (51.0%), 43% were of Christian faith. 2.4% were wedded while an immense majority (94.5%) of the respondents were single, about 62% lived together parents. The relationship might be because; both studies were conducted among adolescents in the Northern region of the countryside [20]. In contrast to the findings in this study, [19] revealed that majority (90.9%) of respondents were primarily Christians. This is because; the study was conducted in a predominantly Christian environment. Another study in Port Harcourt revealed that the age limit of respondents was 14-21 years with mean age of 16.32years, 61.5% of the respondents lived together with their own parents, 0.7% lived with their male partners [21]. Also, a study carried in Enugu, Nigeria revealed that 80% were within the age of 15-17years, but they were predominantly Christian only 1% was Muslims [22]. The slight disparity in socio demographic characteristics of respondents from these two studies (Port Harcourt and Enugu) could be principally because of the geographical location and socio-cultural background of the two study areas. These socio demographic similarities are also in line with the findings in Northern Nigeria Akpokos [23]. There was no significant relationship between religion and sexual engagement/utilization of contraceptive and also no relationship between religion and religious disbelieve in contraceptive usage of respondents in this study. This is contrary to the expectations from the respondents considering their ethnicity (Hausa) and geographical location (Northern Nigeria) where religion (Islam) plays a key role in the lives of the people. This contrary finding could be due to the influence of urbanization, media and other similar agents of socialization as highlighted in the study conducted in Niger, North central area of Nigeria with similar socio-demographic features [20]. There was also a statistically significant correlation between age and sexual engagement, this is similar to the data presented by the [5], which showed similar relationship 49% of women 25-49 of age, were married by the age 18, and 61% were married by age 20, though not all married women are sexually engaged. There was a statistically significant correlation between age and utilization of contraceptive, this is in accordance with the 2013 NDHS report which stated that the use of contraceptive methods among currently married women increases with age from 2 percent among women age 15-19 to 22 percent among women age 40-44, after which it falls to 13 per cent among women age 45-49.

4.2 Utilization of Contraceptives

Respondents' sexual engagement and utilization of contraceptives showed that about one third (27.0%) engaged in sexual intercourse, the mean age at sexual debut was 16.3± 1.8years and only about one fifth (21%) have used contraceptives mostly pills and injectables. The early age at sexual debut found in this study is in keeping with the findings of a study conducted in north central region of Nigeria, Plateau State which revealed that the age

at sexual debut was similar for females and males, most of the females reported 10 to 15 years while most of the males reported 11 to 16 years as age of sexual debut. There was no difference in the responses of those in school and those out of school [24]. This similarity could be because both studies were carried out in urban areas where rate of early marriage is low while premarital sex rate is high. However reports obtained from National Demographic Health Survey (NDHS) stated that in Nigeria the use of contraception amongst female adolescents is very low, according to the three waves of NDHS: 1.1% in 2003; 4.14% in 2008; and 5.9% in 2013. The relatively higher utilization rate found in this study could be because the NDHS report is a national average for both rural and urban as opposed to this local study which was conducted in an urban location. However, among the 40.2% of the respondents who thought it was wise to use contraceptives, 56% could access it from hospital and chemists. A study carried out in Ethiopia revealed that only 13.1% of the respondents' utilized contraceptives, this difference could be because; the Ethiopian study was carried out in a rural district with only 16.8% of the respondents who were literate [25]. A higher contraceptive utilization rate was found in a study conducted in Tanzania where 35% of the respondents reported to be using contraceptive methods. The most common contraceptive method reported to be used was modern contraceptives (about 66%), followed by traditional method "Mpigi" which is a string out of a tree worn in the waist and is believed to provide contraception (15.3%), while the least reported types were withdrawal (1.8%) and abstinence (0.9%). This higher value could be because the Tanzanian study was conducted amongst women in a stable marital relationship with high literacy level [26]. Moreover, a study in Uganda among female Undergraduate revealed that, 55.1% indicated they had ever used any method to prevent pregnancy while only 46.6 % were presently using contraceptives with male condoms being the largely commonly mentioned methods used (34.5 %). The higher level of utilization could be elucidated by the fact that the Ugandan study was conducted among undergraduate students' not secondary school students [27].

4.3 Barriers to the use of Contraceptives

Limited knowledge on contraception was the commonest barrier to contraceptives use, followed by societal rules and regulation, location of family planning centres in the hospitals and lack of parent, partner and community support, lack of money to purchase contraceptive option, negative social norms e.g. contraceptive not meant for adolescent and inadequate family planning centres. Only about one third of the respondents stated that their religious belief does not accept use of contraceptive, minority mentioned unavailability of the contraceptives as their barriers. However a study conducted in North-western zone of Nigeria across Kaduna, Kano and Katsina states showed similar barriers but concluded that females were more likely to mention side effects as the barriers for not using contraceptives [22]. This could be because this index study was conducted among adolescents in secondary schools who are more expected to respond appropriately to questions as oppose the North-western zone study that was conducted among both in school and out of school adolescents. There was a low percentage of utilization (21%) in this study due to side effect of contraceptives, which depends on type and direction of use. Similar, barriers was found in another Nigerian study conducted among young men and women aged 10-24yrs revealed that, about a third of participating females said they would not use contraceptive method to keep away from pregnancy in the future and nearly 80% of them mentioned this was

because they feared side effects. A female participant spoke about mistrust of providers and referred to nurses as "wicked" for not telling young people about the perceived dangerous (even if false) side effects of contraceptives. Multiple participants thought modern methods like the IUD were dangerous to their health. Some express grief over the irregularity or unavailability of contraceptives and lack of anonymity when in quest of contraceptives. Among these youth, high cost of FP services was also a concern, particularly as many methods, including some LARCs, were no longer being provided for free [28]. Furthermore, a study on IUD user characteristics established that among IUD insertion patients between 2000 and 2005, merely 8.3% and 18.9% were between 15 and 19 years, and 20 and 24, respectively. The low receiving rate of IUDs amongst this age range was attributed to the fact that government hospital-based FP clinics focus their services toward "mature females in established relationships," which can exclude youth and adolescents. Additional contributing factors included social and religious norms restricting premarital sex and the association between contraception with sexual permissiveness [29]. In keeping with the findings of this study on the effect of knowledge as a barrier to the use of contraceptives was also seen in a Kenyan study which examined implant uptake among young women seeking joint oral contraceptives (COCs) or depot medroxyprogesterone acetate (DPMA) showed that after contraceptive counselling and ensuring informed choice, 24% of the young patients chose implants greater than the shorter-acting COCs or DPMA [30]. A study on provider outlook on factors influencing access to information and contraceptive use and service provision to youth in rural Uganda showed that, on average, providers did not feel capable as much as necessary to provide IUDs or implants to youth. According to the study, this lack of information showed that providers limit youth's access to LARC methods for the reason of their incapability to insert/remove the methods [31]. Also another study examining a turn down in IUD use in Ghana found that health care personnel in Ghana discouraged IUD use among nulliparous clients and also consider these clients ineligible. Despite believing that, IUD was safe and cost-effective method, providers said; "they would recommend an IUD only to parous women and to "faithfully couples or clients with single partners" **Osei *et al.*, (2005).** Buttressing Providers' attitude as a barrier was found in a qualitative research in Uganda which assessed youth's perceived barriers and factors enabling contraceptive use. Youth in this study found service providers of contraceptives to have paternalistic and judgmental outlook towards youth looking for contraception, and thought providers to demonstrate a lack of secrecy and confidentiality [30]. Moreover, a study of private providers' attitudes and practices around IUD provision in Pakistani, found that providers who were more probable to consider women 25 – 29 of age and women with one delivery as candidates for the IUD, but were not as much likely to consider women 19 years and younger suitable IUD candidates [32]. Similar to the results in this study as regards to religion and cost, an Indian study showed that 71.5% agreed that religion was not an obstacle for contraception use but 58.5% respondents thought that contraceptives are costly to purchase [33]. Overall the barriers found in this study are similar to the barriers captured by the Global snapshot on the sexual and reproductive health of youths which reported; inaccurate or insufficient information, complexity in travelling to acquire services, cost and fear that their privacy would be desecrated, fear that their parents would found out fear of violence from their partner, and concerns about side effects among others as the barriers to adolescents' utilization of contraceptives [34]. These similarities with the reviewed studies are

indicative of the facts that adolescents' health needs are marginalised worldwide, especially reproductive health wise.

5. Conclusion

This study confirmed that a greater proportion of the respondents have used contraceptive methods and knew at least one method of contraception, significant proportion of respondents believed it is wise for them to use contraceptives. Although, almost not whole of the respondents thought that modern contraceptives permanently prevent future pregnancies. Majority of the respondent also showed that lack of counselling in the school among others were some the factors that influenced them from access to information and using contraceptives and also fear of unwanted pregnancy was the major factor influencing their use of contraceptives. The findings also showed that most commonly barriers to contraceptives by most of the study participants were limited knowledge of contraceptive options.

6. Recommendations

Recommendations were made on the findings of the study;

Provision of cultural and adolescent friendly services across the diverse ethnic groups in the country. Health talk should be made a routine in secondary schools incorporating contraceptive campaigns to disseminate good knowledge and address the misinformation from friends/peers. The use of social media and electronic devices by the students should be sensored in secondary schools because; they promote risky sexual behaviours and early sexual debut. Parents should be enlightened on how to discuss sexual life with their children especially teenagers.

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