

Original Research Article

Factors Influencing the Utilisation of Contraceptives among Adolescents in the Tamale Metropolis.

Abstract

Background: Adolescent sexual and reproductive health is supreme to healthy living, and because the health of adolescents is of importance, it has compelled most countries across the globe to put up appropriate measures to meet their needs. The main objective of the study was to assess the factors influencing the utilisation of contraceptives among adolescents in the Tamale Metropolis.

Methods: The study employed the community base cross-sectional study. The study recruited 374 adolescents using a using the multi-stage sampling technique. Data was analyzed using SPSS version 25. A p-value < 0.05 was considered statistically significant.

Results: The majority (92.8%) of the adolescents have heard about contraceptives. Half of the respondents have had sex before, with only 29.4% reported to have used contraceptives in the past. Only 30.7% of the respondents feels the service providers were friendly to them, the majority (60.2%) of the study participants feel that the health workers did not respect their privacy during their visit. Over half (51.1%) of the respondents were unsatisfied with the location where contraceptive services are rendered. The majority (82.9%) of the study participants cannot discuss contraceptives issues freely with their parents. The study established a significant association between usage of contraceptives and age ($P < 0.001$), level of education ($P < 0.001$), marital status ($P < 0.001$).

Conclusion: The majority of respondents were sexually active, although contraception use was low in comparison to the teens' high awareness level. Factors such as poor attitudes of health workers, poor accessibility and availability of contraceptives and lack of parental concern have to be addressed by key stakeholders' engagement to holistically address adolescents sexual and reproductive health concerns in the metropolis.

Keywords: Contraceptives, Adolescents, Utilisation, Pregnancy

Introduction

Adolescents according to World Health Organisation (WHO), are the ages between 10-19 years, WHO is conscious that adolescence is a chapter in an individual's life, and cannot therefore, be regarded as an immovable period[1]. Adolescence is a transition period from childhood to adult life during which pubertal development and sexual maturation take place [2]. Issues regarding Reproductive health and Family Planning (FP) services are of great concern to both developed and underdeveloped countries [3]. From the foregoing, issues of family planning have been views of global concern especially in countries with higher fertility rates [4,5]. The majority of women within the ages of 15 to 49 (1.1 out 1.9 billion) have some need for family planning; of the 1.1 billion, eight hundred and forty-two (842) million are using family planning methods, but some two hundred and seventy (270) million have an unmet need for family planning [6,7]. Thus, the 270 million women between the ages of 15 to 49 would have the wish to use a family planning method but have not had access to the methods. The use of contraception advances the human right of people to determine the number and spacing of their children[8,9].

In most developing countries, the focus of Family Planning services had always targeted females in the urban due to the low human resources at the health center [10]. In sub-Saharan Africa (SSA), up to 25% of adolescent girls drop out of school due to unintended pregnancies. This somehow explains partly the reason for high poverty rates in most developing countries [11]. The patronage of family planning methods is proved to avert unsolicited, unintended pregnancies, decrease the rate of abortions and incidence of Sexually Transmitted Infections (STIs), as well as avoid maternal and child death, which is central to meeting Sustainable Development Goal 3 [12].

The use of modern contraceptives has seen a significant increase in most part of the globe, especially in Asia and Latin America[4]. In sharp contrast, the usage of family planning in sub-Saharan Africa continues to be low [13–16]. Hagan & Buxton [17] have shown that adolescent reproductive health and teenage pregnancy require urgent public health attention as it is related to maternal and infant mortality together with other adverse fetal birth outcomes. However, we must be specific in providing adolescent reproductive healthcare and education, since couples and unmarried adolescents tend to hold different views to pregnancy, childbearing and sexually transmitted infections [18]. Pregnancies among single adolescent mothers are often accidental, unplanned and unintended and end in unsafe abortion with serious health implications[19,20]. Over 90% of the maternal mortality and morbidity are associated with

unsafe abortion[13,21,22]. This could be avoided if contraceptive services were made readily available in most developing countries

Ghana is met with higher rates of teenage pregnancies, unsafe abortions, low contraceptive use, early parenthood and low level of formal education among the youth [23]. A study conducted in Northern Ghana by Yidana et al., [24] revealed that a higher total fertility rate of about 6.8 children per woman, and the influence of teenage pregnancy on these rates cannot be disregarded. Hence, if adolescents continue to have sex intimacy without the use contraceptives, this will eventually result to higher pregnancies. Such pregnancies may end up with unsafe abortions or teenage childbearing which come with their attendant problems. Gumanga and colleagues (2011) showed that abortion complications were the major cause of death among young women. In the Tamale Teaching Hospital, unsafe abortion is the fourth leading cause of maternal mortality with most of the deaths occurring between the ages of 15-34 years [25]. Studies conducted in the northern part of Ghana often record very low utilisation of contraceptive methods [18,24,26–28]. Though, low contraceptives usage is often reported, efforts are not made to understand the reasons feeding to the low utilisation of contraceptives. Also, most of these studies often recruit only females. The current study will focus on both males and females. As such the current study aims at assessing the factors influencing utilization of contraceptives among adolescents in the Tamale Metropolis.

Methodology

Study Setting

The Study was conducted in the Tamale Metropolis. The Tamale Metropolis was established by legislative instrument (LI 2068) which elevated the then Municipal Assembly into a Metropolis in 2004. It has Tamale as the Metropolitan capital city and at the same time the regional capital of the Northern Region. Geographically, the Metropolis lies between latitude 9°16 and 9° 34 North and longitudes 0° 36 and 0° 57 west.

Study Design

A community based cross-sectional study was used with the quantitative approach for this study. The cross-sectional design was used because it permits the investigators to collect information at a single spot at a time [29].

Study Population

The study population involved adolescents (10-19 years) residing within the Tamale Metropolis.

Inclusion and exclusion criteria

The study involved adolescents between the age of 10 and 19 years residing in the Tamale metropolis. Adolescent who refuses to consent voluntarily and those who were within the Metropolis but not of sound mind were excluded from participating in the study.

Sample size

The sample size was computed using the Snedecor & Cochran [30] formula for a point estimate sample;

$$N = \frac{z^2 \cdot p(1-p)}{m^2}$$
; N= sample size, z = z- score of a 95% confidence level (5% significance level) of the study equivalent to 1.96, p = no similar study exists on the same topic in the region. Utilisation of modern contraceptive methods among adolescents in Yendi Municipality is 36.3% [18]. Hence p = 36.3% (0.363) in this study. Thus, the calculated sample size was approximately 356. Using 5% as non-response rate, the sample size was rounded up to 374 adolescent males and females.

Sampling Procedure

The study used a multi-stage sampling technique. At the first stage, 10 communities were selected from the 31 communities in Tamale Metropolis using randomization with the aid of Microsoft excel. Random numbers will be assigned to each community and then the first 10 community on the excel sheet were selected. At the second stage, for each of the 10 communities selected at random, adolescents (i.e., both boys and girls) were recruited using convenience sampling technique.

Data Analysis

Data was coded and analyzed using statistical package for social sciences (SPSS) software version 25. Descriptive and inferential statistic and results were displayed using tables and figures. Chi square analysis was used to compare categorical variables and a p-value < 0.05 was considered statistically significant.

Ethical Approval

Ethical approval was sought from the Ghana Health Service through the metropolitan health directorate. Approval was also sought from the chiefs of the various communities since they are the custodians of the

land. Informed consent was sought both verbally and written from all respondents who were involved in this study.

Results

Socio-Demographic Characteristics

The study recruited 374 adolescents. Majority (79.4%) of the respondents were females, 71.9% of the respondents were within the ages of 16 to 19 years. The majority of the respondents (87.7%) were singles, slightly over half (50.5%) were at the Senior High School (SHS). On the level of education of parents, most of the mothers (28.6%) had SHS education whilst most (42.2%) of the father (42.2%) had tertiary education. The majority (48.4%) of the respondents' mothers were unemployed compare to 23.0% of fathers who were unemployed at the time of the study. More fathers (35.8%) were self-employed as compared to the 35.6% of the mothers being self-employed (Table 1).

Table 1: Socio-demographic characteristics

| Variables | Categories | Frequency (%) |
|---------------------------------|----------------|---------------|
| Age | 10 to 15 years | 105(28.1) |
| | 16 to 19 years | 269(71.9) |
| Respondent's level of education | No education | 5 (1.3) |
| | Primary | 56 (15) |
| | JHS | 93 (24.9) |
| | SHS | 189 (50.5) |
| | Tertiary | 31 (8.3) |
| | | |
| Gender | Females | 297 (79.4) |
| | Males | 77 (20.6) |
| Marital Status | Single | 328 (87.7) |
| | Cohabiting | 13 (3.5) |
| | Married | 33 (8.8) |
| Religion | Christian | 135 (36.1) |
| | Muslim | 230 (61.5) |
| | Traditionalist | 9 (2.4) |
| Mother's level of education | No education | 66 (17.6) |
| | Primary | 69 (18.4) |
| | JHS | 64 (17.1) |
| | SHS | 107 (28.6) |
| | Tertiary | 68 (18.2) |
| | | |

| | | |
|-----------------------------|-------------------------|------------|
| Father's level of education | | |
| | No education | 44 (11.8) |
| | Primary | 25 (6.7) |
| | JHS | 62 (16.6) |
| | SHS | 85 (22.7) |
| | Tertiary | 158 (42.2) |
| Mother's Job | | |
| | Private sector employee | 8 (2.1) |
| | Public sector employee | 52 (13.9) |
| | Self employed | 133 (35.6) |
| | Unemployed | 181 (48.4) |
| Father's Job | | |
| | Private sector employee | 41 (11) |
| | Public sector employee | 113 (30.2) |
| | Self employed | 134 (35.8) |
| | Unemployed | 86 (23) |

Knowledge and practice of contraceptives among respondents

The majority (92.8%) of the adolescents have heard about contraceptives. The source of information includes; the health worker (31.9%), media (TV, Radio, Internet) (27.7%), friends (19.3%), school/teacher (17.6%) and relatives (3.5%). More than half (52.1%) believed contraceptives could be obtained from the hospital. More than half (52.1%) of the respondents cannot get contraceptives in their area. Exactly half (50%) of the respondents have had sex intimacy before, with only 29.4% used some form of contraceptives in the past. Only (20.3%) of respondents were currently using some forms of contraceptives. However, most of the respondents (35.3%) preferred male condoms, 26.1% will prefer injectable whilst 0.3% prefer female condoms (Table 2).

Table 2: Knowledge and practice of contraceptives among respondents

| Variables | Categories | Frequency | Percentage |
|--|---------------------------|-----------|------------|
| Have you heard about contraceptive? | | | |
| | Yes | 347 | 92.8 |
| | No | 27 | 7.2 |
| Sources of Information on contraceptives (347) | | | |
| | School/Teacher | 61 | 17.6 |
| | Relatives | 12 | 3.5 |
| | TV/Radio/Internet | 96 | 27.7 |
| | Health Workers | 111 | 31.9 |
| | Friends | 67 | 19.3 |
| Where can contraceptive services be obtained? | | | |
| | Chemical Seller | 56 | 15.0 |
| | Hospital | 195 | 52.1 |
| | Reproductive Child Health | 95 | 25.4 |

| | | | |
|--|---------------|-----|------|
| | Supermarket | 1 | 0.3 |
| | Don't know | 27 | 7.2 |
| Can you get contraceptives in your area? | | | |
| | Yes | 179 | 47.9 |
| | No | 195 | 52.1 |
| Have you ever had sex? | | | |
| | Yes | 187 | 50.0 |
| | No | 187 | 50.0 |
| Did you use any form of contraceptives(N=187) | | | |
| | Yes | 110 | 58.8 |
| | No | 77 | 41.2 |
| Are you currently using any form of contraceptive? (N=187) | | | |
| | Yes | 76 | 40.6 |
| | No | 111 | 59.4 |
| What are your preferred contraceptive methods | | | |
| | Implants | 31 | 8.3 |
| | Injectable | 98 | 26.1 |
| | Pill | 27 | 7.2 |
| | Female condom | 1 | 0.3 |
| | Male Condom | 132 | 35.3 |
| | Withdrawal | 1 | 0.3 |
| | None | 84 | 22.5 |

Majority of the study participants (70.1%) knew Male condoms, 42.0% knew the injectable, 28.9% knew Lactation Amenorrhea, 38.5% knew the female condoms, 33.7% knew implants and pills, 19.3%, 13.6%, 22.2%, 17.4% and 25.4% knew about male sterilization, female sterilization, withdrawal methods, calendar methods and diaphragm as a contraceptive method respectively (Figure 1).

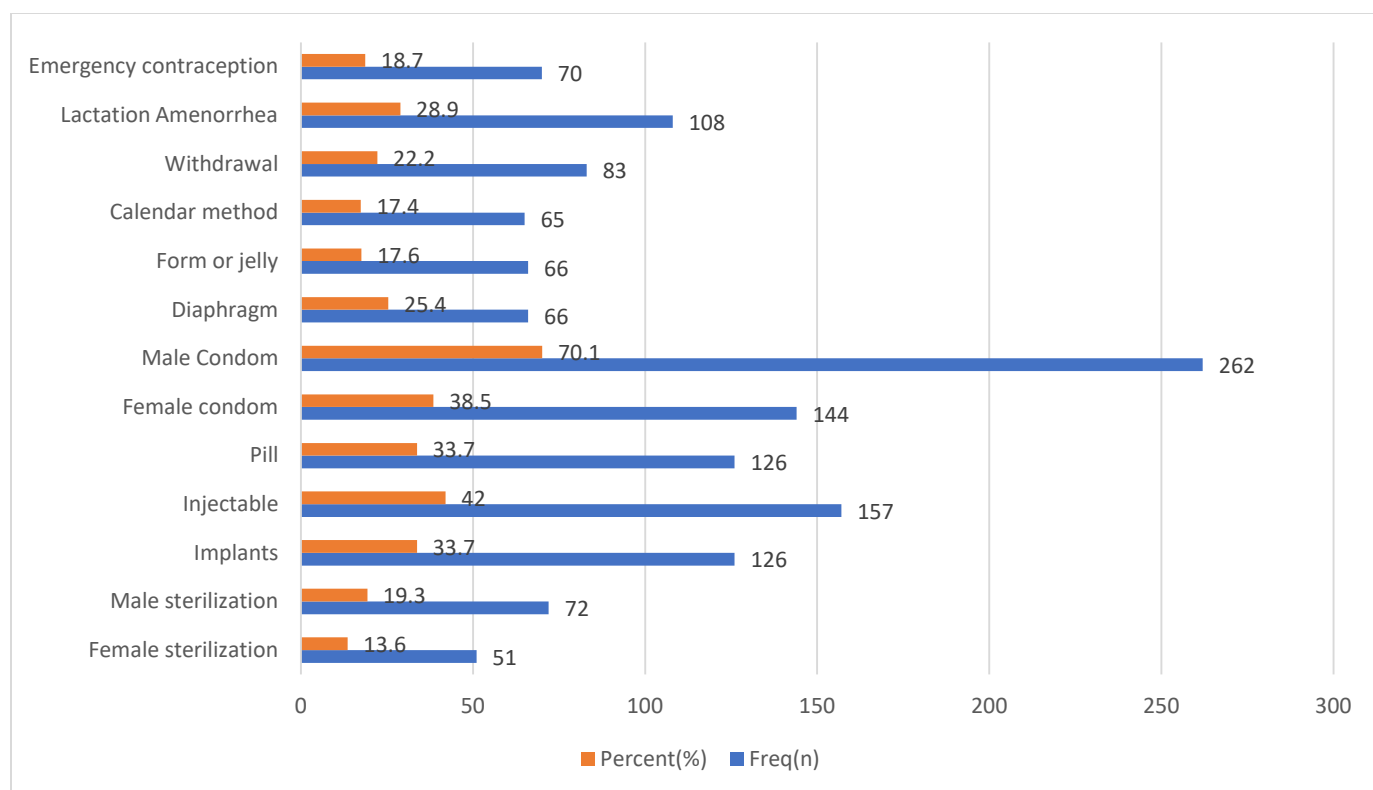


Figure 1: Awareness of contraceptives methods

Regarding the side effects associated with contraceptive usage, the following were identified; Weight gain 116 (31.0%), Excessive bleeding 143 (38.2%), painful periods 81 (21.7%), nausea/vomiting 117 (31.3%), dizziness 112 (29.9%), irregular menstrual period 62 (16.2%), palpitations 51(13.6%) and headache 110(29.4%) (figure 2).

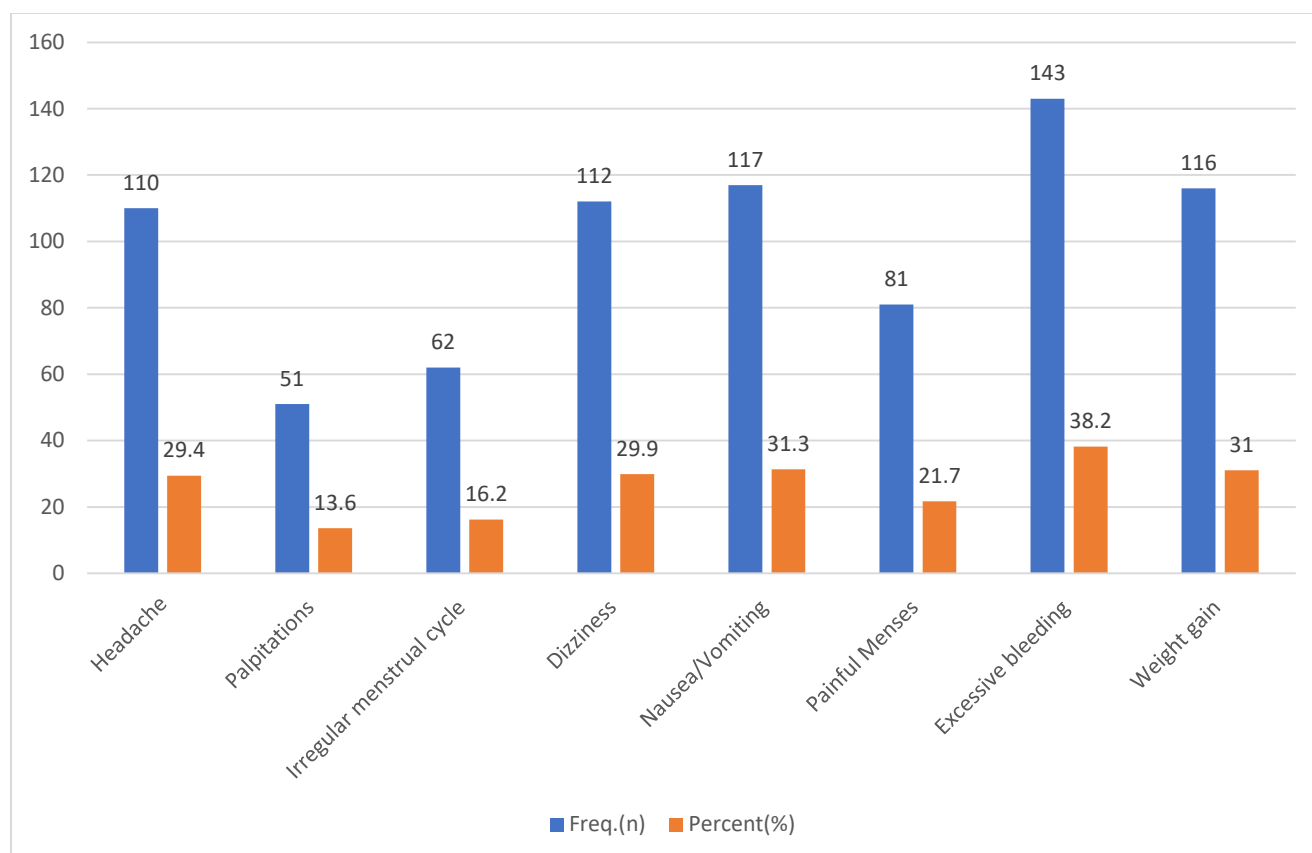


Figure 2: Side effects of contraceptive usage

Health System Factors affecting adolescent contraceptive usage

The majority (63.4%) of the respondents have patronized or knew someone who had patronized contraceptives, 51.1% believe they waited for a reasonable time before being attended to by the health worker. Only 30.7% of the study participants feels the service providers were friendly to them, the majority (60.2%) of the study participants feel that the health workers did not respect their privacy during their visit. Over half (51.1%) of the respondents were unsatisfied with the location where contraceptive services are provided. A total of 16 (4.3%) have been denied access to contraceptive services by a health worker. (Table 3)

Table 3: Health system factors affecting adolescent contraceptive usage

| Variables | Categories | Frequency | Percentage |
|--|------------|-----------|------------|
| Have you or someone patronized contraceptives in a health facility | | | |
| | Yes | 238 | 63.4 |

| | | |
|---|-----|-------|
| No | 136 | 36.4 |
| Did you or your friend wait responsible time before being seen by health workers (N=238) | | |
| Yes | 191 | 80.3 |
| No | 47 | 19.7 |
| Was the service provider friendly to you or your friend (N=238) | | |
| Yes | 115 | 48.3 |
| No | 123 | 51.7% |
| Did the health workers respect your privacy during the visit (N=238) | | |
| Yes | 149 | 62.6 |
| No | 89 | 37.4 |
| Describe the location where contraceptives services are rendered in the health facility (N=238) | | |
| Satisfaction | 29 | 12.2 |
| Unsatisfactory | 191 | 80.3 |
| Very satisfactory | 18 | 7.5 |
| Have you ever been denied access to contraceptives services by a health worker (N=238) | | |
| Yes | 16 | 6.7 |
| No | 222 | 93.3 |

Socio-Economic and Religious Factors affecting contraceptives usage.

The majority (82.9%) of the respondents cannot discuss contraceptive issues freely with their parents. On the challenges in accessing contraceptives, the following were identified; poor attitude of the staff (60.2%), none availability of some contraceptives (50.0%), distance to health facilities (44.9%), Stigma from society and peers (48.4%) and cost of contraceptives (42.5%). A total of 114(30.5%) of the respondents believe their religion support the use of contraceptives. The majority (63.6%) of the respondents will consider their religious beliefs in deciding the use of contraceptives (Table 4).

Table 4; Socio economic and religious factors affecting contraceptive usage

| Variables | Categories | Frequency | Percentage (%) |
|--|------------|-----------|----------------|
| Can you discuss contraceptive issues freely with your parent | | | |

| | | | |
|---|--|-----|------|
| | Yes | 64 | 17.1 |
| | No | 310 | 82.9 |
| Challenges in accessing contraceptives | | | |
| | Poor attitude of staff | 225 | 60.2 |
| | None availability of some contraceptives | 187 | 50.0 |
| | Distance to health facilities | 168 | 44.9 |
| | Stigma from society and peers | 181 | 48.4 |
| | Cost of contraceptives | 159 | 42.5 |
| Religious belief supports the use of contraceptives | | | |
| | Yes | 114 | 30.5 |
| | No | 123 | 32.9 |
| | I don't know | 137 | 36.6 |
| Will you consider your religious belief in deciding to use contraceptives | | | |
| | Yes | 238 | 63.6 |
| | No | 136 | 36.4 |

Association between the Socio Demographics and Use of Contraceptives

The study established a significant association between usage of contraceptives and age ($X^2 = 33.4$; $P < 0.001$), level of education ($X^2 = 28.5$, $P < 0.001$), marital status ($X^2 = 25.6$; $P < 0.001$), and father's job status ($X^2 = 12.2$; $P = 0.007$) (Table 5).

Table 5: Association between the socio demographics and use of contraceptives

| Variables | Categories | Did you use any form of contraceptive | | Statistical Test |
|-----------|----------------|---------------------------------------|-----------|------------------|
| | | Yes | No | |
| Age | 10 to 15 years | 8(7.6%) | 97(92.4%) | $X^2 = 33.4$ |

| | | | | |
|--|-------------------------|------------|------------|------------|
| | 16 to 19 years | 102(37.9%) | 167(62.1%) | $P<0.001$ |
| Respondent's level of education | No education | 3(60.0%) | 2(40.0%) | $X^2=28.5$ |
| | Primary | 6(10.7%) | 50(89.3%) | $P<0.001$ |
| | JHS | 17(18.3%) | 76(81.7%) | |
| | SHS | 68(36.0%) | 121(64.0%) | |
| | Tertiary | 16(51.6%) | 15(48.4%) | |
| Gender | Males | 23(29.9%) | 54(70.1%) | $X^2=0.01$ |
| | Females | 87(29.3%) | 210(70.7%) | $P=0.92$ |
| Marital Status | Single | 82(25.0%) | 246(75.0%) | $X^2=25.6$ |
| | Co habitating | 19(57.6%) | 14(42.4%) | $P<0.001$ |
| | Married | 9(69.2%) | 4(30.8%) | |
| Religion | Christian | 44(32.6%) | 91(67.4%) | $X^2=2.3$ |
| | Muslim | 62(27.0%) | 168(73.0%) | $P=0.32$ |
| | Traditionalist | 4(44.4%) | 5(55.6%) | |
| Respondent's mother's level of education | No education | 15(22.7%) | 51(77.3%) | $X^2=5.0$ |
| | Primary | 27(39.1%) | 42(60.9%) | $P=0.29$ |
| | JHS | 20(31.3%) | 44(68.8%) | |
| | SHS | 29(27.1%) | 78(72.9%) | |
| | Tertiary | 19(27.9%) | 49(72.1%) | |
| Respondent's father's level of education | No education | 14(31.8%) | 30(68.2%) | $X^2=1.9$ |
| | Primary | 7(28.0%) | 18(72.0%) | $P=0.75$ |
| | JHS | 14(22.6%) | 48(77.4%) | |
| | SHS | 25(29.4%) | 60(70.6%) | |
| | Tertiary | 50(31.6%) | 108(68.4%) | |
| Respondents' mother's Job | Private sector employee | 2(25.0%) | 6(75.0%) | $X^2=6.80$ |
| | Public sector employee | 14(26.9%) | 38(73.1%) | $P=0.08$ |
| | Self employed | 50(37.6%) | 83(62.4%) | |
| | Unemployed | 44(24.3%) | 137(75.7%) | |
| Respondent's father's Job | Private sector employee | 6(14.6%) | 35(85.4%) | $X^2=12.2$ |
| | Public sector employee | 40(35.4%) | 73(64.6%) | $P=0.007$ |
| | Self employed | 47(35.1%) | 87(64.9%) | |
| | Unemployed | 17(19.8%) | 69(80.2%) | |

Discussion

The study examined factors influencing utilization of contraceptives among adolescents in the Tamale Metropolis. All the participants in this study were essentially adolescents or teenagers. Adolescence is frequently associated with some dangers as a result of the risky behaviors that teens engage in. Teenage pregnancy is one of these dangers, which can be avoided by using contraceptives. In 2014, adolescents were responsible for 30% of all births reported in the country, and 14% of adolescents aged 15 to 19 had begun childbearing[31,32]. This requires research into adolescent contraception use and other dynamics.

Having knowledge of a contraceptive method is an important first step toward accepting its use [33]. As a result, knowledge of contraceptive methods is important for their proper application. In this current study, almost all of the adolescents had heard about contraceptives. Health workers and media (TV and Radio) were the main sources of information on contraceptives for these adolescents. This is consistent to a study in Tanzania where adolescents in secondary school favored radio as their source of information on contraceptives [34]. Most of the participants knew different methods of contraceptives including male condoms, injectables, lactational amenorrhoea, female condoms, implants and pills. This finding is similar other studies in Ghana where adolescents demonstrated appreciable knowledge on the types of modern contraceptives[35,36]. Similar findings were reported in studies conducted in Uganda [37] and Nepal [38]. This similarity is because, many other countries have recognized the need to bring information of contraceptives to adolescent.

Half of the respondents in this present study have had sex before. Evidence from the Ghana Demographic Health Survey [39] suggests that there is a steady shift from abstinence to the practice of sex. According to the GDHS [39]data, the proportion of adolescent girls 15-19 years old who have had their first sexual activity has increased by 61 percent. When the dramatic physical changes connected with puberty begin to take effect, most adolescents begin to see themselves as adults and participate in risky behaviors such as sex. As a result, it is critical to teach these children about the changes they see and the implications of those changes.

With the high rate of sexual activity noted in this study, it emerged that only 29.4% used some form of contraceptives in the past. This is similar to Tripp & Viner [40], who indicated that the majority of sexual intercourse occurs during early adolescence and is frequently connected with the non-use of contraception. Also, Kumar et al., [41] revealed that the majority of adolescents do not utilize contraceptives because they are unaware of how to use them or which method to use. This necessitates equipping youth with the necessary contraceptive knowledge, including the strategies for preventing both pregnancy and sexually transmitted diseases.

Male condoms were however the most preferred form of contraception of adolescents. Males' condoms are the most popular contraceptives; it is easily accessible and easy to use [15,18,42]. This is refreshing as this could also prevent sexually transmitted infections.

Most of the participants in this study noted that health workers were unfriendly and did not respect their privacy during their visit. These findings are in tandem with qualitative study findings in Vanuatu [43] where health care professionals were seen as a barrier to contraceptive usage among adolescents. Similarly, Kumi-Kyereme et al. [44] in their study found that resistance from parents, attitudes of adolescents and negative attitudes of health care providers were cited as the challenges confronting adolescents' utilisation of contraceptive services. The importance of health professionals' attitudes in drawing people to family planning centers cannot be understated. To ensure that teenagers feel welcome at the health facility, health workers must exhibit positive attitudes towards adolescents.

Religion, society, and cultural customs are socio-cultural elements that interact and have an impact on whether or not a person uses contraceptives. In Africa, religious inclination has been identified as a major barrier to the use of family planning services[45]. This assertion deviates from the religious stance of the dominant religions in the country[45].

Parental hindrance remains a barrier to contraceptive usage among adolescents. Most participants in this study stated they are unable to discuss contraceptive issues freely with their parents. This is related to a study in Tano district of Ghana, research confirmed that parental negligence is a primary cause of teenage pregnancy[46]. This is attributed to adolescents' own fear, shame and judgmental attitudes of service providers and disapproval from parents and community gatekeepers on service utilisation[43]. The majority of children get their information from their parents and at school. However, parents have little or no time to talk to their adolescent daughters and sons about sex, abstinence, and contraception use[42]. Due to negative societal conventions, parents are often hesitant to address sexuality and reproductive health issues with their children [17,20].

The present study established a significant association between age and usage of contraceptives ($P < 0.001$). This is similar to a study by Kayongo[47], which found that age was associated with modern contraceptive use. As adolescent grows the tend to seek ways to prevent risky behaviors whilst keeping up to their sexual life.

The study current study revealed that respondents' level of education was statistically significant with usage of contraceptives ($X^2 = 28.5$, $P < 0.001$). This is also in consonance with the findings of Asiimwe et al., [48]) in Uganda where they found that the educational level of the respondents were significantly associated with the use of modern contraceptive among women. Adolescent with higher education might

have been exposed to a lot of information through learning and exposure colleagues with different backgrounds. This therefore tend to influence adolescence unto accepting contraceptives.

The present study established a significant association between marital status and usage of contraceptives ($X^2 = 25.6$; $P < 0.001$). This finding corroborates with that of Ngome & Odimegwu[49], where characteristics such as marital status influenced the use of modern contraceptives by adolescents. Married couples usually would have had access to the health facilities through either antenatal care services or postnatal care services where they are often educated on the importance of spacing children through the use of contraceptives. Supportive married couples realizing their mistake in their first birth usually would resort to the modern contraceptive methods to adequately spaced their children. This will also enable them fend for the family.

On the limitation of the study, the current study was conducted in urban and peri-urban and the findings may not reflect that of adolescents in the rural areas. The study was limited to the Tamale Metropolis; therefore, the findings cannot be generalized to the region.

Conclusion

The majority of respondents were sexually active with high awareness of contraceptives. However, the use of contraceptive among adolescent is still low in the Tamale Metropolis with the health workers attitude, poor accessibility and availability of contraceptives, culture and religion being a major setback to the realization of the higher utilisation of contraceptives usage among adolescents. Further research could be done involving health professionals and other stakeholders concerned with adolescent Sexual and Reproductive Health (ASRH) to seek their views on how to promote access to contraceptives and other health related services for adolescents.

Data Availability

The data used to support this study are available from the corresponding author upon request.

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