

UNIVERSITY FOR DEVELOPMENT STUDIES TAMALE

**HEALTH SEEKING BEHAVIOUR OF FEMALE ADOLESCENTS TOWARDS
FAMILY PLANNING SERVICES WITHIN THE TAMALE METROPOLIS**



BY

JEMIMA BAMURI KUSEH

UDS/MPH/0015/18



2021

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF GRADUATE STUDIES

**HEALTH SEEKING BEHAVIOURS OF FEMALE ADOLESCENTS TOWARDS
FAMILY PLANNING SERVICES WITHIN THE TAMALE METROPOLIS**

BY

JEMIMA BAMURI KUSEH

UDS/MPH/0015/18

**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH AND
FAMILY MEDICINE, SCHOOL OF MEDICINE AND HEALTH SCIENCES,
UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF A TWO YEAR MASTER OF PUBLIC
HEALTH DEGREE (GLOBAL HEALTH) IN DEPARTMENT OF COMMUNITY
HEALTH AND FAMILY MEDICINE**

FEBRUARY 2021



DECLARATION

Student declaration

I hereby declare that this thesis is my own work towards the award of a master of public health degree and that, to the best of my knowledge it does not contain any material previously published by another person nor material which has been presented for the award of any degree in this university or elsewhere, except for reference to other people's work which have been duly acknowledged.

Name of student Jemima Bamuri Kuseh

Signature

Date

Supervisor declaration

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on submission of thesis/dissertation laid down by the University for Development Studies.

Name of Supervisor Shamsu-Deen Ziblim (Ph.D.)

Signature

Date



ABSTRACT

The purpose of the study was to assess the health seeking behaviours of adolescents towards family planning services. Adolescent family planning seeking behaviour has dire consequences on their sexual and reproductive health. Therefore, these consequences cannot be over looked. An analytical cross sectional study design was used with a multi stage sampling technique to sample 412 respondents within six communities (400 adolescents and 12 health workers). Both questionnaires and interview guide were the data collection tools, SPSS version 25.0 was used to analyze the quantitative data, and the qualitative data was analysed manually. The results indicated that, respondents had fair knowledge (67%) on family planning and contraceptive use by age group for any method was higher among 16-19 age groups. Work status (0.001) and ethnicity (0.023) have a relationship with knowledge on family planning. The internet was the most used source of education on family planning. Age (0.000) and educational status (0.000) were associated with source of family planning education. Attitude of service providers, inadequate health education, religion, traditional beliefs, and financial challenges were the challenges faced by respondents in assessing family planning services. There is the need to strengthen school sexual health education and provide adolescent health corners.



ACKNOWLEDGEMENT

First, I am grateful to the Department of Community Health and Family Medicine of the University for Development Studies for giving me the opportunity to carry out this work. My sincere appreciation goes to Dr. Shamsu-Deen Ziblim, my supervisor, for the passionate support and useful criticisms towards this work. Also, my appreciation to Fati Issah, Mohammed Adamu and Jude Naah for their contribution during the thesis report writing and their assistance during data collection.

In addition, my appreciation goes to the Tamale Metropolitan Health Directorate, the Sub Metro Directorates, and the various health facilities for their assistance.

Finally, to my colleague students at the UDS Graduate School, Master of Public Health 2018/2019-year group who shared in my responsibilities, I feel thankful for your support.



DEDICATION

I dedicate this work to my parents.



TABLE OF CONTENTS

| | |
|---|------|
| ABSTRACT..... | iii |
| ACKNOWLEDGEMENT | iv |
| DEDICATION..... | v |
| TABLE OF CONTENTS..... | vi |
| LIST OF TABLE | xi |
| LIST OF FIGURE..... | xii |
| LIST OF ABBREVIATION..... | xiii |
| CHAPTER ONE..... | 1 |
| 1.0 Introduction | 1 |
| 1.1 Background of the Study..... | 1 |
| 1.2 Problem Statement | 4 |
| 1.3 Research Question..... | 6 |
| 1.3.1 Research Question | 6 |
| 1.4 Main Research Objectives..... | 7 |
| 1.4.1 Specific Research Objectives..... | 7 |
| 1.5 Conceptual Framework on Adolescents Health Seeking Behaviours | 7 |
| 1.5 Significance of the Study | 11 |
| 1.7 Study Limitations | 11 |
| 1.8 Organization of the Study | 12 |



| | |
|---|----|
| CHAPTER TWO | 13 |
| LITERATURE REVIEW | 13 |
| 2.0 Introduction | 13 |
| 2.1 Conceptualizing Adolescent..... | 13 |
| 2.2 Contraceptive Use by Adolescents..... | 16 |
| 2.1.1 Aspects that stimulate contraceptive use amongst adolescents..... | 17 |
| 2.3 Adolescents' Health Seeking Behaviors..... | 20 |
| 2.4 Female Adolescent Knowledge on Family Planning | 20 |
| 2.5 Challenges female Adolescent Face towards Family Planning Services | 22 |
| 2.6 Effects of Socio-Cultural Factors (Family Planning) on Female Adolescent..... | 23 |
| 2.5 Overview of Family Planning | 26 |
| 2.5.1 Global Context | 26 |
| 2.5.2.1 Sustainable Development Goals..... | 30 |
| 2.5.2 The Regional Context..... | 30 |
| 2.5.3 The Ghanaian Context..... | 32 |
| 2.6 Types of contraception use for FP..... | 34 |
| 2.6.1 Blockade process | 35 |
| 2.6.2 Hormonal technique | 36 |
| 2.6.3 Classical Methods..... | 38 |
| 2.7 Unmet Needs of Family Planning | 40 |



| | |
|--|----|
| 2.10 Challenges of Family Planning in Ghana..... | 41 |
| 2.10.1 Demand Creation (DC) | 41 |
| 2.10.2 Service Delivery on Family Planning | 43 |
| 2.11 Why Does Family Planning Still Matter? | 44 |
| 2.11.1 Socio-Economic Effect | 44 |
| 2.11.2 Health Benefits..... | 46 |
| 2.13 Adolescent Friendly Environment for Family Planning. | 47 |
| 2.14 Family Planning Education to the Adolescent | 47 |
| CHAPTER THREE | 50 |
| STUDY AREA AND RESEARCH METHODOLOGY | 50 |
| 3.0 Introduction | 50 |
| 3.1 Study Setting | 50 |
| 3.2 Study area..... | 55 |
| 3.3 Study Design | 56 |
| 3.5 Sampling Technique..... | 56 |
| 3.6 Sample Size..... | 57 |
| 3.8 Data Collection Tools..... | 59 |
| 3.8.1 Questionnaire | 59 |
| 3.8.2 Interview..... | 59 |
| 3.9 Study Variables | 61 |



| | |
|--|----|
| 3.10 Data Analysis and Presentation Methods..... | 62 |
| 3.11 Rigor of the Research..... | 63 |
| 3.11.1 Credibility..... | 63 |
| 3.11.2 Transferability..... | 64 |
| 3.11.3 Dependability..... | 64 |
| 3.11.4 Confirmability..... | 64 |
| 3.12 Ethical considerations..... | 65 |
| 3.13 Operational definition..... | 66 |
| CHAPTER FOUR..... | 67 |
| RESULTS AND ANALYSIS..... | 67 |
| 4.2.1 Contraceptive Method Used and Age of Female Adolescents..... | 71 |
| 4.2.3 Knowledge on Benefit of Family Planning..... | 76 |
| Sources of Family Planning Education and Family Planning Services..... | 78 |
| 4.5 Socio-cultural and economic factors of FP..... | 88 |
| CHAPTER FIVE..... | 90 |
| DISCUSSION..... | 90 |
| 5.4 Socio-cultural and economic factors affecting FP services..... | 93 |
| CHAPTER SIX..... | 95 |
| CONCLUSIONS AND RECOMMENDATIONS..... | 95 |
| 6.1 Conclusions..... | 95 |



| | |
|---|-----|
| 6.2 Recommendations | 97 |
| REFERENCE..... | 98 |
| APPENDICE..... | 120 |
| APPENDIX A..... | 120 |
| QUESTIONNAIRES | 120 |
| APPENDIX B..... | 125 |
| FOCUS GROUP DISCUSSION (FGD) GUIDE..... | 125 |
| APPENDIX C..... | 126 |
| INTERVIEW GUIDE FOR KEY INFORMANT INTERVIEW | 126 |
| APPENDIX D..... | 128 |



LIST OF TABLE

| | |
|--|----|
| Table 2.1: Reproductive Health Indicators for Selected Countries in West Africa, Latest Available Data..... | 25 |
| Table 2.2: Reproductive Health Indicators for Selected Middle-Income Countries, Latest Available Data..... | 26 |
| Table 3.1: Distribution of study communities into sub metros | 54 |
| Table 3.2: Presentation of study setting and participants..... | 58 |
| Table 3.3: Presentation of data collection..... | 59 |
| Table 4.1: Socio-Demographics of Respondents..... | 60 |
| Table 4.2: Cross-Tabulation of Contraceptive Method Used and Age of Female Adolescents..... | 64 |
| Table 4.3: Regression Analysis on the Relationship Between the Demographic Characteristics and Knowledge of Family Planning..... | 67 |
| Table 4.4: Respondents Knowledge on Benefit of Family Planning Services..... | 69 |
| Table 4.5: Association between socio demographics characteristics and the FP education source..... | 75 |
| Table 4.6: Challenges concerning adolescent towards Family Planning..... | 78 |



LIST OF FIGURE

| | |
|---|----|
| Figure 1.1: The Nexus Between Adolescent Health Needs and Reproductive Factors..... | 8 |
| Figure 2.1 : Population Growth Trend, 1921-2010, and Projected Growth, 2015-2020..... | 27 |
| Figure 3.1: Map of the Tamale Metropolis indicating the study communities..... | 53 |
| Figure 4.1: Knowledge Regarding Family Planning Services | 62 |
| Figure 4.2: Sources of Family Planning Education..... | 71 |
| Figure 4.3: Negative effects of family planning service..... | 79 |
| Figure 4.4: Showing the average income of adolescents' family..... | 81 |



LIST OF ABBREVIATION

| | |
|--------|---|
| AIDs | Acquire Immunodeficiency Syndrome |
| CPR | Contraceptive Prevalence Rate |
| DHS | Demographic and Health Survey |
| DFID | Department of International Deutschland |
| FP | Family Planning |
| GDHS | Ghana Demographic and Health Survey |
| GoG | Government of Ghana |
| GFPCIP | Ghana Family Planning Costed Implementation Plan |
| GSS | Ghana Statistical Service |
| HSB | Health Seeking Behaviour |
| HIV | Human Immune Virus |
| LMICs | Low and Middle Income Countries |
| MSIG | Marie Stopes International Ghana |
| MoGCSP | Ministry of Gender Children and Social Protection |
| MoH | Ministry of Health |
| M&E | Monitoring and Evaluation |



| | |
|--------|---|
| MCPR | Modern Contraceptive Prevalence Rate |
| MDGs | Millennium Development Goals |
| PMA | Performance Monitoring for Action |
| PPAG | Planned Parenthood Association of Ghana |
| RHS | Reproductive Health Service |
| STIs | Sexually Transmitted Infections |
| SRH | Sexual and Reproductive Health |
| SDGs | Sustainable Development Goal |
| TFR | Total Fertility Rate |
| UNFPA | United Nations Population Fund |
| UNAIDS | United Nations Program on HIV and AIDs |
| WHO | World Health Organization |
| ZDHS | Zimbabwe Demographic and Health Survey |
| USAID | United States Agency for International Developments |



CHAPTER ONE

1.0 Introduction

This aspect of this project introduces the study from a broad outlook of the subject matter and narrows to specific issues of concern. Thus, it begins with the scope, content, objectives and significance of the study by highlighting topical issues critical to the subject matter. The chapter is divided into subheading, which includes the background of the study, stating the problems, stating the specific objections and main objectives, research questions justification as well as operationalization of some key words, organization of the work and framework guiding the progress of the work.

1.1 Background of the Study

The reproductive health Facilities are described by the United Nation's Population Fund as the obligation of all persons to determine the number and distribution of children openly and reasonably, and have the necessary knowledge and services to do so. Family planning programs are considered an important human right, free of discrimination, exploitation and abuse, to meet the highest level of sexual and reproductive health (UNFPA, 2003). Globally, maternal health programs are a critical part of public health, protecting and safeguarding the wellness of dozens of wives and kids (Blencowe, Chou, Oestergaard, Say, Moller, & Lawn, 2013). Nevertheless, Family plan programs faced a whole host of Byzantine procedures in many African nations, including Ghana, entangled in the financial, political, ethical and cultural network (Dangat & Njau 2013; MacLean 2010).

Adolescent is defined as a period from 10 to 19 years (WHO, 2014). There are presently over one billion adolescents aged 10-19 years, with 70 percent living in countries with low incomes



(UNFPA, 2008). Countries should be ready to interact with and solve their medical needs with this significant part of the population. Health programs will look beyond underage abortion and HIV in order to meet the whole spectrum of health and wellbeing needs of young people (WHO 2014).

Internationally, adolescents are potentially the most disadvantaged category, because they are the targets of early pregnancy, motherhood, unpredictable abortions that lead to morbidity and mortality (UNAIDS, 2011). Indeed, the reproductive capacity of young women and the future of a nation can perpetually be affected by pregnant health problems and sexually transmitted illnesses throughout adolescent years (Paluku et al., 2009). Family planning in young people is dependent on multiple diverse and often separate factors, which include social / cultural pressures (e.g. families, friends, and community), as well as exposure to health care, schooling and jobs (Atuyambe, Kibira, Bukenya, Muhumuza, Apolot and Mulogo, 2015).

The population of Ghana is predominantly young and 22.4% of the population is between the ages of 10-19 (GDHS, 2012). Ghana's demographic transformation strongly signals the beginning of a population dividend that requires concerted actions and methods for extracting or leveraging its advantages. Ghana has held debates in recent years to identify means of leveraging the demographic boom currently faced by the region, illustrated by the evolving ageing system of the young bulgarius and rising the incidence of addiction for young people. The increase in the youth community and in young adults is one of the things that needs consideration (MoGCSP, 2018).

"Action or inaction by people who see themselves as having a health problem or are ill to find an appropriate solution" (Olenja, 2004), has been described as "Health-Seeking behavior." Behavioral health-consciousness can also be called disease behavior. Health-related behavior,



which includes practices to maintain good health, avoid ill health and tackle any deviations from a good health state, are within the broader concept (MacKian, 2003). Studies attempting to explain cause that affect actions in episodes can be generally divided into two classes (MacKian, 2003 and Moyer et al, 2014). The first group is a study that emphasizes the use of the formal system or the behavior of individuals looking for family planning. Research in this group is structured to explain the series of actions that people take in family planning. Sometimes these models are known as 'pathways' (Rosenstock, 2005). These studies show that a range of factors such as socioeconomic status, sex, age, social status, type of disease, access to services and perceived service quality is affecting the decision to communicate with a specific medical channel (Cronin et al 2013; Wabair and Bin-Gouth 2013). In most of the studies in this second category, specific types of determinants which lie in geography and social, cultural, and organizational factors between patients and services (Gao et al, 2012; Worku et al, 2013). Access to family planning services, economic status, perceived service quality and perceived health-seeking choices among the different population segments have, for example, been described as a significant influence (Gao et al, 2012; Babalola and Futusi, 2009; Phiri et al, 2014).

Inappropriate HSB has been related to worse performance, increased mortality and health statistics (Atuyambe, 2008; Mwase, 2015). HSB is not being properly reported. Research into HSBs in Low and Middle Income Countries (LMICs) shows several factors affecting the population's HSB, and specific segments of the population use appropriate HSBs more likely than others do. Adequate HSB has been shown to decrease between different population segments and its above-mentioned consequences. In Pakistan, for example, households with below-average wages were less likely than households with above-average wages to look for formal family planning services. In Kenya, nearly 70% of adolescent in the middle



social/economic stratum in households had family planning services in health facilities, compared to 42% of adolescent in the middle socio-economic stratum and 38% in the low socio-economic stratum (Ng'anjo et al, 2014).

Adolescents are very vocal about the health care providers' preferences. You respect your privacy and reputation and want to make decisions based on correct knowledge. WHO has a variety of items that encourage the advancement of health services for adolescents? The elements include confidentiality, providing the necessary information and services, accepting adolescents as it is, taking into account and respecting the opinions of young people, giving young people the opportunity to make their own choices, making sure adolescents feel welcome and at home, being non-judgmental, and delivering services in a time when young people can come (Atuyambe et al . 2015).

Several causes including low socioeconomic status, poverty, and inadequate education and resources on reproductive health are the susceptibility for many adolescents to unplanned pregnancies and other reproductive health problems. However many young women, including long-term labour with hemorrhages, continue to have problems that often lead young girls older than 19 years of age to die. They are often killed. The demographic and health surveys have shown the highest infant and child deaths (MoGCSP, 2018) in Ghana in adolescent mothers (ages 15-19).

1.2 Problem Statement

Adolescents are still reluctant to pursue sexual and reproductive health care. The other challenges include judicial staff, an inability to include resources, tools, facilities, and private workforce and a shortage of preparation for adolescent sexual needs and knowing it (Cudjoe, 2018; Teffo, 2019).



Adolescents aged 15-19 were 9.7 percent higher than in 1988 and rose to 10.8 percent in 1993 to add to fertility in Ghana. This fell in 1998 to 9.9%, in 2003 8.3% and in 2008 to 8.1%. In 2014, however, it rose to 9.1% (MoGCSP, 2018). It led to all of the young women who needed to complete their education, and unexpectedly shortened their career progression. Many have also involved in forced abortion with adverse lives and public health effects (MoGCSP, 2018).

A 2014 Ghana population and health study report showed that the use of conventional family planning strategies by adolescents between 15 and 19 years of age was 16.7% compared to 24.8% by adults between 20-24 years of age (MoGCSP, 2018). Such adolescents are definitely vulnerable to early abortion and other reproductive health threats. The 2010 Ghana Population and Household Census reported that 7.1% of all recorded deaths in the 12-19 population over the preceding 12 years are linked to abortion, indicating that more of those pregnancy-induced deaths could be avoided if teens had access to and using family planning strategies. Thereby, successful adolescent contraceptives can reduce early abortion, STIs, maternal and child mortality and fistula in adolescents (MoGCSP, 2018).

The annual health report of the Tamale Metropolis for between 2012 and 2016 indicated a steady rise of adolescent pregnancy cases with a rise in figures from 21% in 2012 to 25% in 2016 (GHS, 2016).

Almost one in every three Ghanaians aged 10 to 24 years had ever had unplanned abortion. Most of these young women (Zgambo, Kalembo, & Mbakaya, 2018; Noumsi, 2013), are at risk or are still dealing with the possibility of unplanned abortion or sexual transmission (STI). Policymakers, practitioners and activists need clear information regarding Ghanaian youth's sexual and reproductive health needs in order to reduce these dangers and ensure a safe future for teenagers (Adabla, 2019).



Hence, the study seeks to investigate the health-seeking behavior of adolescents towards family planning services in the tamale metropolis and explore their attitudes towards current services available.

Daka and Shaweno (2014) reviewed Sese and Wirtu 's 2008 study and found that young people have little knowledge of sexual and reproductive health, including the natural puberty process. The lack of awareness encourages the early initiation of sexual intercourse and often contributes to adverse outcomes for reproductive health (Bankole et al., 2007).

Though many studies have been undertaken in the Tamale metropolis on adolescent pregnancy a few studies have been conducted to investigate the health-seeking behavior of adolescents towards family planning services in the Tamale metropolis. Thus, the study sought to fill this gap and set the theme for future studies in this area.

1.3 Research Question.

What are the health-seeking behaviors towards family planning services in the Tamale metropolis among female adolescents?

1.3.1 Research Question

1. What is the level of knowledge of adolescents on family planning services?
2. What are the various sources of family planning and education centers for adolescents friendly in the metropolis?
3. What are the challenges regarding adolescent health-seeking behavior towards family planning services?
4. What are the socio-cultural and economic factors that affect the health seeking behavior of the adolescents towards family planning services?



1.4 Main Research Objectives

The main objective of this study is to assess the health-seeking behavior of female adolescents towards family planning services in tamale metropolis.

1.4.1 Specific Research Objectives

1. To assess the knowledge level of adolescents on family planning services.
2. To identify the challenges regarding adolescent health-seeking behavior towards family planning services and what are they.
3. To identify the socio-cultural and economic factors that affects the health seeking behavior of the adolescents towards family planning.

1.5 Conceptual Framework on Adolescents Health Seeking Behaviours

The study was underpinned by a conceptual framework developed by the author using the objective of the study and other health seeking behaviour models such as the health belief model.

The study also used the Andersen's expanded behavioural model of health services.



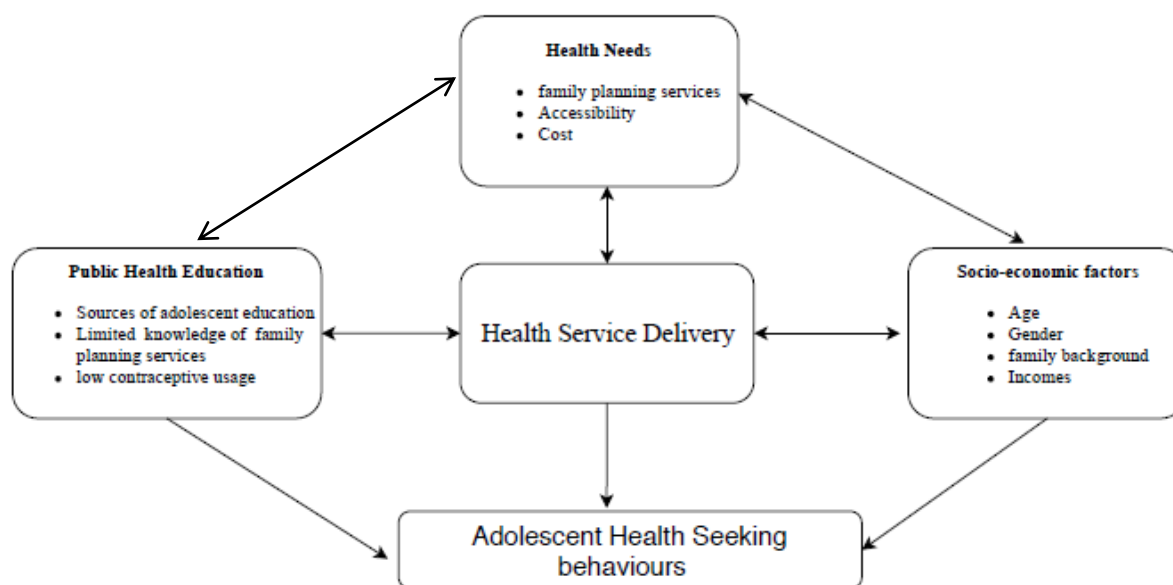


Figure 1.1: Conceptual Framework on Adolescents Health Seeking Behaviours

Source: Author's construct (2020).

The study draws the relationship between adolescent health needs, socio-economic factors, public health education, health service delivery and how it impacts adolescent health-seeking behaviors. The literature review therefore, draws from current and emerging debates around these key concepts.

Health Needs: the health needs of adolescents are affected by the family planning services available to them. The accessibility of the services affects its patronage and usage. The availability of the services is also influenced by the cost of the services. High cost of family planning services discourages its patronage by adolescents. Therefore, the availability, accessibility and cost of family planning services affect the health seeking behaviour of adolescents.



Socio-Economic Factors: Socio-economic issues such as age, gender, family background and income affect the health seeking behaviour of adolescents. The family background of adolescents such as the educational status of parents, the wealth quintile and place of residence of the family; either rural or urban influences the health seeking behaviour of youngsters to family planning services. The educational status of parents and urban dwellers are likely to have good health seeking behaviours towards family planning services due to their exposure to family planning services and education. Gender influences health-seeking behaviour of adolescents, particularly females due to the cultural and societal view of womanhood.

Public Health Education: Sexual and reproductive health education is known to improve the knowledge of adolescents towards family planning and sexual and reproductive health in general. The education on SRH improves the knowledge of adolescents about the sources to access SRH services when the need arises. Also, public health education will help improve misconceptions surrounding contraceptive usage which affects its patronage and use among adolescents.

The aforementioned factors are intertwined and affect each other. Each factor affects the other and therefore in issues of adolescent health seeking behaviour, each component or factor cannot be exempted and must be tackled accordingly.

Andersen's expanded behavioural model of health services

The model was first developed in the 1960s and modified in the 1990s. The purpose of the model in this study is to explain why and how adolescents use family planning services and their access to these services. The model is underpinned by three factors; psychological, enabling and needs.



Psychological factors / predisposing: This factor was derived from the theory of planned behaviour due to its ability to influence decision making of intended behaviour. The psychological factors influences the ability of the female adolescent to make decision regarding their family planning services and their ability to seek those services. This factors also is affected by the socio-cultural characteristics of adolescents that exist before they access family planning services. The predisposing factors or the psychological factors is affected by the socio-demographic characteristics of adolescents, their health belief (knowledge) concerning family planning, and their social structure such as social networks and culture.

Enabling factors: This considers the capacity to access health services by adolescents as dependent on the resources available; at the community or individual level. Thus, it considers the logistical support to access family planning services by adolescents. This include family background (wealth quintile of the family), and the community in which the adolescent find herself with respect to access to health facility and the availability of family planning services and health staff. These factors can lead to the utilization of family planning services.

Needs factors: This component deals with how individuals perceive their health condition or how others perceive the individual's health condition and the judgment of the severity of the condition. Adolescents' perception on family planning can influence their decision to seek family planning services. Their needs can be influenced positively or negatively depending on their access to family planning health education as well as incentives or benefits gained from family planning.



1.5 Significance of the Study

The results of this research will provide key audiences with a knowledge system for adolescents, their communities, and society as a whole.

Findings from the research would produce baseline information on knowledge about the health-seeking behavior of adolescents towards family planning services in the study area. Also, Ministry of Health, Non-Governmental Organizations and other interested parties in developing and integrating adolescent health-seeking behavior into policies or programs concerning family planning services in Ghana. This can be adopted into national and regional reproductive health plans.

It is also hoped that the findings from this study will be added to the body of research and scholarly works and generate further interest in the research field to improve the situation of adolescents patronize to Reproductive Health Services (RHS) in the study area and the country at large.

1.6 Scope of the Study

The study was conducted within the tamale metropolis. The study assessed the health seeking behaviours of adolescents towards family planning.

1.7 Study Limitations

The study focuses on the factors that influence the health-seeking behavior of adolescents towards family planning services in Tamale Metropolis. The study was limited to some selected communities within the Tamale Metropolis for the sake of time and resources. An appreciable number of communities were selected enough to represent the entire metropolis. The corona



virus pandemic affected the data collection because respondents were not willing to come into contact with the research assistants.

1.8 Organization of the Study

Chapter one entailed the introduction of the study which includes the study background, problem statement, research questions and objectives, operational terms, the significance of the study, the limitation and organization of the thesis.

Chapter two focused on review of related literature.

Chapter three covered the geography of the study area and the methodology of the study; research design, ethical considerations, sampling procedures, sources of data, tools, and techniques of data collection.

Chapter four was devoted to the data presentation, analysis, and results

Chapter five was devoted to the discussion of the results.

Chapter six focuses on the summary, conclusion and recommendation for policy direction and implementation.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The section offers a theoretical structure of the analysis, which focuses on the complex meaning, interpretation and explanation. Among the elements to be explored in this chapter are:

Knowledge on Health Seeking Behavior (HSB), Challenges of FP and the benefits of FP, effects of Socio-cultural factors on HSB, some definitions of adolescent by different authors, over view of Family planning, the unmet need on Family Planning (FP), and Contraceptive use by adolescents.

2.1 Conceptualizing Adolescent

The chronological concept of adolescence is most widely used between 10 and 18 years old; however, it can encompass the period 9 to 26 years, depending on the source (APA, 2002). Inconsistencies in "adolescent" and sub-stage inclusion requirements that create uncertainty in the development of youth research and the planning of youth programs. Although it is important to recognize developmental variation when discussing adolescence, conceptual clearness is equally required. Moreover, Steinberg further defined "Adolescence" in 2014 is a physiologically, psychosocial, temporal and culturally aware theoretical construct. The years from the onset of puberty to social maturity are conventionally known as this crucial growth phase.

World Health Organization (WHO) (2018) Adolescent is define as, each youth between 10 and 19 years old. The time this young individual advances is known as the adolescent period. This



phase of life spans from infancy to adulthood (Sawyer, Azzopardi, Wickremarathn and Patton, 2018). This time has scientifically been defined by Sharp (2018) as a time span from adolescence to maturity. In addition, the period can thus be divided into three stages of growth: early ten to five years, mid 14 to seventeen years and late seventeen to nineteen years (WHO 2010).

Freud (2005) notes that there are several issues during this time the adolescent must make changes to this time. He says these issues contribute to the self-image of pubic hair in sexes, breasts production in females, and the first symptoms of beard in males. This can be seen as obstacles in the sense that, whether or not the young person loves it, he or she will survive throughout his / her life with these public images. Hall (2007) also said that adolescence is a time of the individual is knocked over by contrasts such as movement versus inaction, anticipation versus calmness, elation versus despair, and self-confidence during the storm and tension versus questions about self-recognition and the desire for authority versus need to be rebellious against power.

The young person at this stage, too, Erikson (2013) added sets a sense of personal identification and avoids the risks of role diffusion and uncertainty about identification. Razak (2016), identified this time as an experimentation phase and exposure, including unprotected sex, to behavioral danger. In recent decades, teenagers have grown older, which has had many negative effects, especially on reproductive and sexual health (Skrzeczowska, Heimrath, Surdyka & Zalewski, 2016). The number of accidental or unintended births in all sexually transmitted contagious individuals in young adults is growing (Skrzeczowska et al., 2016), which calls for the need to avoid such phenomena. Again, Razak (2016) observed that 75% of teenagers in SubSaharan Africa report having sex by age 20, and that, internationally, the majority of adolescents became sexually active before their 20th birthday.



Green and Merrick (2015), too, state that nearly one in six individuals is adolescent worldwide. That refers to 1.2 billion individuals aged 10 to 19 years. Of these, over 46,000 girls are born every day (Green & Green). Maclean (2016) estimates that high birth rates that not only impact mortality between mothers and infants, but frustrate the government's delivery of health and social services for families, for example the implementation of national health insurance policies that provide medical care. In a survey, Maclean (2016) identified the great advantages of engaging in family planning, including lower rates of deprivation, increased health for maternity and small children, and female labor force involvement. What about following a global demand for funding and innovation in family planning (Maclean 2016), 200 million girls in developed countries have an unmet need for family planning.

The bulk of the results were Yidana et al.,(2015). In developed nations, sexually active adolescent girls do not use contraceptives. This could lead to multiple social and health implications, including high mortality rates for maternal and newborns, pregnancy and risks linked to pregnancy (Greene & Merrick, 2015). Recent figures from several sub-Saharan African countries show that just one-third of sexually active, unmarried girls aged between 15 and 19 use contraceptive medicinal products, with most indicating that methods of delaying or space pregnancy are not necessary (Greene & Merrick, 2015). Any form of family planning used to avoid a Pregnancy. The natural process of ovulation, fertilization and implantation can be accomplished by intervention (Deri, 2016). This was a significant challenge to find an appropriate method that everyone would quickly navigate. This challenge lies primarily in driving forces that may be socio-demographic, political, environmental, religious or mentally dependent on a number of contextual factors (Deri, 2016). Yidana et al (2015). Contend that the reproductive and sexual wellbeing of adolescents are a big problem, because the planet currently



has a greater teenage demographic than ever. This group was seen as sexually active and needs information on reproductive wellbeing and exposure to contraception resources and products (Guttmacher Institute 2015). Most of them often skip it by being subjected to incorrect or unreliable knowledge in their attempt to obtain information from multiple sources (Yidana et al., 2015).

2.2 Contraceptive Use by Adolescents

The high fertility rate in Ghana fuels rapid population growth. High fertility is the product of various causes such as early marriage and accidental pregnancy due to low contraception, as mentioned earlier. About 25 percent (15–49 years) of married women of breeding age used FP methods in 2014. New approaches in the last few years have nevertheless stagnated and remain below the policy documents 'target goals (GHS, 2009).

Variations in the reproductive situation in rural and urban areas arise by sex, marital status, unemployment, social circumstances and geographical location. The use of contraceptive methods is higher than in married women for single women of reproductive age (GSS 2014). Among more schoolchildren, CPR is higher. In middle and high school married women, the CPR is nearly twice (34.3 percent) higher than women without education. (18.6 percent). Higher use of the women who die from the lowest is 28.5 percent, relative to those who use a 22.2 percent higher mean CPR in the bottom quintile, with a form of family planning in the highest quintile of wealth. Contraceptive treatment is higher in rural areas than the homologous women in urban areas (26.3% for all methods and 20.3% for modern methods) (CPR 27% for all methods, 24.2% for modern methods). Regional variations are also evident (PMA2020, 2013). A slightly greater percentage of population in the two major metropolises of Accra and Kumasi is compounded by



the clustering of healthcare workers, in particular physicians and university-educated nurses, which contribute to an inadequate number of rural healthcare personnel (GHS, 2014).

2.1.1 Aspects that stimulate contraceptive use amongst adolescents

Suchoff, Arora, Rourke and Vanessa (2017), are of the view that, sum of 214 million in developed nations, women of reproductive age seeking to prevent abortion do not use a conventional form of contraception. A number of elements converge to form the views of women towards contraceptive use and the need for it. Ambivalence over abortion is another consideration. In a new survey, 62% of women found it very important to prevent pregnancy, 20% considered it to be only of certain significance and 18% considered it to be of little to no importance to avoid pregnancy. People that are ambivalent about abortion avoidance are less inclined to use contraceptives and are more inclined to have disparities about contraceptive usage, placing them at risk of accidental pregnancy (ARHP, 2008). Literature shows that adolescents have increased the incidence of contraceptives more rapidly than older adults (Blanc et al., 2009) have lower numbers of young people abandoned their use of a form of contraception or had reproductive failure within one year (Blanc et al., 2009).

Another factor, which affects the use of contraceptives by a woman, is the degree of satisfaction with her method chosen. Most women are dissatisfied with their situation tools for birth control. The (ARHP, 2008) reveals that 38 % of women have selected their present approach mainly because they do not want the other. Up to 40 % of women did not pursue their present strategy because of factors such as decreased sexual satisfaction, potential negative consequences or anxiety over effectiveness. Women that were not completely pleased with their system also had loopholes or misused tools, putting them at ease. The risk of accidental abortion has been raised.



Many teens may not use contraceptives because they disclose irregular sexual behaviors and not married. Incomplete source of information can also allow the misuse of contraceptive agents (WHO, 2012). According to Brown and Guthrie (2010), some adolescents believe that health providers are often rude and perhaps excessively judgmental. Resources for young adults are not adequately funded. They take their individual needs and concerns into account, especially as regards anonymity and visibility. The actions of healthcare providers and the poor standard of treatment lead in discontent between young people (Awusabo-Asare & Abane 2008).

Amoako (2016) has also found that misunderstandings regarding the efficacy and effectiveness of reversible long-acting contraceptives and inadequately trained provisioners may include certain factors that affect contraceptive use. A further region, reported by Amoako (2016), indicates incidents in which health providers did not deliver care because there was no access to funding and logistics. Awusabo-Asare and Abane (2008) found that the quality of care is one of the reasons affecting young people's contraceptive use. Sexual and reproductive problems, particularly between adults and young people, cannot be dealt with at home. This will potentially restrict teenagers' link to sex and abortion knowledge (Boamah et al, 2013). Adolescents may feel ashamed to visit health facilities for sex and contraception information or resources if they feel they are unfamiliar with the hospital, because care providers in the group, are the same people they live with (Boamah et al, 2013).

Studies around the globe showed that the use of conventional contraceptive methods differs with socio demographic factors including age, marital status, schooling and faith, living children's numbers, willingness to have more babies, current contraception usage at all times, urban / rural residency and socio-economic status (Abdulai, 2015). A domestic study of Kuwaiti women (Rahayu et al. 2009) quoted in the research (Abdulai, 2015) showed that women have substantial



and optimistic relations with the entry of contraceptives, age, gender, educational status and residency in urban areas. The socio demographic characteristics can determine how the individual understands how the approaches are used and how effectively. They can also influence the willingness of the patient to use various types of contraception (Atiemo, 2015). A research in California explained how IUC consumers were different from women who were using other contraceptives. More women were found to use the IUC (period married), although very few women were using the other contraception drugs (nulliparous).

A research on the use of long acting obtained comparable outcomes in United States women with reversible contraception (LARC) Birth monitors. Since the modification of main functions, LARC participants were more likely to be married couples and people over 35 as compared to non-long active reversible hormonal approaches. Furthermore, LARC consumers were much more likely to be women who had ever-unhealthy pregnancy and women who had never started using a short-term hormone system due to frustration (Kost & Henshaw, 2012). A Kenya study found that, combined with those under 20 and over 37 years, contraceptive use was most prevalent in women between 20 and 39 years of age (Akoth 2010). It shows that 49% of the women. The contraceptives were aged 20-29 years, 41% aged 30-39 years, while the use of some form of family planning was not observed at a woman of 50 years or older. Ultimately, fewer than 20 years were 4 percent of women accessing family planning facilities (Akoth 2010). The GDHS study in Ghana (2014) shows the use of new technologies with age up to 44 years abortion decreases and with different approaches, it declines. With age and number of live babies, the use of IUD and of implant increases. The marital status has been found to be associated with the use of contraception in Ga East District of Ghana. In the study, married



women are twice as likely to have used a conventional form of contraception (Statistical Service of Ghana (GSS), 2013).

2.3 Adolescents' Health Seeking Behaviors

Suneth et al. (2008) suggest that in most situations adolescents accept that most of their health issues are first-hand experiences with peers. In general, girls preferred mother guidance in particular for minor problems. Few girls suggested that they could speak to their mothers about something while most of them were seeking advice from their best friends. Few participants in their study mentioned being able to speak to a teacher about reproductive health issues. Nonetheless, most young women disagreed and said they had no faith in teachers on these subjects. Boys decided in one hand to not speak to parents or teachers about these issues. We said we contacted their mates for minor difficulties. However, they did not even consult their friends for big problems. According to young children, isolation and bullying were very common among peer groups, which was why they did not want to come up with these issues. Both boys and girls have consistently identified that parents often carry them for family planning services to private practitioners. The participants did not speak about the use of alternative medicine and home remedies.

2.4 Female Adolescent Knowledge on Family Planning

Reproductive health consciousness in most healthcare organizations is now fixated, as the issue of increased population expansion is now a worldwide priority (Appiah-Agyekum and Kayi, 2013). Research shows that population development and prosperity are not only dictated by young people's intellectual capacity but also by young people's demands for reproductive health. Notwithstanding an understanding that the use of contraceptives appears to be very small



(Awusabo-Asare, Abane and Kumi-Kyereme 2004; Yidana et al, 2014), in terms of meeting the needs of young people in the reproductive field and high education rates. Therefore, it is critical that people are aware of family planning approaches and of their attitude to their related services that actual contraceptive use is increased in time or not (Longwe et al., 2012).

In recent years, interest in adolescent reproductive health has increased. This is because of the health consequences that can lead to maternal or child mortality due to adolescent pregnancy, miscarriages, stillbirths and illegal abortions (Solomon-Fears, 2015; Machel, 2001; Magadi, 2006). Pregnant girls are usually discarded because they have no social and economic means of raising children (Whitaker & Gilliam, 2008).

While early pregnancy risks are known, the use of contraceptive drugs among 15-19 years of age and sexually active adolescents is small (Kinaro et al. 2015). While young women have declined since 1990, girls between the ages of 15 and 19 years account for 11% of all birth rates worldwide (WHO, 2014).

According to Ghana, the pregnancy rate in these ages is still high, although there has been a small decrease from 14% in 2000 to 12.2% in 2007. In a study in Ghana's northern and sub districts Kintampo, the national average was higher in pregnant adolescents and young moms. In males, maternal mortality rates typically are double the levels of women at 20 (WHO, 2003). For low- and middle-income countries, the use of contraception will reduce maternal mortality by 20% to 30%; however, the provision of socio-cultural practice (FP) in the field of family planning for adolescents (UNFPA, 2005).

Awusabo-Asare et al. (2006) demonstrated inadequate knowledge of adolescent reproductive health issues in Ghana between 12 and 19 years of age. These adolescents (78.9% females and



67.0% male) knew women could be in fertility, but only 26% knew exactly when they were in pregnancy. A woman may conceive of her first sexual experience 60% of the women and 53% of the men (15-19 years of age). In addition, after she was cleaning herself right after sexual intercourse, over half (56%) remained ignorant (Awusabo-Asare and Biddlecom 2006).

Most studies suggest that, given the possibility of early pregnancy, adolescents aged 15-19 are unlikely to use contraception (UNFPA, 2001). Women who are not healthy, but sexually active are at risk of unintended pregnancy. Other health risks, including defects, premature child or maternal deaths, are also associated with unplanned pregnancies (Nyarko, 2015). The contraceptives in married or unmarried young women are, in accordance with Blanc et al (2009), reversible in their use and are inconsistent. Furthermore, they discuss the obstacles to women's use of contraceptive methods as anxiety, shame, costs and lack of awareness.

2.5 Challenges female Adolescent Face towards Family Planning Services

There are many reasons why family planning goods are not used. A Cambodian study found that the key reasons for not using modern contraceptives were the side effects of the pill and contraceptive injection and a desire for more kids. Some respondents reported disapprovals from husbands and relatives, husbands often worked away, so contraception became unnecessary, husbands used traditional calendar methods, and individuals felt there was no risk of women being pregnant. According to a study by the University of Lahore, Pakistan, the non-use of family planning services is similar to that of a study in Cambodia, but Pakistan stresses the lack of knowledge of the service resources (Sajid and Malik 2010).

A research in Ghana has shown that young people have access to family planning services in a variety of ways. Such obstacles include costs of services, the social belief that adolescents who



patronize family planning are privileged and the concern among adolescents that healthcare providers are judgmental, biased based on and may not comply with privacy and confidentiality standards when delivering family planning services for adolescents. Shyness and bullying were also shown to be another obstacle to access due to social and healthcare attitudes (Liu et al., 2011).

The non-use factors vary from region to region. Family planning A study of the factors that affect family planning services in Talensi District in Ghana has shown that women have a major constraint on family planning without the agreement of their married couples, perceived misunderstandings about family planning services, for example family planning, are only intended to be harmful for married people.

Moreover, a research conducted in West Ethiopia revealed explanations for the lack of Family Planning Facilities for some study participants. Most of the participants referred to causes of fertility linked to breastfeeding and not sex. Some women had no family planning, but others had been because of social considerations or of resistance from husbands or relatives. The study also showed that potential family planning users sometimes decided not to apply more reliable methods because of misconceptions and health concerns, compounded by a lack of adequate knowledge about family planning methods.

2.6 Effects of Socio-Cultural Factors (Family Planning) on Female Adolescent

Latest studies on young reproductive health directly linked to contraception have taken place in Africa. A research in Kenya showed high rates of obstacles for contraceptive usage in adolescents even though only 43.0 per cent understood how the contraceptive method was to be used (Kinaro et al, 2015). The report also showed an inequality in the administration of birth



control pills based on age and the knowledge of the major obstacle to family planning use in adolescents in contraception. Contraceptive study has shown that in Dar Es Salaam, 40.0% of females, who had at least one contraceptive form, in fact used both of the methods of contraception in secondary girls in Tanzania. Many girls understood unwelcome abortion issues among pupils. Schools and media were the primary source of knowledge on contraceptives. In order to improve contraceptive use by adolescent students, the Author proposed educational intervention.

Tayo et al. (2011) surveyed contraceptive awareness, use by female high school students in Lagos in Nigeria, and found that 5% of female contraceptive students had a user base. It emerged that most sexually active individuals were non-users. Moreover, their parents of contraceptives users have told 45% of those adolescent girls. The research therefore proposed that reduction of sexual activity would improve focus on adolescent reproductive health. The Commission also called for information to be spread among adolescents in the area on family planning methods.

A multi-level research on the social context in the Zimbabwe use of modern contraceptives by young women was conducted in Ngome and Odimegwu (2014). The study used 2010/2011 Zimbabwe Demographic Health Survey (ZDHS) data as well as data by DHS consultants to evaluate the impact on the use of contraceptive in adolescents in Zimbabwe by adult, household and community variables. This suggests that group characteristics are more important than other individual and household characteristics for adolescent contraceptive use. The study found that young women with children had higher chances of contraceptive use, and that medium and high media exposure both improved chances of contraceptives being used. The research has shown that the likelihood of contemporary contraception usage and the average per-woman pregnancy is negative; the total number of years per woman in education and the percentage of women who



get a minimum of their community at secondary school have been adversely affected. However, the odds of conventional contraception use is very close to the number of women with problems receiving health services. Contrary to the hypothesis, the findings indicate that the patterns in youth contraceptive use were much better described than community-level variables by individual characteristics. Therefore, it concluded that both individual and community variables should be taken into account in determining the use of contraceptives in adolescent girls.

The WHO (2018) notes that condoms can be beneficial in women's health threats related to avoidance of abortion. The willingness of a woman to determine when and when to become pregnant affects her health and well-being directly. Family preparation helps births to be isolated and can postpone young women's pregnancy at elevated risk for health problems and early childhood mortality. Contraceptive use can help minimize the amount of adolescent pregnancy and unprotected abortion in their households. Mother and infant deaths will be lowered, and the risk of death and poor public health will also be greater for mothers who are killed as a result of conception (Darrock & Singh, 2013). Higher risk of premature or low-birth babies are pre-eminent, and may have higher death rates for babies born to teens.

The risk of accidental HIV / AIDS can also be minimized, pregnancies of HIV-positive women lead to fewer babies and orphans born. In the case of accidental abortion and STIs, male and female contraceptives, including HIV (Frost & Lindberg, 2012). Women should choose their sexual and reproductive wellbeing in an educated way. Family planning gives women an opportunity to carry on further education and public life, including paying jobs in non-family organizations (WHO 2014). Therefore, it helps parents to spend more in each child because of a smaller family. Moreover, children with fewer brothers and sisters frequently remain longer at school than many other children (Khraif, Abdul, Abdullah, Ibrahim and Ajumah, 2017). There



should be also a decrease in population growth, as contraception use is critical to reducing rapid population growth and related negative effects on economic, environmental, national, and regional development efforts (Blanc, 2009).

2.5 Overview of Family Planning

2.5.1 Global Context

Levelling FP is among the most cost-effective programs globally to reduce mothers, infants and children's deaths. In fact, the approach of the FP will contribute to reducing death, contributing to the MDGs. The amount of unintended miscarriage in the country is projected to decrease by one quarter to one third of maternal deaths. Family preparation is implicitly regarded as a mechanism for beneficial health impact. For particular, FP programs help alleviate violence, improve reproductive inclusion, deter HIV dissemination and alleviate infant mortality and unintended pregnancy among adolescents (Health Policy Project. 2015). Furthermore, each dollar spent on FP programs on average saves health, housing, sanitation and other public facilities by US\$ 6 (Performance Monitoring and Accountability, 2020). Universal access to care for Sex and Reproductive Health (SRH) was estimated to have annual costs of US\$ 3.6 billion and an annual income of \$432 billion by 2040, removing the need for modern contraception.

Primary cause of the lack of access to family planning for girls, including information on abortion, awareness and facilities, is promoting unintended adolescent pregnancy and mother mortality. The key reasons for death of young girls aged between 15 and 19 years are complications of abortion and birth in low- and middle-income countries (WHO. 2011). 877 million women of replicative age in developed countries need access to contraception by 2014, as they are sexually active but do not want to have a child in the next two years.



In order to boost the reinvigorating global commitment of the UN Department of International Affairs, the Bill & Melinda Gates Project, (Fp 2020), the UK Government has held a conference with representatives from national governments, donors, civil society , the private sector, research and development sectors, and other interest groups to ensure its implementation. The goal of the summit was to 'mobilize collective commitments for politics , economy, infrastructure and facilitate the right by 2020 of 120 million women and girls to access knowledge about contraception and facilities in the poorest countries of the world' (London Family Planning Summit, 2011). Increasing 100 million premature pregnancies, 50 million abortions, 200 000 maternal deaths, and 3 million infant mortality will be kept from meeting this ambitious goal (Family Planning Summit, 2012). This ambitious goal will be met. The London Family Planning Summit asked the participants to operate in many ways (FP2020, 2014), including:

- Increased family planning demand and support;
- New templates for service provision, processes and supply chains;
- Countries must achieve their objectives by providing the additional commodities;
- Encouraging novel FP approaches;
- Increased monitoring and evaluation (M&E) to foster transparency.

Feleke, Koye, Demssie and Mengesha (2013), have submitted in their analysis that contraceptive usage by women aged 15 and 19 years of age is contraceptive. This was only 17%, although the use is expected to be much smaller in non-married sexually engaged adolescents. Regardless of the implications, these young girls sadly run accidental pregnancies and further destroy their



lives or are unintentional. Feleke et al. (2013) revealed furthermore that for 15-19 years old people the risk of dying from abortion or birth-related complications is twice as high as for women in the mid-twenties. In developed countries, an estimated 225 million women choose to pause or avoid their childbearing but are not using any contraception tool (Endriyas, 2017). The global unintended conception figure in 2012 stood at the highest national levels in Africa, 53 per 1000 females aged 15-44. Around 54 million unintentional births, 77 000 infant mortality, and one million deaths each year may be avoided from obstacles to the use of contraception measures (Endriyas 2017). A variety of causes, such as prejudices, stigma, misunderstandings and a restricted use of contraceptives are defined in Herbert (2015). Young people consider Service providers' behaviors one of the most important threats to the use of contraception. Nevertheless, Schuler, Rottach, and Mukiri (2011) found that sex jealousy deterred the use of contraceptors, because men were worried about their unconceived promiscuity by women in contraception.

Twenty to 30 percent of collaborators and significant others in Sub-Saharan Africa contrary to the use of condoms (Clottey, 2012). For this situation, the girls are not allowed to use condoms. For teenagers in Ghana, it is a tabu to speak about sexual issues and contraception. There are cultures that do not speak freely about contraception, the use continues to be small, and young women are vulnerable to an elevated risk of unintended or accidental pregnancy (Clottey 2012) due to strong cultural and religious convictions. Moreover, over 50 percent of African women are weak and analphabets, because they do not learn how to use contraception correctly and thus use them improperly (Clottey, 2012). In a report, Ford and Holder (2016) revealed a big rise from 1970 until 2015, 36% to 64% contraception use by pregnant women respectively. Given this, Africa remains the lowest percentage of people who use contraception and is the world's greatest unmet requirement of their reproductive years. About half of young women aged 15–19



who are sexually active in developed regions do not want a child in the next two years. Frost & Lindberg (2012) reports that 15 million of these children have an unmet need for modern contraception while 23 million are at high risk of unintentional pregnancy. This is the case in the Frost & Lindberg (2012). The population of Ghanaians is estimated to be about 27 million, more than half of which is female, according to Population and Housing Census (2010). A little over 16 % of the population aged 15-19 is the sexually active group in this age range. Nevertheless, this calls for more attention to be paid to improve the sexual health of women and youth in particular. It was also expected in the World Health Organisation (2018), that the number of young births will rise globally by 2030, the most significant growth in Western, Middle, Eastern and Southern Africa, despite the continued growth in global adolescent population. The economic, financial, psychological and social crisis that escalate as a result. The adolescent mother can be exposed to health risks like eclampsia, childhood endometritis and systemic infections compared to women aged between 20 and 24 years. Abortion can lead to maternal mortality and a lifelong health condition. Additionally, pregnant adolescents may have greater physical, psychological and social needs than most women may. Parents and guardians, as well as threats of abuse, can experience extreme stigma and alienation (Maly, McClendon and Baumgartner, 2017). Likewise, pregnant girls before the age of 18 are more likely to have marriage or relationship abuse in Maly et al., (2017). In terms of schooling, the young girl considers abortion as a safer choice than further schooling in her circumstances. Measures to reduce the incidence of adolescent pregnancy and their subsequent complications have now been adopted worldwide. The UN Population Fund (UNFPA, 2011) issued guidance on prevention early on Pregnancy and low sexual efficiency elimination. These recommendations included decreasing marriage by 18 years of age, raising awareness and encouragement to minimize



abortion by 20 years of age and improving the use of contraception for adolescent at risk of accidental abortion (WHO 2011). Around 2.1 million accidental pregnancies, 3.2 million abortions and 5,600 mother deaths could be avoided every year if this requirement was fulfilled.

2.5.2.1 Sustainable Development Goals

Building on the promises of MDGs, the new SDGs (SDGs, 2015), the UN has recently agreed to address national and regional disparities by 2030. Clear and secondary family planning objectives were discussed in Objectives 3 and 5. In addition, 3.1 — the global maternal mortality ratio will decrease to less than 70 in 100,000 living births by 2030. Objective 3 says it "protects safe lives and promotes equality for all ages." Implementation of national programs and policies. 3.7 — Provide fair access to, and integration of, the SRH programs, particularly in the fields of family preparation, information and employment.

2.5.2 The Regional Context

In several countries in western Africa, the overall Total Fertility Rate (TFR) is high because of the low prevalence of contraceptives. Moreover, mother and child mortality continue to be in elevation. (See Table 1)



Table 2.1: The recent official data on family planning in specific areas in Western Africa

| Country | TFR | Maternal Mortality Rate per 100,000 Live Births (2013) | Infant Mortality Rate per 1,000 Live Births (2013) |
|----------------|------------|---|---|
| Nigeria | 7.6 | 560 | 74.3 |
| Niger | 6.1 | 630 | 59.9 |
| Burkina Faso | 6 | 400 | 64.1 |
| Senegal | 5.5 | 320 | 43.9 |
| Ghana | 4.2 | 380 | 52.3 |

Source: FP2020 (2014)

Ghana is not comparable, but with many other productive emerging nations such as Egypt, Brazil and Thailand, it has better indicators than many neighboring western African countries, which are lower fertility levels and more advanced CPRs (MCPRs).



Table 2.2: Identified middle-income nations' family planning factors, recent stats accessible

| Country | TFR | MCPR, Married Women | Maternal Mortality Rate per Live (2013) | Infant Mortality Rate per 1,000 Live Births (2013) |
|----------|-----|---------------------------|---|---|
| Brazil | 2.5 | 70.3 | 69 | 12.3 |
| Egypt | 3.5 | 56.9 | 45 | 18.6 |
| Ghana | 4.2 | 22.2 | 380 | 52.3 |
| Thailand | 2.2 | 63.6 | 26 | 11.3 |

Source: MDGs Indicator (2015)

2.5.3 The Ghanaian Context

The population of Ghana is increasing rapidly, as shown in the figure below. The population has grown more than 10-fold in the past 90 years, from 2.3 million in 1921 to 24.7 million in 2010. The population of Ghana is expected to increase over the last 30 years in 28 years and the yearly growth rate is 2.5%. The population is expected to hit nearly 50 million by 2038 (National Population Council, 2015).



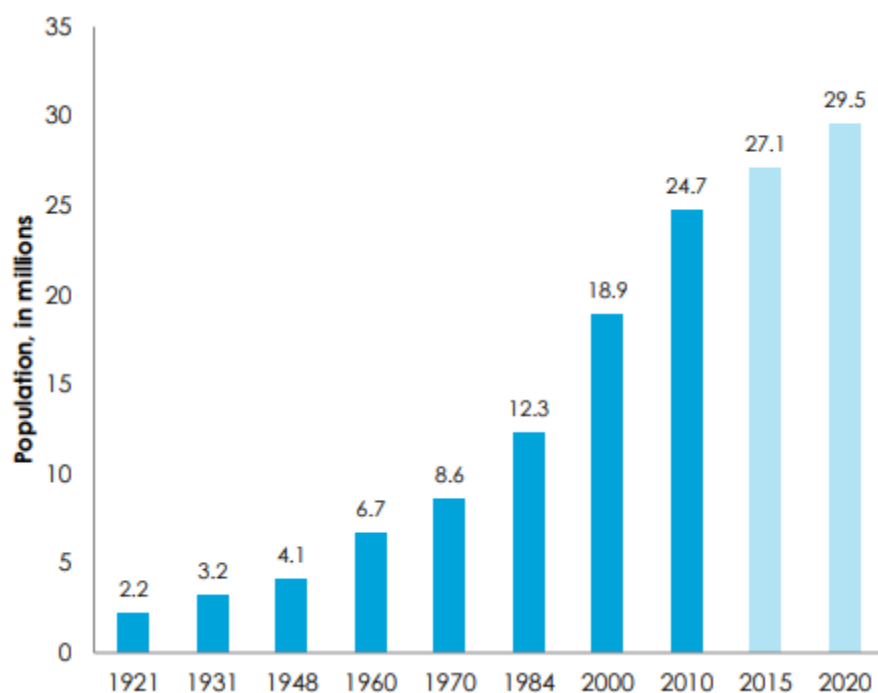


Figure 2.1 : Growth trend for populace from 1921 to 2010, and projected growth from 2015 to 2020

Source: GoG (2014)

Because of the rapid population growth rate, Ghana's population is young, with 38% below the age of 15 years. More than half of Ghana's people live in urban areas. (The Ghana Statistical Service, 2013). This urbanization has had a dramatic impact on the demographic structure since 1960, when only 23 percent of the population lived in metropolitan areas. Ghana's fast and consistently high urbanization rate threatens the capacity of the government to provide basic services, such as sanitation, water and housing and general amenities such as schools and hospitals (MoH, 2007).

Only through reduced fertility and most sustainable aging and social and development investments in FP and contraceptive health programs, multi-spectral programs which allow socioeconomic progress and quality of life change, can Ghana's population dynamics become an useful demographic dividend. In three sectors: familial planning, education and economic policy, it does not necessarily rely on expenditures and changes. FP programs are an important element in enabling couples to meet their fertility targets, while at the same time improving health and saving through developing sectors (Bloom et al, 2003).

By 2020, the Ghana government has committed to increase the current rate of contraceptive prevalence (CPR) by up to 30% and 40% for single sexually active women. The GFPCIP will allow Ghana, by completely executing the cost-covered implementation plan 2016-2020 (GFPCIP 2016), to achieve its ambitious and realistic goals.

Not only safety and rights, but also family planning and all-round care are a matter for sexual and reproductive wellbeing and freedoms. This is a necessity for progress, as it also improves survival and promotes economic growth. Therefore, the GoG prioritizes reliable reproductive health care for mothers, men, youth, and the effective growth of the CPR. Growing CPR and the long-term implementation of family planning will offer Ghana other benefits by rising development and increasing strains on the country's capital.

2.6 Types of contraception use for FP

There are actually two main contraception classifications. The contraceptives are new and conventional (Amoako, 2016) contraceptives. Current contraception, which has a medical prescription, includes barrier methods (male and female barriers, diaphragms and cervical caps, sponges, and spermicides), topical approaches (combined oral contraceptive procedures,



progestin-only tablets, contraceptive patches, injectable birth control, vaginal bands, and implantable rods) and emergency contraceptives. Common approaches are removal (coitus interruptus) (Amoako, 2016); cycle (or pregnancy awareness / periodic abstinence).

2.6.1 Blockade process

The boundary technique involves male and female condoms typically associated for spermicidal diaphragms and cervical caps (Amoako, 2016). Many of the barrier method's benefits include ease of entry, protection from sexually transmitted infections and cheap and safe (Clotney, 2012). The form of double security for contractors and STI-infections is the most effective and can be widely marketed without a prescription. Following a single use, it can be disposed of.

2.6.1.1 Condom for men

The men condom is an erect penis, rubbing on the thin rubber or latex sheath before intercourse. This stops semen (sperm) primarily from reaching the female vagina. This can function well, achieve nearly 95% effectiveness and can be implemented in all age ranges if correctly used (Rakhi & Sumathi, 2012). Compliance, ambiguity and inaccurate use are the key weakness of this strategy.

2.6.1.2 Condom for women

A genital silicone sheath pouch with a ring at either end of a feminine preservative. Inserted into the vagina, the closed ring serves as the inner anchor. The outer portion covers the actual organs and preserves them. It is safe, hypo-allergic and embraces strongly in study groups, but its expense can be a big dissuasive. This is a guided female approach that defends against both unwanted and unintended pregnancy (Rakhi & Sumathi, 2012). Shriver (2013), states that,



during sex, the diaphragm becomes a flake, transparent cup of latex or porous rubber, which prevents sprinkles from reaching the uterus. The diaphragm normally uses spermicidal cream or jelly to dissolve the sperm. Cervical cap is a small silicone cup inserted into the vagina to prevent semen from reaching the uterus before intercourse. This is much thinner, stiffer, less noticeable, and closer to diaphragms.

2.6.2 Hormonal technique

Two hormones should be used by the hormonal method: testosterone and Progesterone (Rakhi & Sumathi 2012).

2.6.2.1 Contraceptive oral medicine (pill)

It is an estrogen medication taken once a day to avoid abortion (Gentle Beginning Midwifery, 2015). It operates by removing an ovum to be released during the time of the child. Progesterone tablets only (Mini pill) and oral pill are two common types. This can also reduce puberty and tumors (which are ovaries which endometrial) and can be used while breastfeeding, without any protection from STI. If done properly then it can control the duration and decrease flow. Many of the adverse symptoms, such as breast irritation, prolonged amounts of time and weight gain, headaches and nausea, can arise.

2.6.2.2 Backup Contraceptive Drugs

This is another form of hormone tablet, which is given in one or two doses. Dose of sexual sex 12 hours later and taken within 3 days (72 h) (Shriver, 2013). A simple and comfortable process operated by women does not mess with the making of love. Regular months often come with lower pain and vomiting, weight gain and fertility recovery can take time.



2.6.2.3 Intrauterine Devices (IUDs)

Hormonal or non-hormonal (IUD) may be present. Shriver (2013), projects that are thin, compact T-shaping, usually copper injected into the uterus after menstruation, miscarriage, or 4-6 weeks after birth, can be placed into the uterus of a trained woman. Rakhi and Sumathi (2012) emphasize that an IUD will remain in place and function successfully for several years at a time. Within the prescribed period, or when a patient no longer requires or desires contraceptives, the system is removed or substituted by a health care provider.

2.6.2.4 The patch for abortion (the glove)

The patch is around 4 cm x 4 cm in size which gradually releases two hormones (progestin which estrogen) into the bloodstream which stops the release of an egg over the duration which can even make the womb unfriendly for women who fail to take pills (Gentle Beginning Midwifery, 2015).

2.6.2.5 The Injector

They are hormones, distributed every 12-13 weeks in the arm and buttocks. Giving the deposits four times a year on a monthly basis (Rakhi & Sumathi, 2012). This may be used while breastfeeding and may avoid the monthly flow (50% of women) entirely or not. This will result in loss of bone mass, which is why only women who cannot use any other contraception are generally prescribed.



2.6.3 Classical Methods

2.6.3.1 Self-restraint

President Bush described that most people generally interpret abstinence to mean refraining from sexual activity or in particular genital penetration for social or religious purposes. Able to avoid unintended births and sexually transmitted diseases as "the best and the only fully successful route" (Dailard, 2003). Therefore, total abstinence from penile genital sexual activities is, of course, the only 100% successful protection of the pregnant childhood. Many people chose abstinence on the grounds of religious or cultural values, partly because of medical conditions.

2.6.3.2 Interruption or retraction of coitus

Penis detachment from the womb shortly before ejaculation, therefore, sperm cannot reach the woman's vagina. It is probably man's best-known form of contraception, but it relies on the male partner's partnership (Amoako 2016). It cannot be an effective approach whether sperm fails or is left on external sex organs before ejaculation. In this approach to work, there are mental and physical demands in strong self-control.

2.6.3.3 Lactational Amenorrhea Method (LAM)

Hormones that control milk development often-hinder ovulation after a woman has been baby and is breastfed, thus avoiding another child. Girls have no menstrual cycles at this time (Shriver, 2013). Throughout the first six months after Digitized Baby conception, the probability of women who are solely breastfed (that is to say, the child has no other source of food or fluid except mom's breast milk) is around 2 per cent small. The risk of breast-feeding for working mothers is much higher because the hormone impulses that are manually pulled by the baby do



not consistently deliver the same. When a child usually receives other types of food this birth control approach is unsuccessful for six months (Gentle Beginning Midwifery, 2015).

2.6.3.4 Fertility-Awareness-Based

Amoako (2016), points out that fertility sensitivity involves predicting ovulation by tracking or mixing the menstrual cycle, body temperature or shifts in cervical mucus (symptom-thermal approach), which is, the duration in which females become most fertile. For the measurement of the secure time the process requires proper documentation. In addition, Amoako (2016) states that sex is prevented during fertile days and that intercourse is limited to only few days a month. This approach is not available to women who have prolonged cycles or after conception or menopause.

2.6.3.5 Women Sterilization (Tubectomy)

It is a continuous surgical method. This involves removing the fallopian tubes and connecting the ends so that the sperm does not reach the eggs. This is a highly efficient approach and is still feasible, preferably after the birth of the last child. Tubes will rarely join, despite the restoration of fertility. After this form, some women appear to have heavy cycles (Shriver 2013).

2.6.3.6 Men Sterilization (Vasectomy)

The vassal connections that bring the sperms to the penis from the testes are covered using a permanent surgical procedure. It prevents the loss of testosterone in semen during ejaculation. Shriver's study (2013), the procedure does not require hospitalization, it is simple and effective. Contrary to the general belief, it does not conflict with sexual activities or the wellbeing.



2.7 Unmet Needs of Family Planning

The unmet requirement is the percentage of women who are pregnant or choose not to space their birth but who do not use contraceptives (DHS, 2014). Thirty percent of women currently married have unmet family planning requirements, while 27% of married women use contraceptive methods. This means that only 47% of the future need for family planning is fulfilled. If all married females with unsatisfactory family planning requirements had to implement FP approaches, CPR would increase from 27% to 57% (GSS, 2015). 42% of non-wed locked sexually active women are unfulfilled in family planning, 45% actually are contraceptive, 87% of women who are unwed locked are in demand overall for family planning and only 51% are satisfied with their existing potential requirements for family planning. In addition, when the use of contraceptive methods will be extended to all single sexually active women who have unmet needs to prepare their families, the CPR will increase from 45% to 87% (GSS, 2014).

Besides that, a high degree of unmet demand in the nation has been undermined by poor access to high quality FP service — which features few qualified suppliers and inadequate goods, which provide customers with little to no preference in family planning activities and weaken women and men's freedom of choice on their child numbers. Ghana 's 2008 Demographic and Health Survey (GDHS) estimates that unintended pregnancy still exists in Ghana with 14% of babies unwanted and 23% mistimed (wanted after) (GSS, 2009). (GSS, 2009). Moreover, strong unsatisfactory need results in premature pregnancies. In the lower wealth quintiles, women often have a greater unmet need than women who have a greater likelihood of meeting their family planning needs at the peak wealth quintile (PMA2020, 2015).



2.10 Challenges of Family Planning in Ghana

Throughout the years, Ghana has strengthened its capacity for national and sub-national community mobilization and FP programs at the institutional and social institutions. However, the FP program, which must be addressed to achieve the FP objectives, remains a series of challenges and constraints.

2.10.1 Demand Creation (DC)

The higher birthrate in Ghana was strong between 6.4 births per woman in 1988 and 4 per cent in 2008, and slightly more than 4.2 births percent in 2014. But the demand for and use of FP overall is still low. The DHS 2014 reports that 56.6% of married women between 15 and 49 years of age seek to postpone the pregnancy (GSS, 2015). Consistent with the need for contraceptive products, only 22.2% use new approaches and 4.4% use conventional family planning strategies such that almost 30 % of women who are married have no family planning tool.

Women's awareness of FP solutions and services over time has improved significantly. Ghana's contraception awareness is consistently strong since the beginning of the 1990s, with 90.6 percent of women reporting at least one form of family planning in the 1993 DHS survey (GDHS 2008). Latest figures from 2008 indicate that about 98% of women have at least a standard framework for family planning (GDHS, 1993). However, the awareness of long-acting reversible or permanent methods was lower with only 43, 64 and 63 percent of women who know intrauterine equipment (IUDs), implants and sterilization. (GDHS, 2008). However, the high degree of understanding and comprehension of FP approaches did not mean that FP resources are used equivalently. In the reproductive age group (or their partners) in 2014, just 22.2 per cent of



married women were using conventional methods of contraception (GDHS 2014). About 29.9% of women have a lack of preparation for their families.

Several research in Ghana have examined obstacles to family planning demand and usage. The major constraint on the demand for these services in Ghanaian communities remain socio-cultural factors. In Ghana, the low socioeconomic status of women, religiosity, educational achievement, misinformation on family planning and the high mortality of infants are factors that lead to the low level of demand and usage of contraception and to the patriarchal character of domestic decision and fear of some side effects. Ghanaian homes, though, have origins in large families' tradition (Ntsua et al, 2011 and Health Policy Project, 2015). Furthermore, Ghanaian homes have a history of having large family sizes (GLSS, 2008). In a culture in which polygamy is also popular, women tend to become more comfortable by carrying more kids for their husbands.

The overall demand for contraceptives rose from 66% to 75% between 2003-2008 in young women aged 15-19 years, though it remained strong, to 69.3% in 2014 (GDHS 2008). Nonetheless, barely 16.7% of young people in this age group have conventional contraceptives and 50% of married women have no contraception devices (GDHS 2014). Young people are also under-served. Contraceptives that show a substantial difference between CPR and unmet criteria in the 15-19-year-old age group have become highly conscious and are challenging. General populace projects like "The choice of life: it is your choice" have led to a transition between the view of family planning as a means to reduce the size of families, and to see it as a means for women and children's health to be empowered and improved (Ntsua et al , 2011). Younger folks assume, though, that family planning is not so necessary for single people but rather for married



couples. Experts say interventions for youth-focused demand and conduct improvement in this age group need to be enhanced and creatively contextualized (Health Policy Project 2015).

2.10.2 Service Delivery on Family Planning

After the establishment of contemporary FP operations as an unrestricted benefit program by the Christian Council of Ghana in 1961, the FP service delivery has progressed in Ghana under a number of innovations. The Planned Parenthood Association of Ghana (PPAG) far along extended FP services in 1967 after the first Family Advisory Center was opened in Accra in 1961 through branch services in different locations around the country (Solo et al, 2005). A broad variety of FP programs is currently offered in government sickbays and health center, private institutions, and NGOs. The National Policies and Requirements of Reproductive Health and Services allow for the introduction of outreach, static programs and approaches to the provision of social marketing services to brand FP facilities reachable to all qualifying persons and married individuals and affordable (GHS, 2014).

During the Health Policy Project in 2015, it was stated that the key contraception suppliers in Ghana would be MoH / GHS, followed by drugstores (including chemists and drugs), private clinics and NGOs including PPAG and Marie Stopes International Ghana (MSIG). While the private sector is increasingly dependent on contraceptives, about 47% of these are currently funded by the public sector, while around 46% by the private sector. The largest provider of injectors and implants is the public sector, while the private sector primarily provides more resourceful pills and condoms. Age groups of 15 to 19 years of age are frequently accessed to pharmacies, or 43% of other sources (29%) and other sources (29%) (USAID 2011). In fact, the USAID (2011) finds that women in rural areas (55 percent) are more economically based than in



urban areas (41 per cent) in their market segmentation study. The private sector provides over half of the modern birth control items in Brong Ahafo, Greater Accra, Eastern and Western regions. Across the northern, Upper East, and Upper Midwest, the majority of contraceptives (63% to 88%) are used by the public sector. Inadequate health care staff in health centers and hospitals are often troublesome for the number and capacity of the population. Highly ineffective and unjustly allocated are the key health staff in the world (MoH, 2014).

2.11 Why Does Family Planning Still Matter?

2.11.1 Socio-Economic Effect

For many, it appears evident that the problem of poverty can only be exacerbated by rapid population growth-usually defined as a 2 percent increase per year or more or a doubling of population size every 36 years, in particular in countries where food safety is already high or of major concern. Nevertheless, population growth rates are obviously rising in the stagnating countries, as in sub-Saharan Africa where people are expected to rise from 164 million in 1981 to 316 million in 2001, for less than one dollar a day (Chen and Ravallion, 2004). The role of demographic factors on economic growth, however, was difficult to measure in part because many other influential powers also already affected poverty reduction. Throughout the eighty years of international investment throughout family planning, the current perspective on demographic economic relationship between economists was paradoxically favorable. After then there has been stronger evidence of increased fertility and demographic growth (Birdsall et al, 2001).

A research by 45 countries calculated that if the actual birth rate decreased by 5% per 1000 population in the 1980s, the proportion of people living in poverty would have dropped one-third



(Eastwood and Lipton, 2001). The reduction in fertility also has a lasting advantage. Roughly, twenty years after fertility decreases, the proportion of people aged 15-65 years is growing higher than that of people aged less economically. This beneficial age only lasts for a few decades, and the elderly are rapidly increasing. This last stage is the product of the uneventful high life standards and low fertility in advanced industrial countries, but remains a distant prospect in the poorest countries today. It has also proven controversial to explain the link between household deprivation and childbearing. There is no question that there is a clear link. The poorest fifth of women had six births, compared to 3-2 births in the wealthiest five countries in 56 developed countries on average (Gwatkin, 2004)

In many poor countries, family planning has been popular and many of the disparities in fertility between rich and poor communities do not occur from reproductive choices, but through the lack of this option for the poor. Among poor people and wealthy individuals, the need for abortion and unintended pregnancies are often higher. Houses with many kids are more likely to become poor over time than households with only a few children and less likely to rebound from poverty (Aassve et al, 2005). In addition, children in larger families tend to be less well-nourished and disciplined than children in smaller families (Greene and Merrick 2005). Effective family planning programs reduce the fertility gap between rich and poor by reaching poor populations with information and services, and make a significant contribution to reducing poverty (Eastwood and Lipton, 2001).



2.11.2 Health Benefits

By contrast, with the complex relations between pregnancy, population change and hunger, the effects of family planning for mother and child health and wellbeing are simple. With successful contraception, women who have chosen not to give birth or interrupt conception in 2000 may have prevented some 90% of overall abortions and 20% of obstetric death and morbidity (Collumbien et al, 2004). A total of 150,000 maternal deaths (32%) with significant cost-effectiveness, most of which are recovered by the benefit in Africa and Asia, could have been eliminated.

Family planning also provides major advantages for health and children's survival, primarily because of longer birth intervals. Research in rich and poor countries show that notions of fetal mortality, low birth weight, premature and a smaller gestational age are more likely to occur in 18 months from previous living births. This partnership's mechanisms are expected to involve a nutritional depression post party, particularly folate deficits (Smits and Essel 2001). The study of birth interval associations to infant and child mortality in the developed world has dominated two major sources of evidence: cross-sectional demographic studies and health surveys (DHS); and forward-looking tracking results in Bangladesh's Matlab district (Rutstein 2005, and DaVanzo et al. 2005). Conservatively speaking, this research indicates that closing intergenerational differences of under 2 years would avert nearly 1 million of 11million annual deaths in children under the age in 5 years. The most important way to accomplish this goal is to use postpartum (and post abortion) family planning properly. Family planning is among the most cost-effective approaches to minimize baby and child mortality (Black et al 2003).



2.13 Adolescent Friendly Environment for Family Planning.

The definition of Adolescent friendly health services developed by the World Health Organization in 2002 generally applies to services of quality and rights. Specific characteristics include:

- (i) Guaranteeing privacy and confidentiality and promoting autonomy so that young people can accept their own treatment and care;
- (ii) Providing healthcare services technically competent in specific areas of adolescence and providing services relevant to maturation and social circumstances of each customer;
- (iii) Community participation and dialog on encounter.
- (iv) Adequate and reliable service that meets the physical, social and psychological needs of growing youth.

The emphasis on sexual and reproductive health youth is relatively recent – single youth are served by child services and married (or pregnant) young people are served by adult services. This strategy has been diluted by improvements. Tendency to postpone marriage (including for education or employment) and to postpone childbirth has widened the gap between puberty, marriage and childbearing (Bearinger, 2007) with changes that are affecting all societies to different degree to make health services more efficient and successful than before.

2.14 Family Planning Education to the Adolescent

In the advanced economy, part of the research focus was on the efficiency of schools for FP education. Many of these services were targeted to reduce pregnancy rates for adolescents. The effectiveness of certain programs was examined by a 1995 study. Barth et al., (1992) note that



almost 90% of the major school districts provide FP education in some way. They also noted that in junior and senior high schools the average spent time on FP education is 6-10 hours per year.

One of the services for eighth graders was noted that 25% of the students were already at the beginning of the program knew about FP. This endorsed the opinion of more than half of the teachers that students should be taught sex, abstinence, STD, birth control and homosexuality by the end of the seventh year. The Alan Guttmacher Institute (1994) supported the view, which showed that 9 percent of 12 and 16 percent of 13 years had a sexual relationship. Their perceptions were supported by national information. The researchers said after evaluating the programs that those programs could instill philosophy in young people although the abstinence is great, the next best thing is contraceptive protection. Four interventions also found that participants had the potential to postpone the initiation of sexual activity. The proportion of sexually active young adults who use contraceptives was significantly increased by three of the five programs (Frost & Forrest, 1995).

Moreover, Brown and Guthrie (2010), too, said the young women not being given contraceptive use is not because of their lack of awareness, but because of their lack of capacity to apply this information, particularly where 'irrational desire' takes over. Knowledge may be common in other cases, but other factors, especially alcohol, may affect contraceptive use. In addition, Onasoga et al. (2016) identified many young women who have limited information and general lacking access to the services or are dissatisfied with their use of the services, posing a high risk of unintended pregnancy. The bulk of the young people have learned of an emergency contraceptive according to Onasoga, et al., (2016), though reliable knowledge about its use is limited. Again, 75 % of the students surveyed were familiar with FP in Nigeria, but only 12% were aware that the first dose of ECPs would take place within 72 hours of unprotected



relationships. Asante, et al., (2016), suggest that the use of FP methods among women is extremely inadequate. Consequently, it is important to revisit and encourage the issue in their reproductive ages.

The poor patronage of most girls and women in Ghana is responsible for a large number of factors. This may provide little to no details about how the body works in relation to chosen FP. Spouses, family members, community leaders and religious leaders may also have conflicts of family planning by citing fears, myths, misinformation and insufficient knowledge of a specific method or pricing as well as theology or traditional views (Ejembi et al., 2015)



CHAPTER THREE

STUDY AREA AND RESEARCH METHODOLOGY

3.0 Introduction

The whole section consists with the geography of the field of study and the research methodology. It includes information on the research site, population in the field of study, services for health and education in the region and economic status of the residents. The second section of the chapter discussed the study design for the study, the data sources, the sampling process, the data collection tools and the procedure for the data analysis.

3.1 Study Setting

The research was done in Ghana's northern Tamale Metropolis. A legislative instrument (LI 2068) created the Tamale Metropolitan Assembly and guided the then Tamale Municipal Assembly in 2004 to become the Metropolis. The Metropolitan Assemblies in Ghana are now part of six Metropolitan Assemblies and one in the Western, Upper Central, Upper West and Southern provinces. Tamale is the headquarters of the metropolitan area and the provincial center of the Northern region (GSS, 2010). The metropolis of Tamale is made up of central Tamale and the political districts of south Tamale and north Tamale.

3.1.1 Location, Size and Physical Features

Tamale is located in the middle of the country, and share borders with the District of Sagnarigu, on the west and north, the District of Mion, on the east, the east, and south and south-west with Central. The total estimated size of the Metropolis is 646.90180sqkm (GSS-2010). The municipality is situated between $9^{\circ} 16'$ and $9^{\circ} 34'$ latitude north and $0^{\circ} 36'$ and $0^{\circ} 57'$



"longitudinal in geographic terms. Tamale is strategically situated in the area and the metropolis has a market potential for local goods from agriculture and industries of other districts in the region through this strategic location. In addition to the competitive benefit of the metropolis in the city, the city benefits from western African markets to neighboring countries including the northern parts of Togo, Burkina Faso, Niger, Mali, and Ghana and the southern parts of the country (GSS, 2010).

3.1.2 Population Size, Structure and Composition

The population of the metropolis Tamale was 233,252, which accounted for 9.4 percent of the region's population, according to the 2010 Population and House Census. Males accounted for 49.7%, while 50.3% of the population were females. In urban areas (80.8%), the percentage of the population was greater than in rural areas (19.1%) of the metropolis.

The urban population was young, with a broad population pyramid (almost 36.4% of the population was under 15 years) with a small number of elderly (60 years and over) that is 5.1%.

The population of the metropolis was young. In the metropolis, the overall age dependency was 69.4. In rural areas, the age dependency ratio was higher (86.5) than in urban regions (65.7) (Ghana Statistics Service, 2010). There are several communities in the metropolis, with 18,382 young people in the city (GSS, 2010).

3.1.3 Family home scale, structure and composition

There were 219,971 households in the metropolitan area who lived in 19,387 apartments. The average size of the household in the city is 6.3 individuals. Children represent 40.4% of the household structure and heads 16.1% (Ghana Statistics Service 2010) of their households constitute the largest proportion of the household structure. Species are approximately 9.4% and the rest of the family make up 12.9% of the population. In comparison to other household forms



(Ghana statistics service 2010), the majority of households lived in an extended structure (head, spouse(s), kids and head's relatives) represented the largest proportion (45.1 percent). Just 19.5 percent of households in the metropolis were in nuclear households (heads, couples and children) (Ghana Statistics Service, 2010).

3.1.4 Economic Activity Status

In the metropolis, approximately 63.3 per cent of the population aged 15 and older is economically active and about 92.6 percent employed according to Ghana Statistical Service (2010), respectively. A greater proportion of those not economically active are students (56.0%), 20.9% are domestic workers, and 12.4% are either too young or too old to work. They are not economically engaged. Roughly five out of ten (52.9 percent) of those unemployed are finding jobs for the first time in the metropolis (Ghana Statistic Service, 2010).

3.1.5 Social and Cultural Structure

The northern regions of the country were historically covered with large areas, with smaller packages of population, and the metropolis is no exception. After many people with different ethnic backgrounds migrated from other areas to settle in, the metropolis began to develop high population growth and was thus made a cosmopolitan area (Statistical Service of Ghana, 2010).

In the metropolitan region, there are the majority of the Dagombas and other ethnicities, including Gonjas, Mamprusis, Akan and communities of Upper East (Ghana Statistical Service, 2010). Other citizens from Africa and other countries around the world are also found in the metropolis. The region has deep cultural practices reflected in annual festivals, naming ceremonies and wedding ceremonies (Ghana Statistical Service, 2010). The two Muslim Eid Festivals (Eid Fitr and Eid Adha) are a part of the festivals celebrated annually in the metropolis



of Damba, Bugum and Ghana (Statistical Service of Ghana, 2010.). Muslims rule the metropolis, followed by Protestants, spiritualists and traditionalists (Statistical Service of Ghana, 2010).

3.1.6 Health Facilities and Educational Institutions

The Tamale Metropolis has several health facilities including private medical diagnostic and laboratory centres. The prominent health facilities in the metropolis include the Tamale Teaching Hospital, the Tamale Central Hospital, the Tamale West Hospital, the Seven Day Adventist Hospital (SDA), Builpela Health centre, Vitting Health centre and Kabsad Scientific Hospital, among others (Ghana Statistical Service, 2010; Tamale Metropolitan Health Directorate).

There are a good number of both private and government schools comprising Secondary, Junior, Primary and kindergarten Schools in the metropolis. For example, 60,1% of the population are literate and 39,9% are analphabets. The literate male ratio (69.2%) is higher than female (51.1%) (Ghana Statistical Service, 2010).

3.1.7 Roads

Especially those connecting the town to other district capitals are the roads in the metropolis. The tarred streets of the city make it easy to move between points. As a result, there are no traffic loads speed is surpassed. The majority of agricultural and industrial areas are connected by feeder road to marketing centers (Ghana Statistical Service, 2010). The access to roads connecting agricultural communities to marketing centers facilitates the transportation of farmers' goods to urban marketing centers. As a result, their losses after harvest will likely be lower or lower (Ghana Statistical Service, 2010).



3.1.8 Transport

Taxicabs with a taxi station in the Central Business District (CBD) are the major transport services in the area. The Metropolis has a link with other cities and towns in the country through the State Transit, O. A. Travel and Tours and other private bus companies (Ghana Statistical Service, 2010 and GHS, 2010). Although not document, a cursory look at the vehicular traffic on the streets of the metropolis indicated that majority of the inhabitants use motorbikes as well as the tricycles (yellow-yellow) as their major mode of transportation inside the metropolitan area (Ghana Statistical Service, 2010).

3.1.9 Occupation

Services and salespeople (33.0 percent) are the most popular profession in the metropolis. Participants in commerce and other related industries (21,5%) are observed (Ghana Statistical Service, 2010). The proportion of employees engaged in qualified forestry and fisheries is 17.6 percent (Ghana Statistical Services, 2010). This represents the third largest occupation in the metropolis. For almost all professions, but in service and sales, there were more males compared with women, where only 16.5% of males worked, compared with a greater 50.3% for women. In the division of primary employment, there were more females (11.3%) than males (6.1%) (Ghana Statistical Service, 2010).

3.1.10 Fertility, Mortality and Migration

The average rate of fertility of the city of Ghana (2.8) was marginally lower than the 3.5 national fertility rate. The overall rate of fertility is 79.9 (Ghana Statistical Service 2010) per 1000 people aged 15-49 years. The CBR is 21.2 per 1,000 people. The CBR average is 1000. The crude death rate in the metropolitan area is 5.6 deaths per 1000. 9,6 percent of all deaths are caused by



accidents / violence / homicide / suicide, while other causes account for 90,5 percent of deaths (Ghana Statistical Service, 2010).

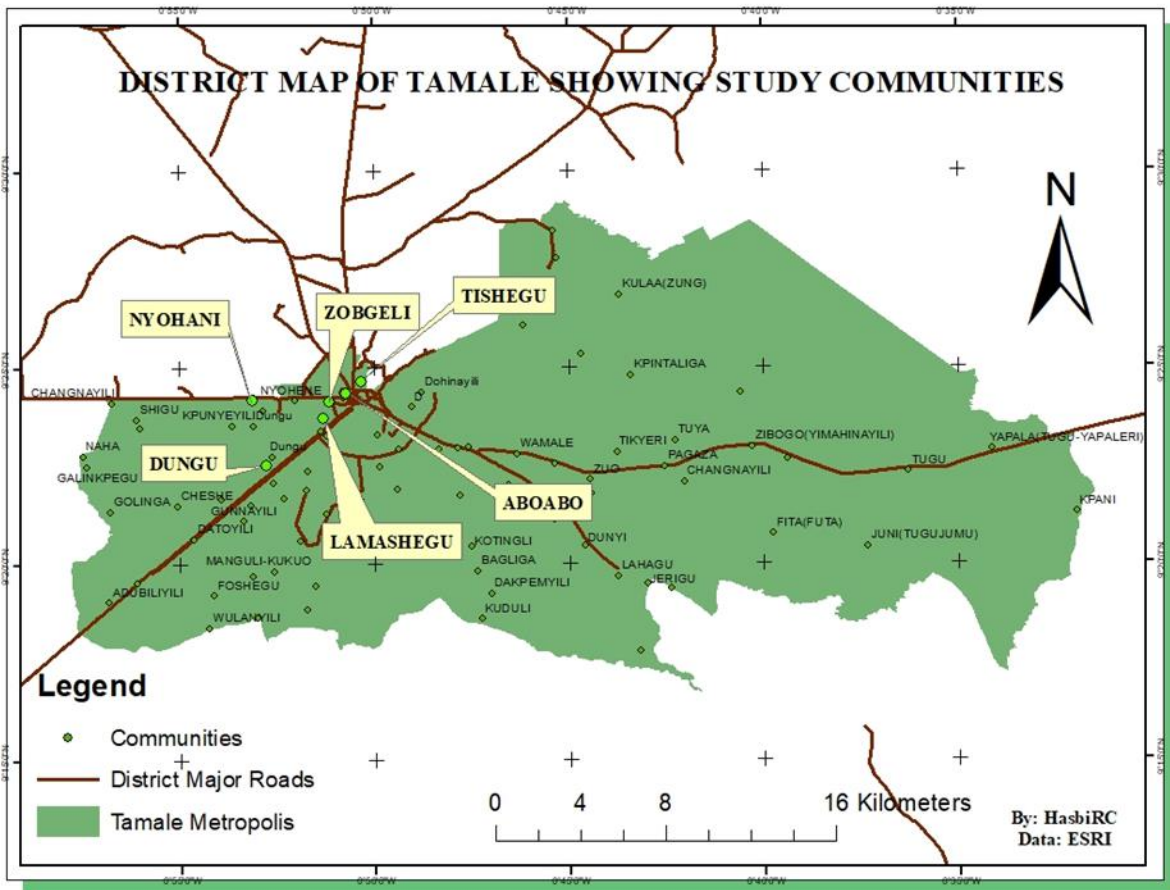


Figure 3.1; Map of the Tamale Metropolis and indicating the study communities

3.2 Study area

Tamale is the regional capital of the northern region, located in the northern part of Ghana. The inhabitants are mainly Dagbani, with clusters of Bimobas, Hausas and Akan living in several areas. The study was conducted among adolescents girls between the ages of 12-19 living in six

communities selected from two sub-metros. Three communities were selected from each selected sub-metro.

Table 3.1: Distribution of study communities into sub metros

| Tamale central Sub-metro | Tamale south Sub-metro |
|---------------------------------|-------------------------------|
| Aboabo | Lamashegu |
| Tishegu | Nyohini |
| Zogbeli | Dungu |

3.3 Study Design

Analytical cross-sectional study design was employed with mixed method approaches (thus using qualitative and quantitative approaches). Cross-sectional design was chosen because it allows the researcher to investigate both the exposure and outcome of the study at the same time (Polit & Beck, 2008). This study is purely observational, inferences was drawn from the study participants.

3.4 Study Population

The study involved female adolescents from 10-19 years within the Tamale Metropolis.

3.5 Sampling Technique

The sampling technique used in this study is multi stage sampling. Multi stage sampling depend on the decision of the researcher when it comes to the choice of units that are to be studied (Jawale, 2012; Etikan and Bala, 2017; Sharma, 2017;). This sampling method was adopted to



gain an insight into the health-seeking behavior of adolescents towards family planning services in tamale metropolis hence the need to select adolescents who are leaving in the communities. The multi stage sampling technique is a combination of cluster sampling and simple random sampling and it selects units that will allow the researcher to answer the research questions in other to meet the objectives.

The Tamale Metropolis was divided into two clusters, Cluster A and B. Cluster A was Tamale Central and Cluster B was Tamale South. Each cluster had communities under them. Three communities from each cluster was chosen using a convenience sampling technique. This technique was used because of proximity of the chosen communities. The chosen communities were Aboabo, Lamashegu, Tishegu, Dungu, Nyohini, and Zogbeli. After choosing the communities for the study, female adolescents within the community were chosen conveniently to make the sample size.

3.6 Sample Size

This calculator uses the following formula for the sample size n:

$$n = N * X / (X + N - 1),$$

Where,

$$X = Z_{\alpha/2}^2 * p * (1-p) / MOE^2,$$

Moreover, $Z_{\alpha/2}$ is the critical value of the Normal distribution at $\alpha/2$ (e.g. for a confidence level of 95%, α is 0.05 and the critical value is 1.96), MOE is the margin of error, p is the sample proportion, and N is the population size. Note that a Finite Population Correction has been applied to the sample size formula.



Calculating for X

$$X = 1.96^2 * 0.50 * (1 - 0.50) / 0.05^2$$

$$X = 3.8416 * 0.50 * 0.5 / 0.0025$$

$$X = 384.16$$

Calculating for n

$$n = N * X / (X + N - 1)$$

$$n = 18,382 * 384.16 / (384.16 + 18,382 - 1)$$

$$n = 7,061,629.12 / 18,765.16$$

$$n = 376$$

From the calculations above, the sample size to use for the questionnaire administration was 376 participants. However, 400 questionnaires was administered to make up the 376 required. This is adopted with the notion that not all respondents will return the questionnaire and some may delay in returning the questionnaire. In addition to the 400 respondents who answered the question, 12 health workers were selected for an interview. In all, 412 respondents were used for the entire study.

3.7 Sources of Data

3.7.1 Primary Data

Primary data in the form of semi-structured questionnaires, data was obtained with basic data. The aim of these semi-structured surveys was to provide certain selected female adolescent who live in targeted communities with information on their actions to search for health services. The



researchers personally managed the questionnaire in order to resolve the problems with the respondents immediately. The questionnaire was processed.

3.7.2 Secondary Data

Secondary statistics are historic data sets of variables historically gathered and compiled, except for the present case, study challenges or opportunities. Secondary data from related textbooks, journals, magazines and the internet have been collected and unpublished for this analysis.

3.8 Data Collection Tools

The tools for data collection were the questionnaire and interview guide.

3.8.1 Questionnaire

The semi-structured questionnaire was the key method for gathering the quantitative results. The problem was answered and questions unanswered. It was established and divided into four parts in keeping with the study aims. Section a contained information on respondents ' demographic features such as age, sex, educational level, and ethnic group. Section B contained information on the sources of family planning education and education centers for adolescent friendly services. Section C also contained information on the challenges regarding adolescent health seeking behaviors towards family. Moreover, Section D contained information on the socio-cultural and economic factors that affect health-seeking behaviors of adolescents. The questionnaire was administered to 400 adolescent girls.

3.8.2 Interview

The interview guide was the tool used in collecting the qualitative. The guidance for the interview was established according to the research goals. The key interview guide and the focus



group discussion guide were developed. Two separate interview guides were developed. For the key informant interview, 12 health workers comprising 8 midwives and 4 four community health nurses from four health centers.

Table 3.2: Presentation of study setting and participants

| Health centers | Number of respondents |
|---------------------------------|-----------------------|
| Nyohini Health Center | Midwives: 2 |
| | Community nurse: 1 |
| Vitting Health Center | Midwives: 2 |
| | Community nurse: 1 |
| Bulpeila Health Center | Midwives : 2 |
| | Community nurse: 1 |
| Reproductive Child Health (RCH) | Midwives : 2 |
| | Community nurse : 1 |

For the focus group discussion, 36 adolescents were used. Six from each community. The 36 adolescents were selected from the sample of 400 respondents who answered the questionnaire. This was done to help verify the response given in the questionnaire. A focus group discussion was conducted in each community and the total for each group was 6.



Table 3.3: Presentation of data collection

| Type of data | Sources of data | Tools for data collection | Population, size of respondents |
|--------------|-----------------|---|---------------------------------------|
| Quantitative | Primary data | 1. Structured questionnaire | 400 |
| | | 2. Interview guide | 12 |
| Qualitative | Primary data | Interview guide | (2) above |
| Documentary | Secondary data | 1. Report from the environmental health unit. | |
| | | 2. Internet sources | |
| | | 3. Published students' thesis. | |
| | | 4. GHS reports | |

3.9 Study Variables

The variable considered under objective one was to examine the various sources of family planning education in order to accomplish the objectives of this study. To identify the challenges for youth healthcare behavior towards family planning services in Objective two and three, as



well as to identify the socio-cultural and economic drivers which influence youth health research behavior towards family planning respectively. The independent variables listed for Objectives 2 and three: employment, place of job, wealth index, marital status, faith, race, health care coverage, home type and area of residence. These variables are labelled in the subsequent segment.

3.10 Data Analysis and Presentation Methods

For the quantitative data, the collected data were entered into Statistical Package for Social Science (SPSS) version 25.0. In order to predict distributions of specific features of the sampled populations, a descriptive analysis was carried out. A comparative study was performed on those with formal and informal schooling. The bivariate analyzes of participant's age, seeking family planning services and the use of health facilities for any general illness was done in conjunction with formal and informal education. Analysis was conducted using descriptive and inferential statistics and results displayed using graphs and tables. Chi square analysis was use to establish association between dependent and independent variables and a p-value < 0.05 was considered statistically significant.

For the qualitative data, the qualitative data was analyzed using content thematic analysis. The audio or recordings were transcribed verbatim. The transcriptions were printed out and read repeatedly to identify similar wordings, phrases, concept and meaning. Heading of each theme was created and then extracts and excerpts were quoted.



3.11 Rigor of the Research

In order to create the real significance of the study, this study adopted the qualitative research rigor criteria which includes credibility, transferability, dependability and confirmability as acknowledged by Lincoln & Guba, (2000).

3.11.1 Credibility

Credibility is a part of the research rigor. It makes the reader to have confidence, truthfulness of this results and findings of the study (Polit & Beck, 2010; Profetto-McGrath et al., 2010; Speziale & Carpenter, 2007). Credibility also “ensures that the research methodology adopted measures what is intended to measure”(Shenton, 2004). To ensure credibility in this research, the researcher read extensively on the topic on current literature and took guidance from the supervisor. The aforementioned informed the choice of the research methodology and design as well as guided the drafting of interview guide that was appropriate to gather the true response from qualified study participants to answer the research questions. To add to this, it was necessary to establish a strong rapport to be able to build trust to allow the participants feel freely in answering the questions. This was attained by prolonging the interviews and asking follow-ups questions to bring forth the real issues concerning hepatitis B. Again, triangulation was done by adopting several tactics such as prolonged engagements of participants, reframing some question and among other.

The supervisor in debriefing on the research methodology and interviews guides made critical inputs, which address some gaps in the work, and necessary corrections were done. Colleagues and peer also made essential contributions that enriched the work. The maiden research findings



and interpretations were showed to the participants to be sure that reflected their views and experiences (Profetto-McGrath et al., 2010) prior to making conclusions on the said results.

3.11.2 Transferability

Another key parameter to ensure trustworthiness of this study was transferability. Transferability refers to the possibility that the outcomes of the study have inferences for others in related conditions (Creswell, 2014). This is often called fitness; transferability decides whether findings can suitably fit well in or are transferable to related conditions. To realize transferability in this study, a vivid description of the setting, methodology, and the characteristics of the participants have been provided.

3.11.3 Dependability

According to (Lincoln & Guba, 2000), dependability is one of the rigor of research. Dependability of a study is consistency and reliability of the research (thus judgments about likenesses and dissimilarities of content are stable with time) (Graneheim & Lundman, 2004). To realize this, same interview guide was used to interviewing all respondents, which produced similar findings. Aside above, an exhaustive explanation of all phases of the methodology in this research process have been outlined to offer readers the chance to follow the parameters to replicate this study.

3.11.4 Confirmability

The final step in ensuring rigor of the study was confirmability. “Confirmability in research is the degree to which the results could be confirmed or substantiated by others. It is to ensure that the meanings of the data collected are not changed by the prejudices, knowledge, and



experiences of the researcher”(Kusi, 2012). The researcher ensured confirmability by “reflexivity and bracketing” her biases, thoughts and assumptions, delimitation etc.

To guarantee confirmability of this study, the data collection tools (in this case the interview guides) were developed after thoroughly reviewing relevant literature and structured in accordance to the study specific objectives. The researcher probed based on answers given to the questions using interview guide to bring about the appropriate response from participants to answer the research questions.

3.12 Ethical considerations

An introductory letter was sought from the Department of Community Health and Family Medicine, School of Medical and Health Sciences, University for Development Studies to the Metropolitan Health Directorate, Tamale and sought permission to undertake the study within health facilities within the sub-metros. The Metropolitan Health Directorate to the selected health facilities gave an approval letter and the permission was granted by the facilities for the study to be conducted.

For the communities, permission and approval was obtained from the heads of Aboabo, Lamashegu, Tishegu, Dungu, Nyohini and Zogbeli (Chiefs, assembly members, and opinion leaders) to conduct the study. Furthermore, participants were clarified on the purpose of the study and their consents were obtained before the questionnaires were administered. Issues of confidentiality and anonymity were ensured.



3.13 Operational definition

Knowledge: awareness of adolescents on family planning services

Health seeking behaviour: Actions or inactions taking by adolescents concerning family planning services

Adolescents: individuals aged 10-19 years

Health education: providing knowledge on family planning to help adolescents gain knowledge.

Family planning services: providing services on issues of contraceptives, counselling, abortion and pregnancy



CHAPTER FOUR

RESULTS AND ANALYSIS

4.0 Introduction

The findings of this chapter were examined to investigate the knowledge about the health-seeking behavior of adolescents towards family planning services in the study area. In-depth interviews and focus group discussions among female adolescents 10-19 years of age have been used for a qualitative approach. In the conversation and in-depth interviews were attended by approximately 386 young women and the results were as follows.

4.1 Socio-Demographics of Respondents

The socio-demographic characteristics of participants involved in the study are summarized in Table 4.1. From the table, majority (78.6%) of the respondents were within 16-19 years, followed by 13-15 (17.0%) and 3.9% were within 10-12 years. Therefore, the primary school was 5.7%, the JHS 21%, and the SHS 54.7%. More than half (54.7%) of respondents were in SHS, 21% were in JHS, followed by tertiary (10.2%), no education (8.3%) and primary (5.7%). Among the respondents, majority (74.4%) were Dagombas, 3.6% and 3.6% were Hausa and Bimoba respectively, and 158.1% were from other ethnic group. The Muslim respondents were more than half (87.3%) and Christian were 12.7%.

For parental level of education, majority (67.4%) of mothers had no education, 10.1% had vocational of technical education, and 8.5% had tertiary education followed by SHS (7.8%), JHS (3.6) and primary (2.6%). For fathers, 42.7% had no education, 35% had tertiary education, followed by vocational or technical (12.4%), SHS (7.8), JHS (1.6%) and primary (0.5%). In



addition, from the table, majority (94.0%) of respondents were single, 5.7% were married and 0.3% was divorced. Majority (90.5%) of respondents were not employed or had no occupation while 9.6% were in some form of employment.



Table 4.1: Socio-Demographics of Respondents

| VARIABLE | Frequency | Percentage |
|-------------------------------|------------------|-------------------|
| Age Of Respondent | | |
| 10-12 | 14 | 3.9 |
| 13-15 | 67 | 17.3 |
| 16-19 | 303 | 78.6 |
| Religion Of Respondent | | |
| CHRISTIAN | 49 | 12.7 |
| MUSLIM | 337 | 87.3 |
| Tribe of Respondent | | |
| BIMOBA | 13 | 3.4 |
| DAGOMBA | 287 | 74.4 |
| HAUSA | 14 | 3.6 |
| OTHERS | 72 | 18.1 |
| RESPONDENTS EDUCATION | | |
| NO EDUCATION | 32 | 8.3 |
| PRIMARY | 22 | 5.7 |
| JHS | 81 | 21 |
| SHS | 211 | 54.7 |
| TERTIARY | 40 | 10.2 |
| MOTHER EDUCATION | | |
| NO EDUCATION | 260 | 67.4 |
| PRIMARY | 10 | 2.6 |
| JHS | 14 | 3.6 |
| SHS | 30 | 7.8 |
| TECHNICAL/ VOCATIONAL | 39 | 10.1 |
| TERTIARY | 33 | 8.5 |
| FATHER EDUCATION | | |
| NO EDUCATION | 165 | 42.7 |
| PRIMARY | 2 | 0.5 |
| JHS | 6 | 1.6 |
| SHS | 30 | 7.8 |
| TECHNICAL/ VOCATIONAL | 48 | 12.4 |
| TERTIARY | 135 | 35.0 |
| MARITAL STATUS | | |
| SINGLE | 363 | 94.0 |
| MARRIED | 22 | 5.7 |
| DIVORCED | 1 | 0.3 |
| OCCUPATION | | |
| EMPLOYED | 37 | 9.6 |
| NOT EMPLOYED | 349 | 90.5 |

Source: researcher's field survey (2020)



4.2 Knowledge Regarding Family Planning Services

From the figure below, the number of adolescents confirmed to have knowledge concerning family planning are 258 representing 67% while those without family planning service knowledge are 128 signifying 33% of the total respondents. This was a quote from an adolescent;

My understanding of family planning is, if you want to have sex but do not want to get pregnant so to avoid pregnancy. You go for family planning service or maybe you are addicted to sex and do not want to be taking the pills all the time after sex so you will inject the family planning so that you can enjoy sex without any problems. [18-year-old female adolescent FGD]

If you have so many children and do not want more, you can go in for Family planning. [15-year-old female adolescent FGD]

They are things done by couples to space out their children so that they are able to take very good care of their children.

[14-year-old female adolescent FGD]

Contraceptives are meant for a student who is not ready for the birth but is being disturbed by a man, for her to have sex, she can inject family planning so that she can further her education. [14-year-old female adolescent FGD]

Me, I have done family planning before. The reason I did it was because I gave birth at a time when I had not planned to give birth, I was learning how to sew and I do not want



abortion, and so I went in for the 3 months injection, and after I gave birth and it has expired I took the 3 years injection which I am on now and it is good for me. [19-year-old female adolescent FGD]

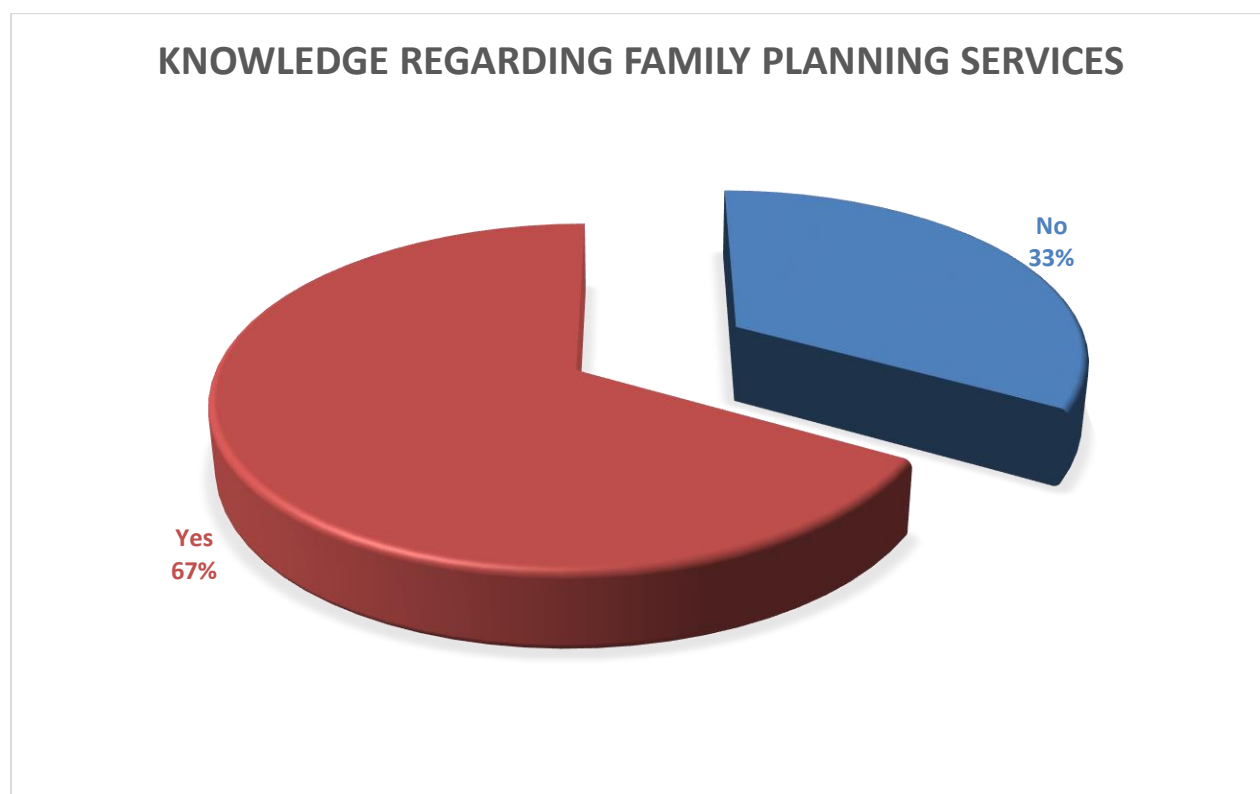


Figure 4.1: Knowledge Regarding Family Planning Services

Source: researcher's field survey (2020)

4.2.1 Contraceptive Method Used and Age of Female Adolescents

The contraception strategies used by adolescents are seen in Table 4.4. It shows the methods used for contraception by respondents at present. Many respondents (77.5%) who used contraception used condoms. In comparison, 44.8 percent of OCP observed. With 44.3 percent, implant was also strong with 32.1 percent, the IUCP and removal, accounting for 6 percent and 15.8 percent, the following contraception forms were used by respondents. Nevertheless, the



study revealed that most of the adolescent between the ages of 10 to 15 are not familiar or do not use the withdrawal and the IUCP method representing 0% each. In order of preference on contraceptive methods used by the adolescent between the ages of 16-19, condom, injectable, OCP, implant, withdrawal and IUCP representing 62.9%, 40.4%, 37.3%, 30.6%, 15.8% and 6.0% respectively. At least one contraception procedure used by 16–19 years of age represented the highest percentage. Moreover, the study also revealed that, majority of the adolescents within the age of 10-15 are more conversant with the use either condoms, injections or OCP.

However, some participants of the Focus Group Discussion indicated to have ever used, whereas some are currently using and some have never used family planning service. From the in-depth interviews, two adolescents were found to have reported of ever using family planning and a few reported not to ever use family planning. In addition, from the in-depth interviews adolescents' knowledge on the use of injectable was reported to involve one month and three months injections and also five years implant, and that they are accessible to women and adolescents to prevent unplanned pregnancy. Intra-Uterine Devices (IUD) was cited during the discussion as a method that is inserted into the womb of a woman and could prevent pregnancy for up to ten years. An 18years adolescent reported,

I have one child already and because of this, I am not ready for another child and so I went for the family planning. [18years old female adolescent during FGD]



Table 4.2: Cross-Tabulation of Contraceptive Method Used and Age of Female Adolescents

| Contraceptive | Age 10-12 | Age 13-15 | Age 16-19 | Total |
|---------------|-----------|-----------|------------|-------------|
| OCP | 4 (2.3) | 25 (14.5) | 144 (83.2) | 173 (100.0) |
| Injectable | 1 (0.5) | 14 (8.2) | 156 (91.2) | 171 (100.0) |
| Implant | 0 (0.0) | 6 (4.8) | 118 (95.1) | 124 (100.0) |
| IUCP | 0 (0.0) | 0 (0.0) | 23 (100.0) | 23 (100.0) |
| Withdrawal | 0 (0.0) | 0 (0.0) | 61 (100.0) | 61 (100.0) |
| Condom | 7 (2.3) | 49 (16.4) | 243 (81.3) | 299 (100.0) |

NB: figures in parenthesis shows the percentages of the respondents

An 18years adolescent reported,

I have one child already and because of this, I am not ready for another child and so I went for the family planning. [18years old female adolescent during FGD]



4.2.2 Regression Analysis on the Relationship between the Demographic Characteristics and Knowledge of Family Planning

The study found out the relationship between the demographic characteristics and the knowledge of family planning services among the adolescent in the metropolis. The dependent variable is the knowledge and use of the family planning method and the independent variables are; level of education of respondents, work status, wealth index of respondents' families, marital status, religion, ethnicity and health insurance coverage.

From the regression analysis in table 4.3, the coefficient (1.565) of constant, which is positively, related to the use of family planning among the youth when all other variables are held constant, is statistically significant at 95% confident interval. This signifies that, with or without the variables used in this analysis, the portion of adolescent who use family planning services is the constant figure from the regression. Moreover, the coefficient of level of education is 0.068 is positively related to the use of family planning services when all else remain constant however it is statistically insignificant. In addition, the coefficient (0.001) of work status from the adolescent is positively related to the use of family planning method when all other variables remain constant and has a 5% significant level. The wealth index of the adolescent families has a coefficient of 0.014, which is positively related to the use of family planning method when all other variables are held constant. The wealth index is statistically significant at 10% confident interval. This index in the study is linked to the notion that, wealthier parent's children can easily have access to funds in patronage of family planning services.

Furthermore, the coefficient of marital status is negatively related to the use of family planning method when all else are held constant and it is also statistically insignificant from the regression analysis. This in the analysis means that, married adolescents are most likely or do not seek for



family planning method. Moreover, the coefficient of religion is also negatively related to the use of family planning method when all other variables remain constant and at the same time statistically insignificant from the analysis. This could also suggest that religion frowns on the use of family planning services among the Muslims. Because, from the analysis majority (87.3%) of the respondents were Muslims and most of them mentioned that Islam frowns on the use of such services.

Besides, the coefficient of ethnicity (0.023) is positively related to the use of family planning services when all other variable remain constant and it is statistically significant 5% confident interval. Lastly, the coefficient of health insurance coverage is negatively related to the patronage of family planning services when all else remain constant but is highly significant at 1% confident interval. Under normal circumstance, this variable should have been positively related to the use of family planning but it the other way round because 88.3% of the adolescents interviewed are Muslims and this can still be linked to the religious dominant of the respondents.



Table 4.3: Regression Analysis on the Relationship between the Demographic Characteristics and Knowledge of Family Planning

| | R ² | 0.028 |
|---------------------------|-------------------------|----------|
| | Adjusted R ² | 0.009 |
| | Significant | 0.173 |
| Variables | Coefficients | T-test |
| Constant | 1.565*** | 5.379 |
| Level of education | 0.068 | 0.817 |
| Work status | 0.001** | 0.076 |
| Wealth index | 0.014* | 0.388 |
| Marital status | -0.062 | -0.680 |
| Religion | -0.096 | -1.165 |
| Ethnicity | 0.023** | 0.821 |
| Health insurance coverage | -0.055*** | (-2.891) |

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

4.2.3 Knowledge on Benefit of Family Planning

From table 4.4 below, the research seek to find out the benefits adolescents derive from the use or patronage of family planning services and the responses of the participants are outlined as follows;

Primarily, about 80.8%, which is the majority of the adolescents, suggests that they use or patronize family planning services to be able to prevent or avert unwanted pregnancy. From the analysis, it was revealed that most of the respondents in this category of prevention of unwanted pregnancy are the single or unmarried adolescents. Furthermore, due to the prevalence of



sexually transmitted transmissions (STIs) the research revealed that most (31.9%) of the adolescents resort to the use of the family planning services to prevent this STIs.

However, 24.6% of the adolescents resort to the family planning services to be able to space or control their births. In addition, 6.9% of the adolescents are of the view that, the use of the family planning services helps them to attain the maximum education they want in life. Last but not the least, a few (2.5%) of the adolescent believe that the use of family planning services enables them to derive or get a healthy life. They believe a healthy life is a precious treasure one cannot afford to lose.

Table 4.4: Respondents Knowledge on Benefit of Family Planning Services

| Variables | Frequency | Percent |
|--------------------|-----------|---------|
| Birth control | 100 | 24.6 |
| Healthy life | 10 | 2.5 |
| Early education | 28 | 6.9 |
| Prevention of STIs | 159 | 39.1 |
| Unwanted pregnancy | 329 | 80.8 |

Source: field survey, 2020

For me, I have ever taken the 3-months injections, and it affects my menstrual cycle; my menses does not flow normally for 5 days but it was due to the family planning, my menses can just come for 2 days [17-year- old female adolescent FGD]



In terms of how effective the contraceptive methods they had ever used, many of the adolescents indicated the use of injectable because it can easily be taken at the hospital. Also, emergency contraceptive pills such as Lydia, Levon-2, postinor-2, the male condom, and IUD were cited to be effective, affordable and easily accessible

Hmmm I take injection because it protects me from giving birth and makes me abstain from childbirth [17-year-old female adolescent FGD]

I also think the IUD is most powerful because it has no effects

[19-year-old female adolescent FGD]

The condom is the most effective because it is more affordable and accessible as compared with the others. It saves you the troubles of going to the pharmacy to buy and the rest. [15-year-old adolescent FGD]

But the problem the family planning thing gave me was two weeks menstruation, my fingers also freezes (numbness) and after every menstrual period I have taken medicine else I will be feeling dizzy. This made me stop using it [18-year-old female adolescents FGD]

Sources of Family Planning Education and Family Planning Services

4.3.1 Source of Family Planning Education

In exploring the various sources of family planning education and education centers for adolescents friendly in the metropolis, which is, related the first objective, it was realized that, some young people have gained information from TV commercials, radio advertising,



community durbar, colleges, friends, internet source, from parents and health professionals on the preferred contraceptive methods through extensive interviews. Nevertheless, the internet source as a means of family planning education to the adolescent has a 96.3%. The study also revealed that, the next source of family planning education which most of the adolescents mentioned was from the health professionals with 91.8%.

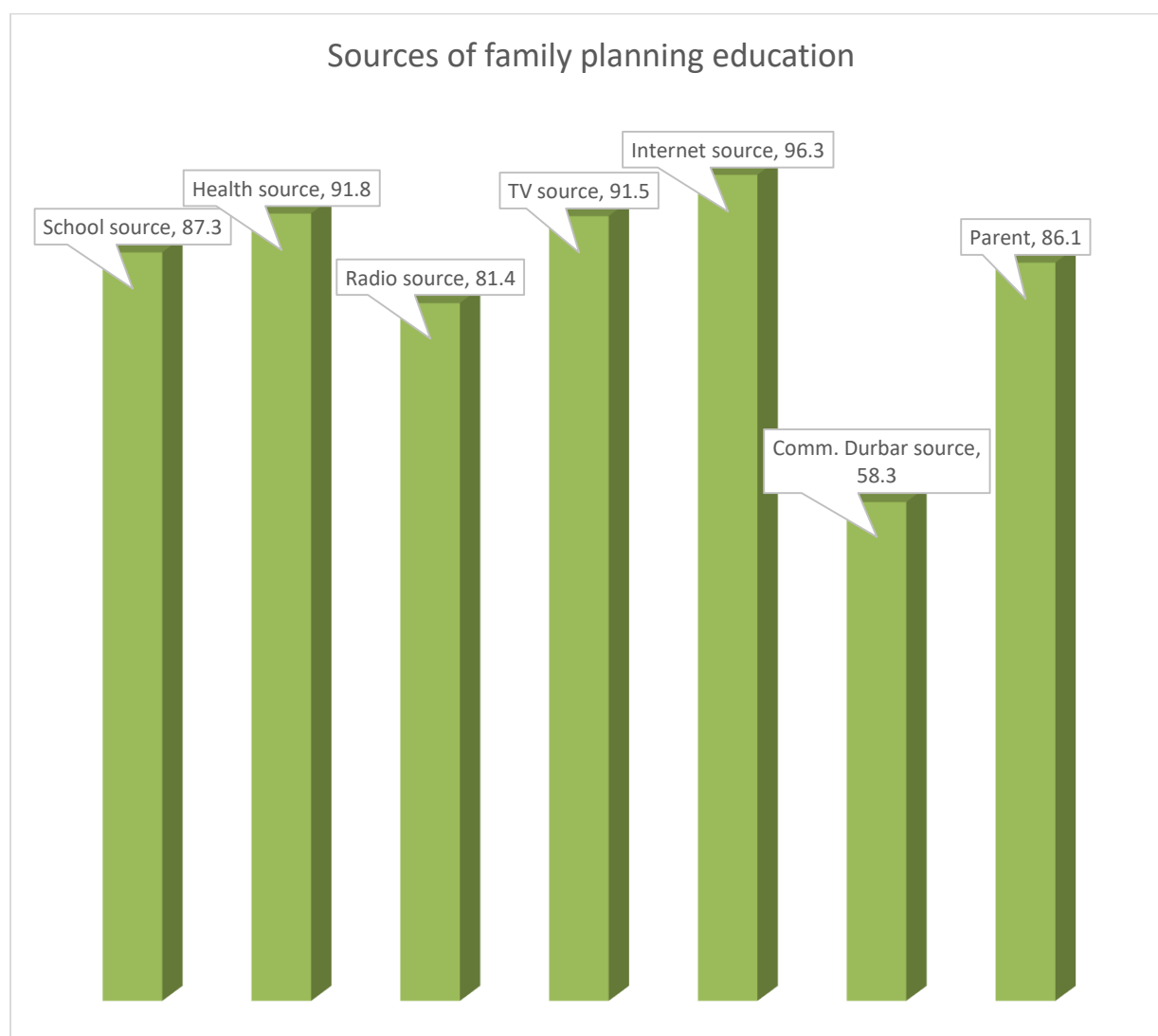


Figure 4.2: Sources of Family Planning Education

Source: researcher's field survey (2020)

I heard the family planning thing from the radio and television advertisement and also from friends” [17- year -old adolescent FGD]

However, the overall cross tabulations analysis shows that the percentage of total within the schools or colleges on family planning education was 47.2, which is the highest among the various sources.

For me I learnt it at school and from my friends [16-year-old adolescent FGD]

The analysis also revealed that, the percentage of total within the health professionals on family planning education in some of the Tamale sub metros was 37.6% as the second source of receiving the FP education and the next source the study revealed for the adolescent was the TV commercial with the percentage of 36.8%.

4.3.2 Association between Background Characteristic and Family Planning Education Source

From table 4.3, a Pearson chi-square test at 95% confidence interval and p-value of < 0.005 was computed to establish any association between family planning use and the demographics of the respondents. It was revealed that, the mainstream (73.6%) of the adolescent agreed that there has been family planning education in their communities while 26.4% are of the view that they do not have access to family planning education. This was the response between the ages of 16 to 19. In addition, 55.2% of the adolescent who are between the ages of 13 to 15 mentioned that there is no family planning education in their various communities. The least group is the age group between 10 to 12 where 68.7 % of the respondents agreed that there is no education on the



family planning issues to them in their communities. This is statistically significant at 5% confident interval, that is of those who mentioned of the availability of family planning education in their communities ($P= 0.000$). Moreover, the unmarried adolescents who are the majority (66.7%) have confirmed the availability of family planning education in their various communities while 33.3% of them said they have never received any source of education of family planning issues. Furthermore, 72.7% of the married adolescents mentioned that there is a family planning education going on there communities although 27.3% of them are of the view that they do not have such education in their locality. However, this did not establish any significant association between marital status and availability of family planning education ($P; 0.307$).

On religion, the dominated adolescents are the Muslim with 67.1%, and 32.9% are of the view that they have family planning education and have no family planning education respectively. The Christians who are the minority (65.3%) in this study mentioned that they have family planning education whereas 34.7% believed they have never enjoyed such education from any source. This is seen not to establish any significant association between religion and family planning education ($P; 0.807$).

In order of occurrence, 65.2%, 94.4%, 68.2% 85.7% and 61.5% among the adolescents belong to Dagbani, Gonja, Mamprusi, Hausa and Bimoba respectively had received some form of education in relation to family planning but 34.8%, 31.8%, 46.2% and 34.8% of adolescents belong to Dagomba, Mamprusi, Frafra and Bimoba respectively had received some form of family planning education. The research revealed statistically insignificant between ethnicity and availability of family planning education in the Tamale metropolis ($P; 0.173$).



Besides, the study participants (40.6%, 26.3%, 48.1%, 78.2%, 81.3% and 95.8%) who had no formal education, primary, JHS, SHS and tertiary respectively had ever received or confirmed the availability of family planning education in their communities. On the contrary, 59.4%, 77.3%, 51.9%, 21.8%, 18.7 and 4.2% of the study partakers who had no formal education, primary, JHS, SHS and tertiary respectively are of the view of not receiving or non-availability of family planning education in the various communities. There is a statistically significant at 5% confident interval between educational status of adolescents and availability of family planning education (P; 0.000).

In addition, in relation to occupational status of adolescents 70.3% and 66.4 % of those that have a job and those without a job respectively have received some form of education on family planning issues while, 29.7% and 33.6% of adolescent who have job and those with no job respectively have not received any form of education on family planning in their communities. There was a statistically insignificant between occupational status and availability of family planning education (P; 0.726)



Table 4.5: Association between socio demographics characteristics and the FP education source

| Variables | Categories | Availability of FP education | | Statistical Test |
|----------------|-------------|------------------------------|-----------|------------------------|
| | | Yes (%) | No (%) | |
| Age groups | 10-12 years | 5(31.3) | 11(68.7) | $X^2=48.1$ P; 000 |
| | 13-15 years | 30(44.8) | 37(55.2) | |
| | 16-19 years | 223(73.6) | 80(26.4) | |
| Marital status | Single | 242(66.7) | 121(33.3) | $X^2=2.37$ P;0.307 |
| | Divorce | 0 | 1(100.0) | |
| | Married | 16(72.7) | 6(27.3) | |
| Religion | Christian | 32(65.3) | 17(34.7) | $X^2=0.060$ P;0.807 |
| | Muslim | 226(67.1) | 111(32.9) | |
| Ethnicity | Gonja | 17(94.4) | 1(5.6) | $X^2=0.173$ P;16.4 |
| | Mamprusi | 15(68.2) | 7(31.8) | |
| | Ashanti | 1(100) | 0 (0.0) | |
| | Bimoba | 8(61.5) | 5(38.5) | |
| | Dagomba | 187(65.2) | 100(34.8) | |
| | Ewe | 4(80.0) | 1(20.0) | |



| | | | | |
|---------------------|--------------|-----------|-----------|-------------|
| | Fante | 1(100.0) | 0(0.0) | |
| | Frafra | 7(53.8) | 6(46.2) | |
| | Hausa | 12(85.7) | 2(14.3) | |
| | Kasena | 1(100.0) | 0 (0.0) | |
| | Moshi | 5(55.6) | 4(44.4) | |
| | Sisala | 0 (0.0) | 1(100.0) | |
| | Others | 0 (0.0) | 1(100.0) | |
| Educational status | No education | 13(40.6) | 19(59.4) | $X^2=64.9$ |
| | Primary | 5(26.3) | 17(77.3) | P;0.000 |
| | JHS | 39(48.1) | 42(51.9) | |
| | Secondary | 165(78.2) | 46(21.8) | |
| | Technical | 13(81.3) | 3(18.7) | |
| | Tertiary | 23(95.8) | 1(4.2) | |
| Occupational status | Employed | 26(70.3) | 11(29.7) | $X^2=0.696$ |
| | Not employed | 232(66.4) | 117(33.6) | P;0.726 |



4.3.3 Sources of family planning services

From the discussions, many adolescents knew the sources of family planning and stated that they could be obtained from pharmacies, drug stores/chemical shops, through traditional medicine sellers locally, mobile vendors, friends, polyclinics, health centers, hospital, child welfare clinic (CWC). In spite of these, there were reported negative experiences among adolescents who break all odds in their quest to access contraceptives.

For me, it is not easy accessing contraceptives at pharmacies, they ask too many questions, and sometimes threatens to tell your parents if they knew them and so we always decided to go to a local hide-out, because over there if you want condoms, people will not see you and be asking you questions. [16-year- old female adolescent during FGD]

4.4 Challenges faced by adolescents towards family planning services

Challenges regarding adolescent health-seeking behavior towards family planning services relating to the second objectives is discussed toward the context of little education among the adolescents with the issue of family planning service. From the analysis, unfavorable attitudes of service providers, financial challenges, religious problems, traditional belief and inadequate contraceptives, which represent 10.1%, 26.7%, 25.1%, 34.7% and 6.2% respectively were those mentioned as the challenges they face. However, some of the adolescent mentioned of other issues such as shyness, misconception and stigmatization, which they see as challenge. The most challenge from the analysis by the adolescent are little education between adolescent, traditional belief and financial challenge with 49.7%, 34.7 and 26.7 respectively.



Table 4.6: Challenges concerning adolescent towards Family Planning

| Variables | Frequency | Percentage |
|-----------------------------------|------------------|-------------------|
| Little education among adolescent | 192 | 49.7 |
| Attitudes of service providers | 39 | 10.1 |
| Inadequate contraceptives | 24 | 6.2 |
| Religion | 134 | 25.1 |
| Traditional belief | 97 | 34.7 |
| Financial challenges | 103 | 26.7 |
| Others | 28 | 7.3 |

Source: researcher's field survey (2020)

We are under-aged and normally feel shy because we think they will be asking us about our age, and shyness is a major hindrance. [14 years old female adolescent during FGD]

Also, as adolescents, we normally feel shy buying condoms at the pharmacy, because when the older people are around and see you they will either insult you or stigmatized you by saying you are a bad girl and this makes us feel shy and afraid [15-years-old female adolescent FGD]

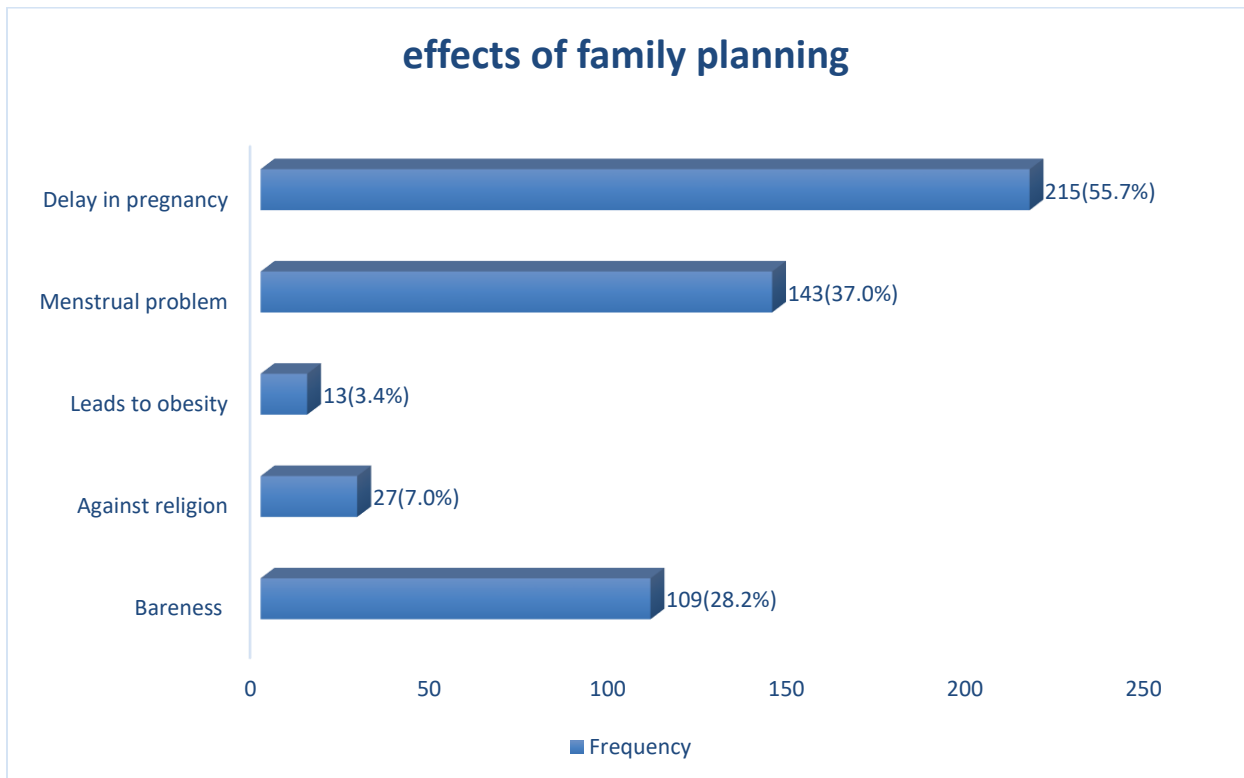
4.4.1 Negative effects of family planning service

The adolescent also complained of some disadvantages when they use the family planning service. Out of a number of the negative effects outlined, more than half of the adolescent were of the view that, delay in pregnancy was a major drawback. The delay in pregnancy has a



frequency of 215, which represent 55.7% of the respondents. Moreover, most of the adolescent with the frequency of 143 also complained of having menstrual problems when they use the family planning service. Nevertheless, some of the adolescent (109 respondents representing 28.2%) from the analysis also revealed that, bareness is another problem or a disadvantage they experience after using the family service. With the issue of religion, out the total respondents, only 7% of them mentioned religion as a draw back on the use or seeking the service of family planning. However, some of the adolescent are of the view that using any form of family planning services leads to a person becoming fat, which eventually will lead to obesity. This is presented in the figure below:

Figure 4.3: Negative effects of family planning service



Source: researcher's field survey (2020)



My families are Christians and they believe the use of contraceptive is a taboo. [16-year-old female adolescent FGD]

I am Muslim, and they do not allow us to use family planning/contraceptives. Even, when you are menstruating, you are not allowed in the mosque. So it serves as a barrier for us to use contraceptives. [18- year- old female adolescent FGD]

As for me my church always preaches chastity for adolescents and abstinence from sex so even when we go to youth camp they advise us not to have sex and use contraceptives...they say if you have sex and use contraceptives, and you go to the face of God, you are unclean and you'll not get what you want from God when you pray. [17-year- old female adolescent FGD]

4.5 Socio-cultural and economic factors of FP

In identify the socio-cultural and economic factors that affect the health seeking behavior of the adolescents towards family planning. The research revealed that, more than half of (67.4%) of the respondents' mothers' have no form of formal education. In addition, the educational status of the respondents' fathers' was encouraging with 35% got to the tertiary level while those with no any form of education are 42.7%. However, out of the total population sampled the research discovered that, about 13%, 11%, and 10.9% earn 400, 300 and 200 Ghana cedis respectively which is the highest percentage. While 3%, 3.6% and 1.3% of the family of the respondents earn 2,500, 2000, and 1800 Ghana cedis respectively.



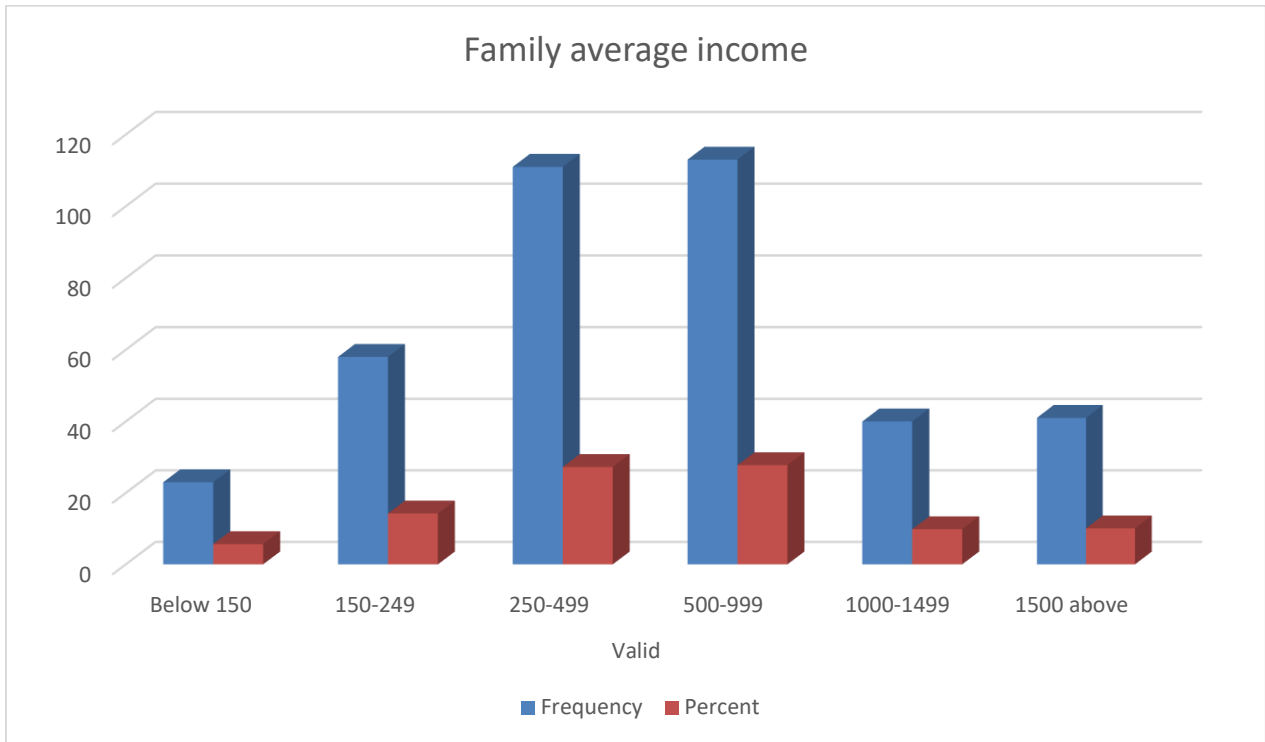


Figure 4.4: Showing the average income of adolescents’ family

Source: field survey, 2020

Furthermore, from the figure above, the study revealed that most of the adolescents’ families are earning between GHS 250 and GHS 999. Only 5.7% of the respondents’ families are earning below GHS 150. In addition, GHS 150-249, GHS 1000-1499 and GHS 1500 above are some of the average income of respondents’ family representing 14%, 9.8% and 10.1% respectively.



CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discussed the findings of the study. In addition, it elaborate appraisal of the research results with like studies carried out somewhere else. The study aimed at investigating the health seeking behavior of adolescents towards family planning services in the Tamale metropolis. The study also examined the source of information on family planning, knowledge on family planning, and socio economic and cultural challenges associated with family planning.

5.1 Knowledge on family planning and use of family planning services

The knowledge of family planning services in the various communities is a very imperative role in the use of the family planning services. The study revealed that majority (67%) of the respondents has ever heard of family planning method. This finding is consistent with a study by Onasoga et al., (2016) in Nigeria. Their study found out that, three-fourth (75%) of respondents had knowledge about family planning in Nigeria.

A regression analysis was performed to know the relationship between knowledge on family planning and socio demographic characteristics. It was found that, work status (0.001), wealth index (0.014), an ethnicity (0.023) influences contraceptive knowledge whiles level of education (0.068), marital status (0.062), religion (0.096) were not predictors of family planning knowledge.

The study also found out that, about 81% of respondents knew that family planning services helps in preventing unwanted pregnancy. Also, 39%, 24.6%, 6.9%, and 2.5% of respondents knew the benefit of family planning to be prevention of STIs, birth control, early education and healthy life respectively. Through the use of effective contraceptives, adolescents who chose to



postponed or discontinue childbearing could have avoided about 90% of total abortion-related and 20% of Obstetric mortality and morbidity in 2000 (Collumbien et al, 2004). Respondents had knowledge on the different types of contraceptive methods such as the injectable, emergency contraceptive pills, condom and intra uterine device. Onasoga et al (2016) indicate that, bulk of young people has learned about emergency contraceptive pills.

However, the study went further to seek the association between family planning use and the respondents' demographics. It was unrivaled that more than half of the total respondents are of the view that, they adequately receive family planning education, which had a high confident level from the analysis. Furthermore, more than half of the single or unmarried respondents are of the view that, family planning education has been going on in their communities and they are those benefiting from it.

In addition, religion was also seen as a factor affecting the patronage and use of family planning education in the various communities use as the study area. Almost all the communities use for this study is Muslim (58.5) dominated communities. From the analysis, it revealed that, most of the Muslim adolescents have the family planning education in one way or the other, but making use of it is the problem. However, the few Christians among the respondents made it clear that they use the service a lot. Moreover, the dominated ethnic group in the study was the Dagbani followed by the Gonjas then the Mamprusi. This has actually influence the outcome of the study. Besides, majority (42.75) of them were SHS graduates while a few of the attained tertiary education as of the time the study was carried out. Furthermore, most of the adolescents were jobless because some were saying they are still school while others have just finished and searching for jobs.



Additionally, these adolescent have some particular contraceptives they use in avoiding pregnancy and spacing of childbirth. The most common one used by all the age groups was seen to be the condom, OCP was the next used contraceptive, then followed by IUCP and the least used contraceptive among the adolescent was the withdrawal. Nevertheless, the withdrawal was seen to be high among the 16-19 age group which some of them explained it as they having more experienced in issues relating to sex. Whereas condom was the one most of the adolescents within the ages of 10-12 used a lot.

5.2 Source of information on family planning and family planning education

This result revealed that the dominated source of family planning education attained by the adolescents was the internet source followed by the education received from the health professionals in their communities. Moreover, TV source was seen to be the next media of acquiring family planning education by the adolescents in the metropolis. Thus, most adolescents learn about family planning on the internet rather than the health centers. Bankole et al (2007) also attested that in Ghana and Burkina Faso, mass media was the most sought after source of information on sexual and reproductive health. Kyilleh, Tabong and Konlaan (2018) indicated that the media makes adolescents vulnerable to misinformation. Baheiraei et al (2014) also affirmed that 37.9% of the respondents in their study preferred internet as the source of information to educate themselves on sexual and reproductive health.

The study also found out that, adolescents have different sources where they obtain family planning services from. Pharmacies, drug stores/chemical shops, through traditional medicine sellers locally, mobile vendors, friends, polyclinics, health centers, hospital, child welfare clinic



(CWC) are the sources adolescents obtain family planning services from when they need such services.

5.3 Challenges faced by adolescents towards Family Planning

The study found out that, nearly (50%) of adolescents sees inadequate education on family planning as a challenge. The challenges adolescents face while seeking for family planning services are to be of national concern. In a research conducted by (Collumbien et al, 2004), a total of 150,000 maternal deaths (representing 32% of all these deaths) with considerable cost-effectiveness could have been avoided, most of which are between the ages of 10-19 years and reaped by the benefits in Africa and Asia. However, some of the adolescent mentioned of other issues such as shyness, misconception and stigmatization, which they see as a challenge. The most challenge from the analysis by the adolescent are traditional belief and financial challenges.

The use of family planning service mostly comes with some cost and benefits. Out of the total population sample, more than half of the married adolescents are of the view that, the use of family planning delays them any time they are ready to conceive. The other challenges mentioned by the adolescents are having menstrual problems, bareness and they even complained of becoming fat, which eventually leads to obesity.

5.4 Socio-cultural and economic factors affecting FP services

The socio-cultural and economic factors that affect the health seeking behavior of the adolescents towards family planning was revealed where more than half of (67.4%) of the respondents' parents' have no form of formal education. However, out of the total population sampled the research discovered that, the majority of the adolescents parents fall within the category of earning between GHS 250 and GHS 999. Only a few earn more a GHS 1000, which



could affect these adolescents. Because, an in-depth interview revealed that, most adolescents whose parents are rich can easily have some reserves to purchase any contraceptive to prevent unwanted pregnancy.



CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The findings and recommendations from the study are presented in this Chapter. The results are based on the key findings in the research that aimed at exploring the use of family planning in female adolescents in Northern Region, Tamale. The guidelines were taken from the findings of the analysis and were structured to assist them in their decision taking on facts and to deliver effective approaches.

6.1 Conclusions

Established on the finding, the following conclusions were made;

- Most adolescents understood family planning as a tool which helps in preventing unwanted pregnancy. Men's contraceptives, emergency contraceptive tablets, injections and IUDs, were the contraceptives used by adolescents. Participant information about contraception was acquired from TV ads, radio, health professionals, friends and internet.
- The majority of the adolescent agreed that there has been family planning education in their communities while few are of the opinion that they do not have access to family planning education.
- From the analysis, unfavorable attitudes of service providers, financial were the challenges the adolescents face. However, some of the adolescent mentioned of other issues such as shyness, misconception and stigmatization, which they see as challenging.



The most challenge from the analysis by the adolescent are little education between adolescent, traditional belief and financial challenge.

- Out of a number of the negative effects outlined, more than half of the adolescent were of the view that, delay in pregnancy was a major drawback. Moreover, most of the adolescent also complained of having menstrual problems when they use the family planning service. Nevertheless, most of the adolescent from the analysis also revealed that, bareness is another problem or a disadvantage they experience after using the family service. With the issue of religion, out the total respondents, only a few of them mentioned religion as a draw back on the use or seeking the service of family planning. However, some of the adolescent are of the view that using any form of family planning services leads to a person becoming fat, which eventually will lead to obesity.
- Level of education is seen to be positively related to the use of family planning services. In addition, work status of the adolescent is positively related to the use of family planning method. Moreover, the wealth index of the adolescent families is positively related to the use of family planning method and marital status is negatively related to the use of family planning method as well. However, religion is also negatively related to the use of family planning method, which suggest that religion frowns on the use of family planning services among the Muslims. Because, from the analysis majority (87.3%) of the respondents were Muslims and most of them mentioned that Islam frowns on the use of such services. Ethnicity is also positively related to the use of family planning services and health insurance coverage is negatively related to the patronage of family planning services due to dominance of Muslims in the study.



6.2 Recommendations

This study came out with the following recommendation. The recommendations were grouped into strategy, public well-being and alternatives.

6.2.1 Strategy

The study recommended that the Ghana Education Service (GES) in partnership with parents through the Parent teachers' organization to inform their teenagers at home about their identity and successful use of contraception through the School Health Education System.

In addition, in order for the provider to strengthen the interaction of the client and the treatment of the young people to seek contraception, the Ghana Health Service should intensify on-site preparation, as some have indicated that they have turned back due to minors as well as a constructive interaction and attitude to young people.

6.2.2 Public wellbeing

Ghana Health Service should improve awareness in public health through the mass media, in particular on the correct use and availability to family planning services.

Moreover, the Tamale metropolis healthcare facilities are recommended to designate more young people's corners to encourage the use of healthcare by adolescents.

6.2.3 Study alternatives

Potential research studies need to examine family planning teen applications from a parent and service provider point of view. Moreover, prospective work will concentrate on lesser-known family planning activities.



REFERENCE

- Aassve A, Engelhardt H, Francavilla F (2005). Fertility and poverty in less developed countries: a comparative analysis. Paper presented at International Population Conference. Tours, France.
- Abdool-Karim, Q., S.S. Abdool-Karim, and E. Preston-Whyte. 1992. "Teenagers seeking condoms at family planning services: A provider's perspective." *South African Medical Journal* 82, 5: 360– 362.
- Abdulai, M. (2015). *Contraceptive uptake in the Tamale Metropolis*, (Master of Public Health (Mph) Degree). University of Ghana, Legon, Accra. Retrieved from <http://ugspace.ug.edu.gh>
- Adabla, S. (2019). *Perceptions, Attitudes and Beliefs of Youth Regarding the Use of Sexual and Reproductive Health (SRH) Services in Ashaiman, Ghana* (Doctoral dissertation, Bowling Green State University).
- Agyei, W.K.A. and E.J. Epema. 1992. "Sexual behavior and contraceptive use among 15–24-year-olds in Uganda." *International Family Planning Perspectives* 18,1: 13–17.
- Akoth, B.O. (2010). *The effect of age difference on contraception use among married women in Kenya* (Master of Arts Degree). [erepository.uonbi.ac.ke /.../Odaa](http://erepository.uonbi.ac.ke/.../Odaa)
- Amoako, D. J. (2016). *Modern contraceptive use among young women in budumburam refugee camp In Ghana* (Master of Public Health (Mph) Degree). Retrieved from <http://ugspace.ug.edu.gh>
- Andersen RM. (1995) Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health And Social Behavior*. 1:10.



APA (2002). *Developing adolescents: A reference for professionals*. Washington, DC: American Psychological Society.

Appiah-Agyekum, N. N. and Kayi, E. A. (2013), Students' Perceptions of Contraceptives in University of Ghana. *Journal of Family and Reproductive Health*, Vol. 7, No. 1, March 2013, 39-44.

Association of Reproductive Health Professionals (ARHP). (2008). *Health Matters: Understanding Menstrual Suppression*.

Association Zairoise pour le Bien-être Familial (AZBEF) and Population Council. 1993. "Survey of parents' ability to answer questions on family life." In PC Compiler. *Operations Research Family Planning Database Summaries*. New York: PC Compiler. P.16.

Atiemo, M. (2015). *Factors influencing utilization of contraceptives among women in reproductive age (15-49 years) in the Ashanti Mampong municipality of Ashanti region*. (Master of Public Health). Retrieved from <http://ir.knust.edu.gh/bitstream>.

Atuyambe L. Health care-seeking behavior for sexually transmitted infections among adolescents in Rakai District, Uganda. In: *Master of Public Health*. Kampala: Makerere University. Dissertation; 1998.

Atuyambe LM. (2008) Adolescent motherhood in Uganda: Dilemmas, health-seeking behavior, and coping responses.

Atuyambe, L. M., Kibira, S. P., Bukenya, J., Muhumuza, C., Apolot, R. R., & Mulogo, E. (2015). Understanding sexual and reproductive health needs of adolescents: evidence from a formative evaluation in Wakiso district, Uganda. *Reproductive health*, 12(1), 1-10.



Awusabo-Asare K., Abane A. M. and Kumi-Kyereme, K. (2004), Adolescent Sexual and Reproductive Health in Ghana: A Synthesis of Research Evidence, Occasional Report, New York: The Alan Guttmacher Institute, 2004, No. 13.

Awusabo-Asare, K., & Abane, A. M. (2008). Adolescent sexual and reproductive health in Ghana: A synthesis of research evidence. Occasional report (13). <https://www.researchgate.net/publication>.

Awusabo-Asare, K., Abane, A. M. and Kumi-Kyereme, K. (2006), Adolescent Sexual and Reproductive Health in Ghana: A Synthesis of Research Evidence, Occasional Report, New York: The Alan Guttmacher Institute, No. 13.

Babalola S, Fatusi A. (2009) Determinants of use of maternal health services in Nigeria-looking beyond individual and household factors. *BMC pregnancy and childbirth*. 9(1):43.

Baheiraei, A., Khoori, E., Foroushani, A. R., Ahmadi, F., & Ybarra, M. L. (2014). What sources do adolescents turn to for information about their health concerns?. *International journal of adolescent medicine and health*, 26(1), 61-68.

Bankole, A., Biddlecom, A., Guiella, G., Singh, S. & Zulu, E. (2007). Sexual behavior, knowledge and information sources of very young adolescents in four sub-Saharan African countries. *African Journal of Reproductive Health* 11, (3) 28-43.

Barker, Gary Knaul and Susan Rich. 1992. "Influences on adolescent sexuality in Nigeria and Kenya: Findings from recent focus-group discussions." *Studies in Family Planning* 23,3: 199-210.

Bearinger, L. H., Sieving, R. E., Ferguson, J., & Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *The lancet*, 369(9568), 1220-1231.



Berganza, C.E., C.A. Peyre, and G. Aguilar. 1989. "Sexual attitudes and behavior of Guatemalan teenagers: Considerations for prevention of adolescent pregnancy." *Adolescence* 24,94: 327–337.

Biddlecom, A.E., Munthali, A. and Singh, S. (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 (3), 99-110.

Birdsall N, Kelley AC, Sinding SW, eds (2001). Population matters: demographic change, economic growth, and poverty in the developing world. Oxford: Oxford University Press.

Black RE, Morris SS, Bryce J (2003). Where and why are 10 million children dying each year? *Lancet*; **361**: 2–10.

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. *Int Persp Sexual Reprod Health*.2009; 35(2), 63–71.

Blencowe, H., Cousens, S., Chou, D., Oestergaard, M., Say, L., Moller, A. B., ... & Lawn, J. (2013). Born too soon: the global epidemiology of 15 million preterm births. *Reproductive health*, 10(S1), S2.

Bloom, David E., David Canning and Jaypee Sevilla. (2003). *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change*. Santa Monica, CA: RAND.

Breinbauer C, Maddaleno M. Youth: Choices and Change. Health Behaviours in Adolescents. Washington, DC: PAHO; 2005.

Brown, S. & Guthrie, K. (2010) Why don't teenagers use contraception? A qualitative interview study. *European Journal of Contraception and Reproductive Health Care*. 15(3), 197-204.

Boamah, A., Asante, P., Mahama, E., Manu, G., Ayipah, E., Adeniji, E., & Owusu-Agyei, S. (2013). Use of contraceptives among adolescents in Kintampo, Ghana: a cross-sectional study. *Open Access Journal of Contraception*. 5, 7-15.

Caceres, Carlos F., A.M. Rosasco, J.S. Mandel, and N. Hearst. 1994. "Evaluating a school-based intervention for STD/AIDS prevention in Peru." *Journal of Adolescent Health* 15,7: 582–591.

Castillo, S. 1993. "Costa Rica: Tools for teens." *Populi* 20,2: 8–9

Chen S, Ravallion M. (2004). How have the world's poorest fared since the early 1980s? Washington: The World Bank, Policy Research Working Paper WPS3341.

Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, 368(9549), 1810–1827. doi:10.1016/s0140-6736(06)69480-4

Clotey, C. (2012). *Social barriers that affect the non-use of contraceptives among adolescents in the Gomoa East District*. <http://ugspace.edu.gh>

Collumbien M, Gerressu M, Cleland J (2004). Non-use and use of ineffective methods of contraception In Ezzati M, Lopez AD, Rodgers A, Murray CJL eds. Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. Geneva: World Health Organization: 1255–320.

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. SAGE publications.



Cronin T, Sheppard J, de Wildt G. (2013) Health-seeking behavior for schistosomiasis: a systematic review of the qualitative and quantitative literature. *The Pan African medical journal*. 16

Cudjoe, K. F. (2018). *Assessing the knowledge, access and utilization of adolescent friendly health services in kumbungu district, ghana* (Master dissertation).

Daka, D. & Shaweno, D. (2014). The magnitude of risky sexual behavior among high school adolescents in Ethiopia: a cross-sectional study. *Journal of Public Health and Epidemiology* 6 (7), 211-215. DOI: 10.5897/JPHE2014.0639
<http://www.academicjournals.org/JPHE>

Dangat, C. M., & Njau, B. (2013). Knowledge, attitudes and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. *Tanzania journal of health research*, 15(1).

Darroch, J. E., & Singh, S. (2013). Trends in contraceptive need and use in developing countries in 2003, 2008 and 2012: an analysis of national surveys. *The Lancet*, 381(9879), 1756-1762.

DaVanzo J, Razzaque A, Rahman M (2005). The effects of birth spacing on infant and child mortality, pregnancy outcomes and maternal morbidity and mortality in Matlab, Bangladesh. Santa Monica, California: RAND Working Paper.

Demographic and Health Surveys. 1992. Adolescent Women in sub-Saharan Africa: A Chartbook on Marriage and Childbearing. Washington, DC: Population Reference Bureau.

Demographic Health Survey Programme (2014). *Unmet Need*. Available at: <http://dhsprogram.com/topics/Unmet-Need.cfm>. Retrieved 4 November 2014.



- Deri, M. (2016). *Contraceptive use among women of reproductive age in Jirapa District* (Master of Public Health Degree) University of Ghana. Retrieved from <http://ugspace.ug.edu.gh>
- Desantis, L., and J.T. Thomas. 1987. "Parental attitudes toward adolescent sexuality: Transcultural perspectives." *Nurse Practitioner* 12, 8: 43–48.
- Dialard, C. (2003) Understanding 'Abstinence': Implications for Individuals, programs and policies. The Guttmacher Report. <http://pauldavidtuff.com>
DOI 10.1186/s12978-015-0026-7
- Dynowski, M. 1987. "Family life education in Botswana." *Health News and Views* 10, 1: 3–7.
- Eastwood R, Lipton M (1999). The impact of changes in human fertility on poverty. *J Dev Stud*; **36**: 1–30.
- Eastwood R, Lipton M (2001). Demographic transition and poverty: effects via economic growth, distribution, and conversion. In: Birdsall N, Kelley AC, Sinding SW, eds. *Population matters: demographic change, economic growth, and poverty in the developing world*. Oxford: Oxford University Press, 213–59.
- Endriyas, M., Eshete, A., Mekonnen, E., Misganaw, T., Shiferaw, M., & Ayele, S. (2017). Contraceptive utilization and associated factors among women of reproductive age group in Southern Nations Nationalities and Peoples' Region, Ethiopia: cross-sectional survey, mixed-methods. *Contraception and reproductive medicine*, 2(1), 10.
- Erikson, E.H. (2013). *Identity and the life cycle: Selected papers. Psychological issues. Monograph Series I, No. 1*. New York: International Universities Press.
- Etikan, I., & Bala, K. (2017). Sampling and sampling methods. *Biometrics & Biostatistics International Journal*, 5(6), 00149.



Family Planning Summit Metrics Group. (2012). *Technical Note: Data Sources and Methodology for Calculating the 2012 Baseline, 2020 Objectives, Impacts and Costings*.

Family Planning Summit, 2012.

Feleke, S. A., Koye, D. N., Demssie, A. F., & Mengesha, Z. B. (2013). Reproductive health service utilization and associated factors among adolescents (15–19 years old) in Gondar town, Northwest Ethiopia. *BMC health services research*, 13(1), 294.

Felice ME, Feinstein RA, Fisher MM, Kaplan DW, Olmedo LF, Rome ES, et al. Adolescent pregnancy—current trends and issues: 1998 American Academy of Pediatrics Committee on Adolescence, 1998–1999. *Pediatrics*. 1999;103(2):516–20.

Ford, L. and Holder, J. (2016) Contraception and family planning around the world-interactive. *The Guardian*

FP2020 (2014). *The 2012 London Summit on Family Planning*. Available at: <http://www.familyplanning2020.org/about-us/the-2012-london-summit-on-family-planning>. Retrieved on 2 October 2014.

FP2020 (2015). *Ghana Country Commitments*. Available at: <http://www.familyplanning2020.org/reaching-the-goal/commitments/all-commitments/commitment/>. Retrieved 11 March 2015.

Freud, S. (2005). *Three contributions to the sexual theory. Nervous and mental disease. Monograph Series, No. 7*. New York: Nervous and Mental Disease Publishing Co.

Frost, J., & Lindberg, D. (2012). *Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics*. Guttmacher Institute, New York, U.S. National Library of Medicine. 87(4), 465–47.



Frost, J. J., & Forrest, J. D. (1995). Understanding the impact of effective teenage pregnancy prevention programs. *Family planning perspectives*, 188-195.

Gao W, Dang S, Yan H, Wang D. (2012) Care-seeking pattern for diarrhea among children under 36 months old in rural western China. *PloS one*. 7(8):e43103.

Gentle Beginning Midwifery (2015). *Non-hormonal methods of contraception client handout*: Retrieved from www.sexualityandu.com.

Ghana Family Planning Costed Implementation Plan (2016). Retrieved on 20 November 2019, <http://www.healthpolicyproject.com/index.cfm?ID=GhanaCIPLaunch>

Ghana Health Service. (2014). *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

Ghana Health Services (2016). Family health division annual report 2016

Ghana Statistical Service (2013). 2010 Population & Housing Census. National Analytical Report. [www.statsghana.gov.gh/docfiles/.../2010_PHC_National Analytical Report.pdf](http://www.statsghana.gov.gh/docfiles/.../2010_PHC_National_Analytical_Report.pdf)

Ghana Statistical Service (2013). *Population and Housing Census Report. Millennium Development Goals in Ghana*. July 2013. Available at: [http://www.statsghana.gov.gh/docfiles/2010phc/MDG%20report%20\(24-10-13\).pdf](http://www.statsghana.gov.gh/docfiles/2010phc/MDG%20report%20(24-10-13).pdf).

Ghana Statistical Service (GSS) and Macro International Inc. (MI). (1994). *Ghana Demographic and Health Survey 1993*. Calverton, Maryland: GSS and MI. Available at: <http://dhsprogram.com/pubs/pdf/FR59/FR59.pdf>.

Ghana Statistical Service, Ghana Health Service and the DHS Program (2015). *Ghana Demographic and Health Survey Key Indicators 2014*. March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.



Ghana Statistical Service, Ghana Health Service, and ICF Macro (2009). *Ghana Demographic and Health Survey 2008*. Accra, Ghana: GSS, GHS, and ICF Macro. Available at: [http://dhsprogram.com/pubs/pdf/FR221/FR221\[13Aug2012\].pdf](http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf).

Ghana Statistical Service, Ghana Health Service, and The DHS Program. (2015). *Ghana Demographic and Health Survey Key Indicators 2014*. March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

Ghana Statistical Services (2008). *Ghana Living Standards Survey. Report of the Fifth Round*. Available at: http://www.statsghana.gov.gh/docfiles/glss5_report.pdf.

Government of Ghana (2013). *National Development Planning Commission. Country Report: ICPD beyond 2014*.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105–112.

Green G, Pool R, Harrison S, Hart GJ, Wilkinson J, Nyanzi S, et al. Female control of sexuality: illusion or reality? Use of vaginal products in southwest Uganda. *Soc Sci Med*. 2001;52(4):585–98.

Greene ME, Merrick T (2005). Poverty reduction: does reproductive health matter? Health, Nutrition and Population Discussion Paper. Washington: The World Bank.

Greene, M., & Merrick, T. (2015). *The case of investing in research to increase access to and use of contraception among adolescent*. Alliance for reproductive, maternal, and newborn health; Seattle, Washington <https://www.usaid.gov>.

Guttmaier Institute (2015). Contraceptive services in the US. <https://www.guttmacher.org> infographic.



Gwatkin DR, Rutstein S, Johnson K, Suliman EA, Wagstaff A (2004). Initial country level information about socio-economic differences in health, nutrition and population 2nd edn. Washington: The World Bank.

Hall, G.S. (2007). *Adolescence. 2 vols.* New York: Appleton

Hawkins, Kirstan and David Ojaka. 1992. Review of the Youth Programme of the Family Planning Association of Kenya. Nairobi: International Planned Parenthood Federation, Africa Regional Secretariat.

Health Policy Project (2015). *Costed Implementation Plans for Family Planning: The Basics.*

Available at: http://www.healthpolicyproject.com/pubs/812_CIPTheBasicsFINAL.pdf.

Health Policy Project. (2015). *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

Herbert, S. (2015). Social norms, contraception and family planning. GSDRC Help Res Rep, 1-15.

Jaccard, J. and P. Dittus. 1993. "Parent-adolescent communication about premarital pregnancy." *Families in Society* 74, 6: 329–343.

Jawale, K. V. (2012). Methods of sampling design in the legal research: Advantages and disadvantages. *Online International Interdisciplinary Research Journal*, 2(6), 183-190.

Kagashe, G. A. B. and Honest, G. (2013), Knowledge and Use of Contraceptives among Secondary School Girls in Dar es Salaam Tanzania, *Journal of Applied Pharmaceutical Science*, 2013, 3 (01): 066-068.



Kane, Thomas T., Rose De Buyscher, Tunde Taylor-Thomas, Tamara Smith, and Momoidou Jeng. (1993). "Sexual activity, family life education, and contraceptive practice among young adults in Bajul, The Gambia." *Studies in Family Planning* 24,1: 50–61.

Khoury, M. (1983). "The problem of sex behavior and fertility control in Lebanon with special reference to Lebanese youth." Unpublished.

Khraif, R., Abdul, A., Abdullah, S., Ibrahim, M., Ajumah, E. (2017). Dynamics of contraceptive use: A study of King Saud University women staff, Riyadh. *Middle East Fertility Society Journal*. 22(1), 18-26.

Kinaro, J., Kimani, M., Ikamari, L. and Ayiemba, E. H. O. (2015), Perceptions and Barriers to Contraceptive Use among Adolescents Aged 15 - 19 Years in Kenya: A Case Study of Nairobi. *Health*, 7, 85-97.

Kinaro, J., Kimani, M., Ikamari, L. and Ayiemba, E. H. O. (2015), Perceptions and Barriers to Contraceptive Use among Adolescents Aged 15 - 19 Years in Kenya: A Case Study of Nairobi. *Health*, 7, 85-97.

Kohler, Hans-Peter, and Jere R. Behrman (2014). *Benefits and Costs of the Population and Demography Targets for the Post-2015 Development Agenda: Post-2015 Consensus*. Working Paper as of 3 October 2014. Available at: http://www.copenhagenconsensus.com/sites/default/files/population_assessment_-_kohler_behrman_0.pdf.

Kost, K., & Henshaw, S. (2012). *US teenage pregnancies, births and abortions, 2008: national trends by age, race and ethnicity*. New York: Guttmacher Institute



Kumah, Opiah Mensah, Dan Odallo, Corinne Shefner, N. Muturi, J. Karueru, F. Gachanja, and M. Mwanzia. 1992. Kenya Youth IEC Needs Assessment: Nov. 15–28 Trip Report. Baltimore: Center for Communications Programs.

Kyilleh, J. M., Tabong, P. T. N., & Konlaan, B. B. (2018). Adolescents' reproductive health knowledge, choices and factors affecting reproductive health choices: a qualitative study in the west Gonja District in northern region, Ghana. *BMC International Health and Human Rights*, 18(1), 6.

Lincoln, Y. S., & Guba, E. G. (2000). The only generalization is: There is no generalization. *Case Study Method*, 27–44.

Liu, Z., Zhu, M., Dib, H. H., Li, Z., Shi, S., & Wang, Z. (2011). RH knowledge and service utilization among unmarried rural-to-urban migrants in three major cities, China. *BMC public health*, 11(1), 74.

London Summit on Family Planning (2012). Available at: <http://www.who.int/workforcealliance/media/events/2012/LondonSummitonFamilyPlanningOverview.pdf>.

Longwe, A., Huisman, J. and Smits, J. (2012), Effects of Knowledge, Acceptance and Use of Contraceptives on Household Wealth in 26 African Countries, NiCE Working Paper 12-109.

Lynn M Atuyambe¹, Simon P S Kibira, Justine Bukenya, Christine Muhumuza, Rebecca R Apolot, and Edgar Mulogo. (2015). Understanding the sexual and reproductive health needs



of adolescents: evidence from a formative evaluation in Wakiso district, Uganda. Open Access. Reproductive Health

Machel, J. Z. (2001), Unsafe Sexual Behaviour among Schoolgirls in Mozambique: A Matter of Gender and Class. *Reproductive Health Matters*, 2001; 9(17):82–90.

MacKian S. (2003) A review of health-seeking behavior: problems and prospects. Health Systems Development Programme.

MacLean, L. M. (2010). *Informal Institutions and Citizenship in Rural Africa: risk and reciprocity in Ghana and Côte d'Ivoire*. Cambridge University Press.

Maclean, R. (2016). *High birth rates and poverty undermine a generation of African children Report*. Retrieved from <https://www.theguardian.com/global-development>.

Magadi, M. (2006), Poor Pregnancy Outcomes among Adolescents in South Nyanza Region of Kenya. *African Journal of Reproductive Health*, 2006, 10(1), 26–38.

Maly, C., McClendon, K. A., & Baumgartner, A.(2017). Perceptions of adolescent pregnancy among teenage girls in Rakai, Uganda. *Global Qualitative Nursing Research*.

McCauley, Ann P., and C. Salter. 1995. "Meeting the Needs of Adults." In *Population Reports Series J: No. 41*. Baltimore: Johns Hopkins School of Public Health, Population Information Program.

Meekers, Dominique, Anastasia Gage, and Zhan Li. 1995. "Preparing adolescents for adulthood: Family life education and pregnancy-related school expulsion in Kenya." *Population Research and Policy Review* 14, 1: 91–110.

Millennium Development Goals Indicators. (2015). Available at: <http://mdgs.un.org/unsd/mdg/Data.aspx>. Retrieved 10 August 2015.



Ministry of Gender, Children and Social Protection (2018). Retrieved on 25 May 2020, <https://www.mogcsp.gov.gh/meet-the-press-2018/>

Ministry of Health (2007). *National Health Policy. Creating Wealth Through Health*. September 2007. Available at: http://www.moh-ghana.org/UploadFiles/Publications/NATIONAL%20HEALTH%20POLICY_22APR2012.pdf.

Ministry of Health. (2014). *Holistic Assessment of the Health Sector Programme of Work 2013*. Ghana. Final version July 2014. Available at: <http://www.moh-ghana.org/UploadFiles/Publications/Holistic%20Assessment%20Report%20June%202014140811072318.pdf>.

Moyer CA, Adongo PB, Aborigo RA, (2014) "It's up to the woman's people": how social factors influence facility-based delivery in Rural Northern Ghana. *Maternal and child health journal*. 18(1):109–119.

Mueller, K.E. and W.G. Powers. (1990). "Parent-child sexual discussion: Perceived communicator style and subsequent behavior." *Adolescence* 25, 98: 468–482.

Mwase I. (2015) *Social capital and household health-seeking behavior for children in the context of urban neighborhoods. The case of Khayelitsha in Western Cape, South Africa*: University of Cape Town.

National Population Council (2015). *Health Policy Project (HPP). RAPID: The Change We Seek*. Available https://www.healthpolicyproject.com/pubs/154_GHANARAPIDBookletFINAL.pdf.



- Ngome, E. and Odimegwu, C. (2014), The Social Context of Adolescent Women's Use of Modern Contraceptives in Zimbabwe: A Multilevel Analysis. *Reproductive Health* 11:64.
- Noumsi, J. J. (2013). *Socioeconomic status and knowledge of sexually transmitted infections and pregnancy risk factors among Ghanaian Adolescents* (Doctoral dissertation, Walden University).
- Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. (2011). *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS)*. Accra: Population Council.
- Nyarko, S. H. (2015), Prevalence and Correlates of Contraceptive Use among Female Adolescents in Ghana. *BMC Women's Health* (2015) 15:60.
- Olenja J. (2004) Editorial Health seeking behavior in context. *Performance Monitoring and Accountability* (Available at: <http://www.pma2020.org/about-fp2020>)
- Onasoga, O. A., Afolayan, J. A., Asamabiriwei, T. F., Jibril, U. N., & Imam, A. A. (2016). Adolescents' knowledge, attitude and utilization of emergency contraceptive pills in Nigeria's niger delta region. *International Journal of MCH and AIDS*, 5(1), 53.
- O'Rourke-Suchoff, D. K., Arora, K. S., Hildebrand, V. M., & Singer, M. E. (2017). Exploring maternal attitudes towards adolescent contraception: implications for use of LARC. *International Journal of Adolescent Medicine and Health*, 30(6).
- Paluku, L.J., Mabunza, L.H. & Maduna, P.M.H. (2009) Knowledge and attitude of schoolgirls about illegal abortions in Goma, Democratic Republic of Congo. *African Journal of Primary HealthCare & Family Medicine* 2, Art.# 78 doi: 10.4102/phcfm.v2i1.78.



- Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: <http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf>.
- Phiri, S. N. A., Kiserud, T., Kvåle, G., Byskov, J., Evjen-Olsen, B., Michelo, C., ... & Fylkesnes, K. (2014). Factors associated with health facility childbirth in districts of Kenya, Tanzania and Zambia: a population based survey. *BMC pregnancy and childbirth*, 14(1), 219.
- Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47(11), 1451–1458.
- Population Council. (1991). Senegal Project Measures of Quality of International Exchanges in Family Planning Clinics. Africa OR/TA Project Update. New York: Population Council, Pp. 1–2.
- Profetto-McGrath, J., Polit, D. F., & Beck, C. T. (2010). *Canadian essentials of nursing research*. Lippincott Williams & Wilkins. Publishers Ltd, Kampala Uganda 2nd Edition, 1-26.
- Rakhi, J. & Sumathi, M. (2012). Contraceptive Methods: Needs, Options and Utilization. *J Obstet Gynaecol India*. 61(6): 626–634.
- Razak, A. A. (2016). *Factors influencing non-use of modern contraceptives among adolescents in the Sunyani municipality* (Master of Public Health Degree). Retrieved from ugspace.ug.edu.gh/handle/123456789/21151



Richey, L.A. (2008) Population Politics and Development: From the Policies to the Clinics.

Fountain

Rosenstock IM. (2005) Why people use health services. *Milbank Quarterly*. 83(4)

Rourke, K. Suchoff, K., Arora, S., Vanessa M. (2015). Exploring maternal attitudes towards adolescent contraception: implications for use of LARC. *International Journal of Adolescent Medicine and Health*, DOI: <https://doi.org/10.1515/ijamh>

Rutstein SO (2005). Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys. *Int J Gynaecol Obstet*; **89**: S7–S24.

Sajid, A., & Malik, S. (2010). Knowledge, attitude and practice of contraception among multiparous women at Lady Aitchison Hospital, Lahore. *Annals of King Edward Medical University*, 16(4), 266-266.

Sawyer, M. Azzopardi, S. Wickremarathne, D. Patton, G.(2018). The age of adolescence. *Lancet Child Adolesc Health*. [https://www.DOI:https://doi.org/10.1016/S2352-4642\(18\)30079-8](https://www.DOI:https://doi.org/10.1016/S2352-4642(18)30079-8). 2: 223- 228

Schuler, S. R., Rottach, E., & Mukiri, P. (2011). Gender norms and family planning decision-making in Tanzania: a qualitative study. *Journal of Public Health in Africa*, 2(2).

Sharma, G. (2017). Pros and cons of different sampling techniques. *International journal of applied research*, 3(7), 749-752.

Sharp, M. (2018). *Define adolescence. Health guidance for better health*. Retrieved from <http://www.healthguidance.org/entry/10115/1/defineadolescence.html>.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects.



Education for Information, 22(2), 63–75.

Shriver, E. K. (2013). *National institute of child health and human development. Health research through life span*. <http://www.nichd.nih.gov/health/topic/> contraception.

Skrzeczowska, A., Heimrath, J., Surdyka, J., & Zalewski, J. (2016). Knowledge of contraceptive methods among adolescents/young adults. *Polish Journal of Public Health*, 125(3), 144-148. doi:10.1515/pjph-2015-004

Smits LJ, Essel GG (2001). Short interpregnancy intervals and unfavorable pregnancy outcome: role of folate depletion. *Lancet*; **358**: 20, 74–77.

Snow, Rachel, Christopher, H. Herbst, David Haddad, Janet Kwansah, James Antwi, and Victor Francis Ekey. (2013). *Toward Interventions in Human Resources for Health in Ghana*. March 2013. Available at: http://elibrary.worldbank.org/doi/abs/10.1596/9780821396674_CH03.

Solo, J., et al. (2005). *Repositioning Family Planning—Ghana Case Study: ‘Give them the Power.’* Engender Health; The ACQUIRE Project. New York.

Solomon-Fears, C. (2015), Teenage pregnancy prevention: Statistics and programs, Congressional Research Service. <http://www.fas.org/sgp/crs/misc/RS20301.pdf>.

Speziale, H. J. S., & Carpenter, D. R. (2007). Action research method. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, 327–348.

Suneth B Agampodi, Thilini C Agampodi and Piyaseeli UKD (2008). Adolescents’ perception of reproductive health care services in Sri Lanka, *BMC Health Services Research* 2008, **8**:98 doi: 10.1186/1472-6963-8-98

Sustainable Development Goals (2015). *Open Working Group Proposal for Sustainable Development Goals*. Available at: <https://sustainabledevelopment.un.org/sdgsproposal>.



Tayo, A., Akinola, O., Babatunde, A., Adewunmi, A., Osinusi, D. and Shittu, L. (2011),
Contraceptive Knowledge and Usage amongst Female Secondary School Students in
Lagos, Southwest Nigeria, *Journal of Public Health and Epidemiology* Vol. 3(1), 34-37.

Teffo, M. E. (2019). *Exploring psychosocial issues and coping strategies of health care
providers at termination of pregnancy services in two South African provinces* (Doctoral
dissertation).

TFR and MCPR: Benin: 2011–12 DHS, Burkina Faso: 2010 DHS; Cote d'Ivoire: 2011–12 DHS;
Ghana: 2014 DHS; Guinea: 2012 DHS; Liberia: 2013 DHS; Mali: 2012–13 DHS; Niger:
2012 DHS; Nigeria: 2013 DHS; Senegal: 2010–11 DHS; Sierra Leone: 2013 DHS. ICF
International. 2015. *The DHS Program STATcompiler*. Available at:
<http://www.statcompiler.com>.

Tylee A, Haller DM, Graham T, Churchill R, Sanci LA. Youth-friendly primary-care services:
how are we doing and what more needs to be done? *Lancet*. 2007;369(9572):1565–73.

UNAIDS (2011) Report on the Global AIDS Epidemic, 2011. Geneva.

UNFPA Annual Report (2001). Retrieved on 15 November 2019,
<https://www.unfpa.org/publications/unfpa-annual-report-2001>

UNFPA (2003) The State of World Population 2003. Making 1 Billion Count: Investing in
Adolescents' Health and Rights. Geneva, United Nations Population Fund (UNFPA).

UNFPA: Generation of Change: Young People and Culture. Youth Supplement to UNFPA's
State of the World Population Report New York 2008.

United Nations Population Fund (UNFPA). 1993. Parent Education. New York: UNFPA.



United Nations Population Fund [UNFPA] (2005) State of the World Population 2005: The Promise of Equality, Gender Equity, Reproductive Health and the Millennium Development Goals.

USAID/ DELIVER PROJECT, Task Order I. (2011). *Ghana: Market Segmentation Analysis*. Available http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/GH_MarkSegm.pdf.

Valenzuela, M.S., J.M. Herold, and Leo Morris. (1989). Encuesta de Salud Reproductiva en Adultos Jóvenes: Gran Santiago—1988. Informe final. [Young Adults Reproductive Health Survey, Santiago, Chile— 1988. Final information.] Santiago: University of Chile, Department of Public Health.

Vijay OA (2003). Reproductive health problems of female Adolescents-an overview in Pediatric and Adolescent Gynecology. New Delhi: Jaypee Brothers New Delhi;. p. 206–16.

Webair HH, Bin-Gouth AS. (2013) Factors affecting health-seeking behavior for common childhood illnesses in Yemen. *Patient Preference & Adherence*.

Whitaker, A. K., and Gilliam, M. (2008), Contraceptive Care for Adolescents, *Clinical Obstetric Gynaecology*, 51, 268–280.

WHO (2011). *WHO Guidelines: Preventing Early Pregnancy and Poor Reproductive Health Outcomes amongst Adolescents in Developing Countries*. Available at: <http://www.who.int/reproductivehealth/publications/adolescence/9789241502214/en/>.

Worku AG, Yalew AW, Afework MF. (2013) Maternal complications and women's behavior in seeking care from skilled providers in North Gondar, Ethiopia. *PLoS One*. 8(3):e60171.

World Health Organisation (2003), Preparing for Adulthood: Adolescent Sexual and Reproductive Health, *Progress in Reproductive Health Research*, 64, 1-2.



World Health Organisation (2014). Health for the World Adolescents A second Chance in the Second Decade. Geneva: World Health Organisation

World Health Organization (2014): Health topics. Adolescent Health.
www.who.int/topics/adolescent_health/en/

WorldHealth Organisation (2018). *Adolescent health*<http://www.who.int/topics/adolescenthealth/en/>www.who.int/mediacentre/factsheets/fs364/en/

Yidana, A., Ziblim, A., & Abass, Y. (2015). Socio-cultural determinants of contraceptives use among adolescents in Northern *Ghana Public Health Research*. 5(4), 83-89.

Yidana, A., Ziblim, S., Azongo, T. B. and Abass, Y. I. (2015), Socio-Cultural Determinants of Contraceptives Use among Adolescents in Northern Ghana, *Public Health Research* 2015, 5(4), 83-89.

Zgambo, M., Kalembo, F. W., & Mbakaya, B. C. (2018). Risky behaviours and their correlates among adolescents living with HIV in sub-Saharan Africa: a systematic review. *Reproductive health*, 15(1), 180.



APPENDICE

APPENDIX A

QUESTIONNAIRES

SOCIO-DEMOGRAPHICS OF RESPONDENTS

1. Which age bracket do you belong?

12-15 16-19 20+

2. What religion do you belong?

Orthodox Christian Protest M n ers,
specify.....

3. What is your ethnic group?

Dagbani Bimob Ha h rs,
specify.....

4. What is your marital status?

Married Unmarried Divorced Single

5. What is your educational status

Primary JHS SHS Tertiary No education Others
specify.....

6. What is your Mother's Educational Status?

Primary JHS SHS Tertiary No education Others
specify.....



7. What is your Father's Educational Status?

Primary JHS SHS Tertiary No education Others

specify.....

8. What is your family income in GH¢?

Below 150 150-499 500-999
1000-1499 1500 above

9. How many children do you have?

One Two Three and above None

10. Are you a worker?

Yes No

11. Do you have any health insurance?

Yes No

Knowledge regarding Family Planning services

1. What immediately comes to mind when you hear the term family planning or contraceptive methods.....

2. Are there any source of family planning education in your community?

3. Yes No

4. If yes, which form of education do you receive? 1. Contraceptive usage 2. Sex education
3. Early marriage 4. GBV 5. Others specify

5. What contraceptive methods do you know could be used to avoid or delay pregnancy?

OCP Injectable Implant IUCD Withdrawal

Others specify.....

6. What are the benefits or advantages of using contraceptives as an adolescent?



1. Birth control 2. Healthy life 3. Early education 4. Prevention of STIs 5. Prevention of unwanted pregnancy 6. Others

7. In your opinion what are the negative effects or disadvantages of family planning?

1. Bareness 2. It is against my religion 3. Leads to obesity 4. Menstrual problems
5. Others

8. Have you heard of any traditional methods for delaying or avoiding pregnancy in this community? Yes No

If yes, specify

9. In your opinion, which family planning method is more effective?

OCP Injectable Implant IUCD Withdrawal

Others specify.....

9x. Give reasons for your answer

10. Where can you access family planning contraceptives in this community?

1. Community clinic/hospital 2. Drug store 3. Drug peddlers 4. Family member 5. Friends
6. others

11. Which of the above service providers do you think adolescents in this community patronize?

1. Community clinic/hospital 2. Drug store 3. drug peddlers 4. Family member
5. Friends 6. others

12. Do you think youth or adolescents should have access to contraceptives? Yes No

13. Explain your answer in above

14. Are family planning services easily accessed by all adolescents in this community?



Yes No

15. What is the attitude of providers towards adolescents in contraceptive delivery in this community? Very Good Good Moderate Bad Very Bad

16. Have you ever been turned back/ refused family planning service at any time of the day or for any reasons? Yes No

17. If yes what was the reason.....

18. What are the reasons why some adolescents in this community do not patronize family planning services? 1. Little education among adolescent 2. Attitudes of service providers
3. Inadequate contraceptives 4. Religion 5. Traditional belief 6. Financial challenges
7. Others

19. Does your religion/ culture act as a barrier to family planning service in this community?

Yes No

20. What measures can be taken to improve family planning uptake in this community?

1. Adolescent health education 2. Availability of family planning services 3. Educate service providers
4. Household empowerment 5. Community sensitization on FP
6. Others

21. Should contraception be encouraged or discouraged among adolescents in this community?

Encouraged Discouraged Don't know

22. Are you using any contraceptive methods now? Yes No

23. Did you use any method of contraception before pregnancy? Yes No

24. Who and how it is decided which type of family planning method you should use.

Husband Mother Self Friend Sister



25. Have you discussed about the family planning with your husband and family members?

Yes No

26. Did you talk about family planning with health care provider before and after the pregnancy?

Yes No



APPENDIX B

FOCUS GROUP DISCUSSION (FGD) GUIDE

1. How do you consider family planning?
2. Have you had any family planning contraceptive problems recently?
3. What did you do when you needed help on family planning the last time?
4. How do you decide for family planning?
5. What do you think about the facilities available when in need of family planning service?
6. Did you have any discomforts related to family planning while reaching out to the healthcare facility?
7. Do you have to pay for the family planning service?
8. What is your impression about staff's treatment on family planning service when you seek for it?
9. Will you go to the health facility next time when you need family planning service?
10. Are you using any contraceptive methods now for family planning?
11. Did you use any method of contraception before pregnancy?



APPENDIX C

INTERVIEW GUIDE FOR KEY INFORMANT INTERVIEW

1. Do you know about any family planning (FP) policy in Ghana? (please tell me about it)
2. Please tell me about FP services in this facility? (probe for type of services available, the commonly sought after service)
3. What is the primary objective of FP in this facility and who initiated it?
4. How did local leaders, religious leaders and family heads felt about the facility providing FP services?
5. What are they saying about it now?
6. Do you organize health education to encourage patronage of FP services? (If yes, probe for the kind of education given and the target audience).
7. Do adolescents seek FP services? (if yes, probe for the kind of service adolescents mostly come in for; if no, why are they not seeking FP services).
8. Do you provide counseling before rendering these services?(if yes, how is the counselling done, what are they counselled about)
9. Are FP services to adolescents integrated with other health services? (probe for kind of services)
10. How often do adolescents do adolescents seek FP services?
11. How do you ensure their privacy while seeking for such services? (Do you have adolescent friendly corners)
12. Are FP services free to adolescents? (probe for the cost of the services, are they able to completely pay for such services, are there any flexible payment options for those who cannot readily afford?)



13. What barriers do you encounter in rendering such services?

14. How do you address such barriers?

15. Is there anything you want to add?

Thank you



APPENDIX D

UNIVERSITY FOR DEVELOPMENT STUDIES
School of Medicine and Health Sciences
(Department of Community Health and Family Medicine)

Tel : 03720 - 93295
E-Mail :
Local : 5:7811/106.15
Internet: www.uds.edu.gh



Post Office Box TL 1883,
Tamale, Ghana, West Africa.

10/03/2020

Office of the Head

The Chairperson
Institutional Review Committee
University for Development Studies
Tamale,
Northern Region

LETTER OF INTRODUCTION

I write to introduce to you Miss Kuseh Jemima Bamuri, a second-year Master of Public Health student in the Department of Community Health and Family Medicine, School of Medicine and Health Sciences. As part of the requirement, Ms Kuseh, is expected to write and submit a well-written thesis to the Department as part of the requirements for graduation. As part of the process, Ms Kuseh is applying to your committee for ethical clearance on the topic: *Health seeking behaviours of Adolescents towards Family Planning Services in Tamale Metropolis*. I would be very grateful if you could assist her by way of ethical clearance to enable her execute this project to a successful end.

Thank you very much.


Yidana Adadow (PhD)
(HoD, CH&FM)



APPENDIX E

GHANA HEALTH SERVICE

Core Values

1. People Centered
2. Professionalism
3. Team Work
4. Innovation
5. Discipline
6. Integrity



METRO. HEALTH DIRECTORATE
GHANA HEALTH SERVICE
P.O. BOX TL. 1191,
TAMALE

23RD MARCH, 2020

Tel: 233 - 71: 23765
Fax: 233 - 71: 23765

My Ref No: GHS/MHD/
Your Ref No:

THE SUB-DISTRICT HEADS

- BILPEILA HEALTH CENTRE
- VITTIN HEALTH CENTRE
- NYOHINI HEALTH CENTER
- TAMALE CENTRAL HEALTH CENTRE

Dear Sir/Madam,


LETTER OF INTRODUCTION TO UNDERTAKE A RESEARCH

This is to introduce Miss Kuseh Jemima Bamuri a Master of Public student of School of Medicine and Health Sciences, University for Development Studies that, wish to conduct a research on the topic "**Health Seeking Behaviours of Adolescents towards Family Planning Services in Tamale Metropolis.**"

She has been given approval to undertake a research at your facility.

Please kindly accord her the needed assistance and support.

Thank you.


DR. FRANCIS SOAH ALI
(METRO. DIRECTOR OF HEALTH SERVICES)

