NEIGHBORHOOD FACTORS INFLUENCING CONTRACEPTIVE KNOWLEDGE AMONG ADOLESCENTS IN ILE-IFE, NIGERIA

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CERTIFICATION

This is to certify that ADEGUN ADENIKE GRACE of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic NEIGHBORHOOD FACTORS INFLUENCING CONTRACEPTIVE KNOWLEDGE AMONG ADOLESCENTS IN ILE IFE.In partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision

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DEDICATION

The project is dedicated to God Almighty, the beginning and the ending.

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AIDS – Acquired Immune Deficiency Syndrome

COCs – Combined Oral Contraceptives

GYRHS - Ghana Youth Reproductive Health Survey

HIV – Human Immunodeficiency Virus

ICPD - International Conference for Population and Development

IUD - Intra Uterine Device

MMR - Maternal Mortality Ratio

MDGs – Millennium Development Goals

NBS - National Bureau of Statistics

NDHS - Nigerian Demographic and Health Survey

PRB - Population Reference Bureau

SRH - Sexual and Reproductive Health

STDs- Sexually Transmitted Diseases

STIs - Sexually Transmitted Infections

TOP - Termination of Pregnancy

TFR - Total Fertility Rate

UNFPA - United Nations Fund for Population Activities

UNICEF - United Nations International Children's Emergency Fund

UN - United Nations

WBC - World Bank Collection

WHO - World Health Organization

ABSTRACT

The study described the neighborhood factors influencing contraceptive use among adolescents in Ile Ife. The problems of unwanted pregnancy and inadequate use of contraceptive methods among adolescents is worse in developing countries like Nigeria due to uneven distribution of contraceptives and lack of knowledge on its uses. This study was carried to examine the neighborhood factors affecting contraceptive knowledge among adolescents in Ile Ife.

The study made use of primary data which were obtained through questionnaires. Two hundred respondents, both males and females were selected from three schools in Ile Ife (ObafemiAwolowo University, St. Mulumba Catholic College and Ife City High school). Information collected included background characteristics, knowledge about contraceptive, usage of any method of contraceptives, neighborhood factors like place of residence, school attended, parental education, peer group influence. The data were analyzed at univariate, bivariate and multivariate levels.

The bivariate result showed that the level of significant association of family background and adolescent contraceptive knowledge (P<0.05). There is significant relationship between age of respondents and knowledge of contraceptives (X^2= 5.32, Pr= 0.021). The result between level of education and knowledge of contraceptive is statistically significant (X^2= 13.16, Pr=0.004).

In conclusion,neighborhood factors influencing the uptake of contraceptive knowledge included access to contraceptive knowledge in school, contraceptive as way of preventing pregnancy, good knowledge and adolescent needs to know about contraceptives greatly influence contraceptive knowledge and acceptability.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Sexual and reproductive health is an important issue to all stakeholders in the global health sector particularly with regards to youth/adolescent (Tien, 2006). Various indications

about adolescent sexual and reproductive health for most countries is in a bad shape. The cause of the degenerating health conditions of adolescent according to Tien (2006) is as a result of lack of knowledge and access to contraceptives.

In 1979, survey among sexually active unmarried black adolescents from Chicago found that 28 percent of the young women and 18 percent of the young men used a contraceptive at first intercourse. Statistically, significant differences in such contraceptive use among teenage women were found for three social and environmental characteristics: social class, parents' marital status and neighborhood quality. In Nigeria, Harrison (2009) observed that the countries high Maternal Mortality Ratio (MMR) is attributed to her youth's sexuality. The latter is characterized by low contraceptive usage by the youth, high incidence of illegal abortion amongst the youth, ignorance of contraception among the youth, and lack of sex education from parents and teachers. The situation in Nigeria is likened to a reflectionof the situation in the entire Africa.

World Health Organization Report on the statistics of contraceptive prevalence in 53 African countries, shows that Nigeria has 14.1% contraceptive prevalence rate, unlike other African countries like Mauritius with 75.8%, Morocco 63.0%, Algeria 61.4%, Cape Verde 61.3%, Egypt 60.3%, South Africa 60.3%, Tunisia 60.2%, Zimbabwe 60.2%, Namibia and Swaziland with 55.1% and 50.6% respectively. The concern here is that since the MDGs were set in 2000, there have been steps deliberately taken by Nigerian government to reduce incidences of unwanted pregnancies, particularly among the youth. Promotion of contraceptive practices has also intensified yet with 14.1% contraceptive prevalence in Nigeria, it shows low knowledge and usage of contraceptives among the youth necessitating enquiring into factors that

could explain the trend.Contraceptive prevalence of women ages 15-49 in Nigeria was reported at 20.4 in 2016, according to the World Bank Collection of development indications.

Teenagers living in metropolitan areas of Africa begins sexual intercourse at earlier ages than other teenagers living in a non-metropolitan area and they also have higher rates of premarital pregnancy. Many adolescents lack adequate health education coupled with low contraceptive knowledge. As a result of this, they may experience the negative health consequences of early unprotected sexual activity as well as its social and economic implications. Adolescents in sub-Saharan Africa face numerous sexual and reproductive health hazards, including unintended pregnancies, unsafe abortions, and Sexually Transmitted Infections (STIs) as a result of their involvement in early and often unprotected sexual activities. In addition, approximately 40 percent of all pregnancies worldwide are unintended, with higher unintended pregnancy rates in African countries. In a review of the sexual and reproductive health and rights of adolescents in Nine countries in sub-Saharan Africa, it was noted that adolescents in the region are particularly vulnerable to sexual and reproductive health issues such as high adolescent birth rate, as well as over 23 percent of the burden of diseases associated with pregnancy and child and maternal ill-health.The high level of unintended pregnancies in Africa is associated with a low level of contraceptive knowledge in the region, especially among adolescent girls who not only face significant discrimination and inequality when accessing contraceptive information and services, including particular information on where and how to access contraception.

Global health has improved considerably over the last four decades, but everywhere the health status of the poor compares unfavorably with that of the more affluent sectors of society. Parallel disparities in fertility and in contraceptive use are found between poor and wealthy

countries. The world's total fertility rate has dropped dramatically, from 5 children per woman in early 1950s to 2.6 children per woman today, largely owing to more widespread use of modern contraceptives, especially in the developing world. Furthermore, in 1960, only around 9 percent of married women in the developing world practiced any form of contraception; today, this figure is 62 percent. Yet in less developed countries, modern contraceptive methods are used by only 43 percent of women of reproductive age overall, and a wide gap in use is seen between the highest and lowest wealth quintiles (52% versus 35%, respectively). This gap between the rich and poor in the use of contraception has persisted despite general global improvements in socioeconomic status and the expansion of family planning services.

An unjust act exists when people are unfairly deprived of something they want or require to protect them from an unwanted or undesirable condition. One of the major factors is that youth often lack basic reproductive information on the consequences of sexual intercourse. In addition, youth also lack skills in negotiating sexual relationship, and knowledge about affordable confidential reproductive health services. Again, many do not feel comfortable discussing sexual issues with parents or other key adults with whom they can talk about their reproductive health concerns. Likewise, parents, healthcare workers, and educators frequently are unwilling or unable to provide complete and accurate age-appropriate reproductive health information to young people. This is often due to discomfort in discussing the subject or the false belief that providing the information will encourage increased sexual activity. This is because most youth enter into sexual relationships with very little knowledge on the consequences. The little knowledge they have is either gotten from their peers or from the media.

Nigeria, the seventh most populous nation in the world, has a current estimated population of 183 million, which is projected to reach 285 million by 2050 (United Nations,

2013). There are an estimated 35 million women of reproductive age in the country, with an annual number of births of approximately 7 million and annual population growth of 3.2%. The country's rapid population growth is attributed to a high Total Fertility Rate (TFR) of 5.5% children per woman. Contraceptive use particularly modern methods remains prominent in demographic and health literature because of its numerous health benefits to women and families such as preventing unintended pregnancies, promoting healthy birth spacing, reducing lifetime risk of maternal deaths, and enhancing attainment of developmental goals. In addition, contraceptive use remains a dominant population and health issue because of its important role in the demographic transitions in different countries with varying degrees of demographic situations. Large numbers of studies across the world have examined individual, institutional and community determinants of contraceptive use among different groups of women. The study is to show adolescent's knowledge about contraceptive methods and the neighborhood factors influencing adolescent's knowledge about contraceptive. The variables to be considered include: place of residence, father's and mother's employment status, age, father's level of education, mother's level of education, knowledge of adolescent about contraceptive.

1.1 STATEMENT OF PROBLEM

Studies in Nigeria indicate high rate of sexual activities as well as limited knowledge and use of contraceptives among secondary school students/undergraduates (Ogbuji, 2005; Iyaniwura and Salako, 2005). The resultant effect of this result is an increased rate of unwanted pregnancy,

maternal mortality rate, sexually transmitted infections including HIV/AIDS etc. The increasing number of pregnancy, abortions and sexually transmitted infections including HIV/AIDS among the youths in Sub-Saharan Africa indicates that successive efforts towards preventing the scourge remain inadequate in the continent (Atere, Shokoya,Akinwale and Oyenuga, 2010). It is obvious that many young people are sexually active with low knowledge about contraceptive.

However, the age at which youth engage in sexual activities varies considerably depending on the various socializing influences and the opportunities available for practicing sexual behavior. Studies on adolescent sexual behavior in several parts of Nigeria have shown that pre-marital sexual activities are quite common especially in urban areas. As a result, unintended pregnancy arises when sexually active women do not use contraceptive or use them incorrectly or do not even have knowledge about contraceptive. The tendency for adolescent and young adults to engage in sexual activity without the use of contraception, despite exposure to educational programs, has led to consider the potential predictors of contraceptive use. These studies have indicated that multiple factors influence contraceptive decision-making; amongst them are perceived risk and benefits, values and personality factors.

The inadequate contraceptive coverage is multifaceted; social, ethical and cost issues are focused on the consequence of unintended pregnancy; long-term consequences of unintended pregnancy are far reaching. For example, teenage pregnancy, out-of-wedlock birth, welfare dependency, child abuse, domestic violence, and abortion are some of the major social ramifications of unintended pregnancy. The Nigerian situation is similar to that prevailing in developing societies in Africa and Latin America. Although reports indicate a decline in teenage pregnancy, maternal mortality and morbidity, yet most of the premarital births still occur among young women aged 15-24 years, the majority of whom are neither economically nor emotionally

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ready to deal with parental responsibilities. Contraceptive usage still remains low in African countries because majority of those in the reproductive age are not using any method of contraceptive. Also, assisted reproductive technology used to ease complications of pregnancy among women of reproductive age in developed countries are not widely available to women of reproductive age in developing countries. Thus, improving reproductive health is key to improving the situation of youth as well as the world's future generation.

1.2 RESEARCH QUESTION

The following research questions are formulated to guide the study;

1. What is the level of contraceptive knowledge and use among adolescents in Ile Ife, Osun State?
2. What is the adolescents' level of access to contraceptive method in Ile Ife?
3. To what extent do neighborhood factors affect contraceptive knowledge among adolescents in Ile Ife?

1.3 OBJECTIVES

The general objective of this study is to know the neighborhood factors influencing contraceptive knowledge among adolescent in Ile Ife, Osun State, Nigeria.

1.3.1 SPECIFIC OBJECTIVES

- To examine the level of contraceptive knowledge and use among adolescents.

- To identify neighborhood factors affecting contraceptive knowledge among adolescent in Ile Ife.

- To examine the problems adolescents encounter in accessing contraceptive in Ile Ife.

1.4 DEFINITION OF TERMS

For more clarity and consistency of the use of concepts in this study, it is important to give meanings operationally to some key terms in this study. This is necessary to avoid conceptual confusion. The terms are as follows

1.4.1 ADOLESCENTS:

In this study, adolescents refer to a distinct group in terms of their health needs and opportunities to reach them with preventive health programs. Adolescence is a transitional stage of physical and psychological development that generally occurs during the period from puberty to legal adulthood. Adolescence means to grow up; it is usually associated with teenage years. According to WorldHealth Organization, adolescentare defined to be,those between age 10 and 19 years.

1.4.2 NEIGHBOURHOOD FACTORS:

Neighborhood factors such as poverty and residential instability have been identified as being important in explaining neighborhood problems such as delinquency and crime encountered in many poor urban neighborhoods (Sampson, 1992). Neighborhood effect is an

economic and social science concept that posits that neighborhoods have either a direct or an indirect effect on individual behaviors. Neighborhood factors influencing adolescents include parenting practices, peer group affiliations, secondary school attended, parental education, ethnic diversity etc. To study the effects of community functioning on adolescent outcomes, researchers make important distinctions between neighborhood structure and neighborhood social processes. Neighborhood structure refers to socio-demographic or compositional features of community (e.g. employment rate, concentrated poverty, residential mobility, and racial.), while neighborhood social processes refers to the community's social organization (e.g. social connections among neighbors) and is usually evaluated on the basis of residents' perceptions of how their communities function.

1.4.3 FAMILY PLANNING:

It can be conceptualized as to steps people take to have children by choice and not by chance. In this work it refers to steps taken by individual and couples to decide on attain their desired children and the spacing between births which could be achieved through contraception or treatment of involvement infertility.

1.4.4 CONTRACEPTION:

It refers to artificial methods/techniques for prevent pregnancy through temporal or permanent means. Pernoll (1994) stated that contraception is practiced for many reasons, such as pregnancy planning, limiting the number of children, avoiding medical risks of pregnancy and controlling of world population.

1.4.5 CONTRACEPTIVE METHODS:

It refers to artificial device use for prevention of individual from both pregnancy and HIV/STIs.

1.4.6 CONTRACEPTIVE KNOWLEDGE:

This is the general awareness and understanding of various contraceptive methods among adolescents.

1.4.7ABORTION:

This is the spontaneous or induced termination of pregnancy (TOP) before the foetus has attained viability i.e. becoming capable of independent extra uterine life.

1.4.8FERTILITY REGULATION:

Is the process by which individuals and couples regulates their fertility through, for example, use of contraception, treatment of infertility and termination of an unwanted pregnancy.

1.4.9MATERNAL MORTALITY:

Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy or its management but not from accidental or incidental causes. It can also be called "obstetrical death" (WHO and UNICEF, 2005)

1.4.10REPRODUCTIVE HEALTH:

This is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes (German and Kyte, 1995). The key element of reproductive health include people's ability to have a safe and satisfying sexlife, capability to reproduce, and freedom of choice to decide if they want to reproduce as well as the freedom to decide the timing and frequency of reproduction. It also includes accessibility to health services that are affordable, safe and good quality.

1.4.11 UNSAFE SEX:

This is the practice of sexual activities that carry a higher risk of negative consequences. In this work, it is activities that involve exchange or contact with semen, vaginal fluids, penile or vaginal discharges, or bloods at high risk.

1.5 JUSTIFICATION OF STUDY

There is a growing interest in adolescent reproductive health. Teenage pregnancies are important public health issues because they are associated with maternal, fetal and neonatal adverse outcomes, teenage girls who get pregnant are likely to drop out from school and teenage parents are unlikely to have the social and economic means to raise children. These, and many other reasons, justify the promotion of sexual abstinence among teenagers and/ or contraception. Adolescent sexual behaviors are a significant public health concern because of the risks of Sexually Transmitted Diseases (STDs) and the negative social consequences of teenage pregnancies. Associations between neighborhood characteristics and adolescents initiation of sex and contraceptive use are poorly understood. For females, living in a neighborhood with a greater concentration of youth who were idle or black residents was associated with increased odds of sexual initial. Higher initiation among males was associated with a higher concentration of poverty or idle youth.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

An adolescent as a person aged 10-19 years (WHO, 2008). It is a time of increased physical and mental changes that affect their sexuality and sexual preferences. Adolescence, with its many changes, has long been considered a turbulent life stage (Imaledo, Peter-Kio, &Asuquo, 2012). In addition to pubertal stages, the adolescent faces psychological challenges associated with peer relationships, self-identity and exploration of possible sexual relationships with the opposite sex (Imaledo, Peter-Kio, &Asuquo, 2012).

Contraception is defined as the use of a contraceptive method to prevent pregnancy by interfering with ovulation, fertilization, and/or implantation (Csapo, 2002). Contraceptives help women plan when and how many children to have (Csapo, 2002). Contraceptive methods are classified as hormonal or non-hormonal methods. They include condoms, pills, sterilization, injections, intra-uterine devices, spermicidal and implants (Apter, 2012). The main contraceptive options for adolescents are condoms backed up by hormonal contraception however, hormonal contraceptives should be used in a longer, mutually monogamous relationship (Apter, 2012). With the exception of male and female sterilization, all methods that are physiologically safe for adults are also physiologically safe for adolescents (WHO, 2007).

The International Conference for Population and Development (ICPD, 1994) recognized that reproductive health problems of adolescents had been ignored largely by existing health, education and other social programs. The conference adopted an action plan for programs addressing the SRH problems of adolescents globally. Among the objectives outlined were; "To address adolescent sexual and reproductive health issues and to substantially reduce all adolescent pregnancies," (ICPD, 1994). Without contraceptives, women of any age will be unable to realize their own desire to avoid a pregnancy (Cleland, Ali, & Shah, 2006). The

prevention of unplanned adolescent pregnancies requires: a desire to use contraceptives, a good contraceptive method, ability to obtain the contraceptive method, and ability to use it. If one of this is missing contraception will fail (Apter, 2012).

2.1 LITERATURE REVIEW

In this literature view, efforts will be made to examine some of the previous studies related to the title of this work under the following sub-headings; maternal mortality in developed and developing countries, contraception in Nigeria, factors affecting contraception, neighborhood factors in Nigeria, contraceptive knowledge among adolescents and economic factors on adolescents.

2.1.1 MATERNAL MORTALITY IN DEVELOPED AND DEVELOPING COUNTRIES

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnant, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal mortality is a major public health issue in developing countries due to its shocking magnitude and lower declining pattern. According to the 2010 United Nations Population Fund report, developing nations account for ninety-nine percent of maternal deaths with the majority of those deaths occurring in Sub-Saharan Africa and Southern Asia. Globally, high and middle income countries experience lower maternal deaths than low income countries. In most cases, high rates of maternal deaths occur in the same countries that have high rates of infant mortality. In sub-Saharan Africa, a number of countries halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway

was made. Between 1990 and 2015, the global maternal mortality ratio (the number of maternal deaths per 100 000 live births) declined by only 2.3% per year between 1990 and 2015. However, increased rates of accelerated decline in maternal mortality were observed from 2000 onwards. In some countries, annual declines in maternal mortality between 2000-2010 were above 5.5%. Over 99% of mothers die in developing countries.

Maternal mortality is a public health issue in many countries especially in the developing countries, where an estimated 585,000 women die every day from pregnancy related deaths (Ali, 2009). Similarly, World Health Organization (WHO 2010) report shows that, in developed and developing countries, maternal mortality adds up to 600,000 each year. And that every minute, at least one woman dies from complications arising from pregnancy and child birth. The report further shown that maternal mortality represents one of the widest health gaps between developed and developing nations, with 99% of all maternal deaths occurring in developing countries.

2.1.2 CONTRACEPTION IN NIGERIA

Contraception is one of the essential elements of youth reproductive health. It allows youth to determine the timing and the number of their children and empowers them to manage their lives with respect and dignity. Adolescent reproductive health is increasingly being recognized as one of the major determinant of human development. Among the essential development concern about contraception or prevention of unwanted early pregnancies considered to have a significant potential in improving the status of youth. In developing countries, surveys have shown that the highest level of contraceptive use, are among unmarried, sexually active youth between the ages of 20 and 24 years, the lowest levels are among adolescent married women between the ages of 15 and 19 years (WHO, 2005). Consequently,

from the survey, few married adolescents use contraception. For example, only 13% of married youth in this age group use contraception, among unmarried, sexually active adolescents in this same age group, the level of contraceptive use reaches 39% married women and 60% of unmarried, sexually active women between the ages of 15 and 19 years use contraception (Zlidar, 2003; WHO, 2005).

Compiled data from the 2015 report of the National Bureau of Statistics (NBS), on health shows that contraceptive use among sexually active women of child bearing age increased by seven per cent compared to 2014. In 2014, 23 per cent of sexually active Nigerian women used contraceptives, while 30 per cent used in 2015, the Bureau's latest data showed. Contraceptive are methods, devices or drugs used among sexually active people to reduce or prevent unwanted pregnancy and unsafe abortion. A cross section of women interviewed in Abuja on family planning methods showed that most women engaged in one form of contraceptive method, either modern or traditional, to prevent unwanted pregnancy. Aisha Jamiu, a plantain trader, said what she used to do to prevent pregnancy was count the days of her safe period with her husband and abstain from sex when she is not safe. This is one of the traditional forms of contraceptive method to prevent pregnancy. The NBS data also showed a 2 per cent increase in use of traditional contraceptive methods between 2014 and 2015.

According to the Nigerian Demographic and Health Survey (NDHS) 2013, about 23 per cent of teenage girls between the ages of 15 and 19 are either pregnant with their first child or are already mothers, while half of the women between the ages of 25 to 49 years married between 18 to 20 years; thus the need for birth control pills or contraceptive technique to reduce unintended pregnancies, and encourage child birth spacing.

2.1.3 FACTORS AFFECTING CONTRACEPTION

Approximately half a million women die around the world each year, as a result of pregnancy and associated complications. Most of these deaths could be prevented, not only by providing immediate and appropriate medical care, and also by offering family planning counseling and services, which could prevent many future unintended high-risk pregnancies and unsafe induced abortions. Contraception methods can prevent at least 25% of all maternal deaths by allowing women to prevent unintended pregnancies and unsafe abortions, and to protect themselves from sexually transmitted diseases including HIV. Demographic characteristics, cultural and religious beliefs, and economic and education levels of the female population can also affect the selection of a contraceptive method. Women attitude is much more important in the adoption of temporary methods of contraception and also in limiting the family size. Many rural women are reportedly reluctant to accept any method of contraception. Several studies also revealed that rural women who were unwilling to accept family planning methods were concerned about child survival and viewed children as a source of support in old age. The perceptions and the behavior related to reproduction are strongly, even predominantly, determined by prevailing cultural and religious values.Low use of modern methods of contraception was caused by the lack of knowledge of supply sources, low education, low levels of employment outside the home, unavailability of supplies and cultures. Understanding the pattern ofcontraceptive use among married women is very important in relation to designing programs and policies to control fertility in order to maintain a low fertility level.

Cherkavoi (2001) and Barnett (2001) from their studies on factors of contraceptive use in Kenya indicated that most women use contraceptives because having smaller families is the norm. Jejebhoy (2004) in his study also shows that young people often decide not to use contraception because they do not want their parents or other adults to know that they are

sexually active. In Kenya, studies also shows that when new client were ask to give a single reason for their choice of specific family planning method, most cited that the attributes of their spouse or their peers, or theirreligion or value. Jacobson (2000) in his own study shows that as women gain more autonomy, they are better able to claim their rights as individuals, including the rights to act to protect it, their own reproductive health. Rutenberg and Watkins (2000) in their study in Nigeria and other West African countries, indicate that some women reported that, it was difficult for them to use contraception because their relatives or friends were not using it. Godley (2001) in his study in urban Nigeria, found that the more widely used a contraceptive method, the more attractive it become to others in the cities and villages. Therefore, based on a review of various studies over the previous two decades, the results found that program have helped convert people's interest in having fewerchildren into a demand for contraception (Oladimeji, 2008).

2.1.4NEIGHBORHOOD FACTORS IN NIGERIA

The basic concept of neighborhood refers to a physical boundary where people lead their private lives. Neighborhood is about physical environment, economy and social which constitute the sense of community and place attachment. The development and neighborhood changes for urban renewal, urban regeneration and redevelopment are to fulfil the people's needs and requirements. The neighborhood changes are required to improve the neighborhood conditions such as neighborhood quality, livable neighborhood, healthy neighborhood, sustainable neighborhood, dynamic and self-stabilizing neighborhood, safe neighborhood and better neighborhood. All of these are shared towards people's well-being, health, safety and sustainable communities. Factors that influenced the quality of neighborhood namely physical, social and economic aspects. The physical aspects were examined in four categories namely dwelling unit,

facilities and services, accessibility and surrounding environment. The social aspects were classified as socio-demographic, social community and social interaction and place attachment. The economic aspect focused on the socio-economic of the residents.Neighborhood factors such as poverty and residential instability have been identified as being important in explaining neighborhood problems such as delinquency and crime encountered in many poor urban neighborhoods (Sampson, 1992).

Contraceptive use particularly modern contraceptive use remains prominent in demographic and health literature because of its numerous health benefits to women and families such as preventing unintended pregnancies, promoting healthy birth spacing, reducing lifetime risk of maternal deaths, and enhancing attainment of development goals. In addition, contraceptive use remains a dominant population and health issue because of its important role in the demographic transitions in different countries with varying degrees of demographic situations. Large numbers of studies across the world have examined individual, institutional and community determinants of contraceptive use among different groups of women.

2.1.5 ECONOMIC FACTORS ON ADOLESCENTS

Adolescents are dependent on their parents for economic support contributing to the non-utilization of contraceptives. This is because some contraceptives are expensive. Adolescents may have to take time off work or school to get to the reproductive health centers. Similarly, clinic fees and the contraceptive fees hinder adolescent utilization of contraceptives (Moore, et al., 2008). In a study done by World Bank, when a girl has power to delay pregnancy, she is also empowered socially to stay in school, and then economically to secure a more lucrative job or pursue other income-earning opportunities (Chaaban& Cunningham, 2011). A research by Ikamari and Towett on sexual initiation and contraceptive use among adolescent females in

Kenya showed economic status was significantly associated with the use of contraception. Those in poor households were less likely to use since they could not afford the contraceptives (Ikamari&Towett, 2007).

2.2 THEORETICAL FRAMEWORK

2.2.1 CONTRACEPTIVE USE AMONG ADOLESCENTS

Sexual activity among some groups of adolescents in Nigeria, particularly among the unmarried in urban areas, is thought to be high and rising. Resulting unwanted pregnancy and illegal abortion among the young unmarried population are creating major social and health problems. A number of explanations both social and biological, have been developed to explain this unfortunate trend – one that is neither unique to Nigeria nor even to sub-Saharan Africa.

Worldwide approximately 16 million adolescents give birth annually; this constitutes 11 percent of all births. The majority (95%) of these births occur in low and middle income countries (WHO, 2008). Many unmarried adolescents worldwide are becoming sexually active at early ages, prompted by the mass media presentation of sex as exciting and risk-free (Were, Kioli, &Kargat, 2012). In many developing countries the situation is not different. Girls under age 15 account for 2 million of the 7.3 million births to girls less than 18 years every year (UNFPA, 2013). About 19 percent of young women in developing countries became pregnant before the age of 18 years (UNFPA, 2013). In sub-Saharan Africa for example 28% of women give birth by age 18 years (Population Reference Bureau, 2007). If current trends in sub-Saharan Africa continue, the number of girls under 15 years who give birth is expected to rise from 2 million to about 3 million in 2030 (UNICEF, 2012).

Over 200 million women worldwide have no access to modern and effective contraceptives (UNFPA, 2013). In the developing countries, the lack of access to family planning results in 76 million unplanned pregnancies each year (Population Reference Bureau, 2007). Disapproving healthcare providers and community discourages adolescents from seeking reproductive health care (UNFPA, 2003). Contraceptive services need to be "youth-friendly" in order to encourage adolescents to seek reproductive health care (Godia, et al., 2013). Adolescents often terminate unwanted pregnancies through clandestine induced abortions, which can lead to maternal complications, including death while children born to adolescent mothers are more likely than those born to older women to be underweight and premature most dying within the first month (Gipson, Koenig, &Hindin, 2008). In East Africa, one in five maternal deaths is due to unsafe abortion; a large proportion of these deaths are due to unplanned pregnancies (Bankole&Malarcher, 2010).

Though contraception can prevent these abortions, modern contraceptive use remains low among sexually active adolescents in developing countries (Lloyd, 2005). In Haiti for example, only 33% of single sexually active adolescents and 9% of their married peers use a modern method of contraception (Population Reference Bureau, 2007). Among sexually active Nigerian female high school students, 47% use the rhythm method of contraception; 21% oral contraceptive pills; and 6% condoms (Okpani, 2000).

2.2.2 CONTRACEPTIVE KNOWLEDGE AMONG ADOLESCENTS IN GHANA

There is a bigger interest in reproductive health of adolescents. Teenage pregnancy is an important public health issue because they are associated with maternal, fetal, and neonatal unfavorable outcomes. Teenage girls who get pregnant are likely to drop out from school and teenage parents are unlikely to have the social and economic means to raise children (Whitaker & Gilliam, 2008). Further, unintended pregnancy constitute a major challenge to the reproductive health of young adults in developing countries. With decreasing age of menarche and onset of sexual activity, young people are exposed early to unplanned and unprotected sexual intercourse leading to unwanted pregnancies and invariably abortions especially very common in many Sub-Saharan African countries where persistent high rates of unmet need for family planning and low rates of contraceptive use are reported (Okonofua, 1995 & Westoff, 2001).

The low levels of utilization are typically a function of both the limited capacity of their health system and the framework within which family planning services are delivered. Other factors affecting service provision include tenuous commodity security and suboptimal service factors (Population Reference Bureau, 2008). At the individual level also, multiple barriers to utilization have been identified, including risk perception, insufficient knowledge needed to make informed choices, opposition from male partners, and health service limitations. Various studies conducted in Ghana show that the awareness of young people about contraceptives and where to obtain them is high. Results from the 1998 Ghana Youth Reproductive Health Survey (GYRHS) indicated that 76% of female and 88% of males all aged between 15 and 19 years were aware of at least one modern family planning method (Tweedie& Witte (2000). Among the 12-14 year-olds, 33% of females and 6% of males knew at least one modern family planning method. The condom was the most reported method known by 77% and 66% of males and

females respectively. In spite of the general recognition of the importance of meeting the reproductive health needs of young people and the high level of awareness among adolescents of modern methods of contraception, contraceptive use among them is generally low. Thirteen percent of all 15–19 years old females and 35% of married females had ever used a modern family planning method on the basis of the 1998 GDHS findings. Tweedie and Witte (2000) observed in the 1998 GYRHS that 77% of female and 85% of male sexually experienced adolescents had ever used any contraceptive method and 64% of the females and 74% of the males had ever used a modern contraceptive method. The male condom was the most popular contraceptive method that was used by 58% of female and 71% of male respondents while the least ever used contraceptive methods were the Intra Uterine Device (IUD) and diaphragm among females (about 1% for each method). However, contraceptive use was relatively low and the most commonly used methods were the condom and the pill.

2.3CONCEPTUAL FRAMEWORK

INDEPENDENTDEPENDENT VARIABLE

VARIABLES

Socio-demographic variables e.g, age, religion, culture, school attended, father's education, mother's education.

Neighborhood factors e.g, residence.

→ Contraceptive knowledge among adolescent
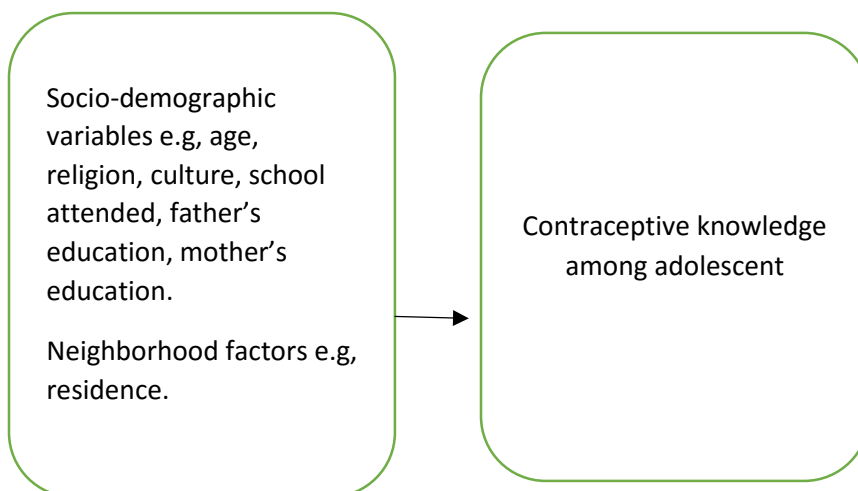
Source: author's construct, 2018.

This section discusses the conceptual framework guiding this study. This framework helps in explaining the mechanisms through which neighborhood factors affects adolescents' knowledge about contraceptive.

The diagram highlights the different independent variables that can affect the dependent variable. The independent variable include: social demographic factors (age, culture, school attended, religion) and neighborhood factors (place of residence). According to this theory, adolescents would have to believe that the knowledge about contraceptives would prevent unwanted pregnancies and Sexually Transmitted Infections (STIs). Complying with the significant others would mean that adolescents would take action or not take action if engaged in sexual intercourse. Taking the action to prevent pregnancy would influence adolescent's knowledge/use of a contraceptive method.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This chapter explains the approach for executing the research work. It presents the research design, independent and dependent variables, study area, sample and sampling procedures, instrument for data collection, method of data collection and method of data analysis.

3.1 RESEARCH DESIGN

Descriptive research design was utilized. Descriptive research design helps to provide answer to questions of who, what, where and how associated with a particular research problem. This research design is used to obtain information pertaining to current status of the problem and to describe "what exists" with respect to variables or conditions in a situation (Sage, 2007).

3.2 STUDY LOCATION

The area of study is Ile Ife, Osun State, Nigeria. Ile Ife is an ancient Yoruba city in South-Western Nigeria. The city is located in the present day Osun State. Ife is about 218 kilometers (135mi) Northeast of Lagos state. Osun state shares boundary with four states in southwestern Nigeria. Osun state is estimated to have the population of 501,000 people.Ile-Ife is located within the tropical savanna climate zone of West Africa. It has average rainfall of 1000-1250mm usually from march to October and a mean relative humidity of 75% to 100%. Ife is east of the city of Ibadan and connected to it through the Ife-Ibadan highway, Ife is also 40km from Osogbo and has road network to other cities such as Ede, Ondo and Ilesha.

3.3 STUDY POPULATION

The study population consists of adolescent between the ages of 10-19 years in Ile Ife, Osun State, the target population includes adolescents aged 10-19 years from secondary schools and higher institution, traders etc.

3.4 SAMPLE PROCEDURE AND SAMPLE SIZE

3.4.1 SAMPLE PROCEDURE

Convince sampling method was used in selecting the study sample. Ile Ife has four Local Government Areas. Out of these four local government areas in Ile Ife, two (2) secondary schools and one (1) tertiary institution were randomly selected based on proximity. From each school, male and female adolescents between 10-19 years were used.

3.4.2 SAMPLE SIZE

In this study, a sample size of 200 respondents was computed. As a result the sample size of 199 respondents were used for questionnaire, 98 respondents from tertiary institution and 101 respondents from secondary schools in which a non-probability sampling method was used. Also, to cover for non-response in the data collection, 10% of the sample size (20) was added to the original sample size to make it 220 respondents.

3.5 DATA COLLECTION METHOD

There are two instruments used in this study. They are questionnaire and in-depth interview schedule. The questionnaire contains three sections. The first section sought to identify the socio-demographic characteristics of the respondents in the study, while the second

part sought information on level of contraceptive knowledge among adolescents in Ile Ife and the third section on neighborhood factors influencing contraceptive knowledge among adolescent in Ile Ife. The questionnaire was the major instrument of data collection as it is the kind of instruments that can cover wide range of most of the issues raised in this study. The interest of the questionnaire is to obtain the background characteristics of the respondents, their knowledge, opinion and behavioral patterns in relation to knowledge and use of contraceptive methods.

The in-depth interview was used to investigate salient issues that may not have been covered in the questionnaire. It seeks information on the respondents' knowledge and attitude to the use of contraceptives. The above two instruments were used, because they will facilitate this research more than any other techniques in gathering the desired data among adolescents.

3.6 METHOD OF DATA ANALYSIS

The quantitative data gathered from the field will be analyzed using STATA 13.0 at a univariate, bivariate and multivariate levels of analysis. Univariate analysis will be conducted using the frequency distribution table to describe both the dependent and the independent variables. Bivariate (chi-square) analysis will be used to describe and compare the relationship between independent variables (neighborhood and socio-demographic factors) and dependent (contraceptive knowledge) among adolescentin Ife, Osun State, Nigeria.

3.7 INDEPENDENT AND DEPENDENT VARIABLES

Secondary school adolescents' contraceptive knowledge as the dependent variable is influenced by significant other variables which are known as independent variables. The independent variables to be considered for this study are neighborhood factors such as residential

factors, peer groups, parents, and school attended. These other variables will either promote or hinder contraceptive knowledge and use among adolescents.

3.8 FIELD EXPERIENCE

There were several limitation and constraint in the course of trying to generate correct and accurate data for this study. The study was collected from three schools in Ile-Ife which are ObafemiAwolowo University, St. Mulumba Catholic College and Ife City High school, it was discovered that most respondents from SSS 3 class in Ife City High school could not actually read and translate very well, this brought a delay in collecting the data as the researcher had to read out and explain every item on the research instrument. It was discovered in St. Mulumba Catholic College that most respondents does not know how and when to use some contraceptive methods, although, they know the name, so the researcher has to explain the usefulness and when to use each contraceptive method in the research instrument. This was time consuming and slowed down the pace of data collection.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND RESULTS

4.0 INTRODUCTION

This chapter focuses on data presentation and statistical analysis on the perception and determinant of teenage pregnancy. The univariate analysis shows the percentage distribution of respondent characteristics and information about adolescent contraceptive knowledge. The statistical techniques used were chi-square test to examine the effect of socio-demographic and neighborhood factors that determinant of adolescent contraceptive knowledge in the study area.

4.1 UNIVARIATE ANALYSIS

4.1.1 Distribution of Respondents by Socio-Demographic Characteristics

Results below showed adolescents socio-economic and demographic characteristics. It was reported that age 10 - 14 years had greater percentage by 52.3%, and age 15 - 19 years by 47.7%. Female Adolescent were reported by 79.9, and male by 20.1. Adolescent from OAU reported by 49.3%, St. Mulumba by 28.6%, and Ife City by 22.1%. It was reported that adolescent in part 1 have the highest percentage by 49.3%, SS 2 and SS 3 were reported by 21.6% respectively, and JSS 3 by 7.5 %. Christian adolescent reported by 68.2%, Muslim by 26.1%, and Traditional religion by 5.5%. It was reported that adolescent from urban area by 73.9%, and rural by 26.1%. It was reported that adolescent living with their parents have highest percentage by 75.4%, and with other by 24.6%. Also, fathers of adolescent that went to high school is reported by 56.8%, secondary school by 28.6%, primary school by 8.1%, and no formal education by 6.5%. Mothers of adolescent that went to high school is reported by 53.3%,

secondary school by 35.7%, primary school by 4.0%, and no formal education by 7.0%. Also, fathers who were fully employed is reported by 53.7%, retired by 21.6%, part time by 15.6%, and unemployed by 9.1%. Mothers who were full time is reported by 56.3%, part time by 19.6%, unemployed by 12.5%, and retired by 11.6%.

Table 4.1.1 Distribution of Respondents by Socio-Demographic Characteristics

Background Characteristics	Frequency	Percent (%)
Age		
10 – 14 years	104	52.3
15-19 years	95	47.7
Sex		
Male	40	20.1
Female	159	79.9
School attended		
St. mulumba	57	28.6
Ife city	44	22.1
OAU	98	49.3
Class/level of respondent		
JSS 3	15	7.5
SS 2	43	21.6
SS 3	43	21.6
Part 1	98	49.3
Religion Affiliation		

Christianity	136	68.2
Islam	52	26.1
Traditional	11	5.5
Residence		
Urban	147	73.9
Rural	52	26.1
Are you living with your parents?		
Yes	150	75.4
No	49	24.6
Father's education		
No formal education	13	6.5
Primary school	16	8.1
Secondary school	57	28.6
High school	113	56.8
Mother's education		
No formal education	14	7.0
Primary school	8	4.0
Secondary school	71	35.7
High school	106	53.3
Father's employment status		
Full time	107	53.7
Part time	31	15.6

Unemployed	18	9.1
Retired	43	21.6
Mother's employment status		
Full time	112	56.3
Part time	39	19.6
Unemployed	25	12.5
Retired	23	11.6
Total	**199**	**100.0**

Source: author's construct 2018

4.1.2 Distribution of Respondents by level of contraceptive knowledge

Results in Table 4.2 below showed Adolescents level of contraceptive knowledge. It was reported that adolescents that have heard about contraceptive before, had greater percentage by 82.4%, and no by 17.6%. Adolescents who heard about contraceptives in school is reported by 30.2%, media by 25.6%, parents by 17.5%, friends is reported by 17.1%, and the lowest were others by 9.6%. Adolescents that know condom is reported by 60.3%, pills by 20.6%, injectable by 10.6%, diaphragm by 6.5%, withdrawal by 1s.5% and the least is COCs by 0.5%. Also, adolescents that support that contraceptive is wrong is reported by 26.6%, and no by 73.4%. Adolescents that has used any contraceptive is reported by 37.2% and did not use method by 62.3%. Adolescents that were not using contraceptive currently is reported mostly by 69.2%, and yes is reported by 30.8%. Adolescents who prefer condom is reported by 61.4%, pills by 17.6%, injectable 9.5%, diaphragm 8.5, and COCs by 3.0%. Adolescents that don't face any difficulty in

accessing contraceptive is reported by 88.9%, and yes by 11.1%. Adolescents who would go to hospital to access contraception are reported by 64.8%, others by 14.6%, friends by 13.6%, and school by 7.0%.

Table 4.1.2: Distribution of Respondents by level of contraceptive knowledge

Background Characteristics	Frequency	Percent (%)
Have you ever heard of contraceptive before?		
Yes	164	82.4
No	35	17.6
Where did you hear about contraceptive?		
Parents	35	17.5
Friends	34	17.1
School	60	30.2
Media	51	25.6
Others (specify)	19	9.6
Types of contraceptive method		
Condom	120	60.3
Pills	41	20.6
Diaphragm	13	6.5
Injectable	21	10.6

COCs	1	0.5
Withdrawal	3	1.5
Is contraceptives wrong?		
Yes	53	26.6
No	146	73.4
Have you ever used any contraceptive method?		
Yes	74	37.2
No	125	62.8
Are you currently using any contraceptive method?		
Yes	60	30.2
No	139	69.8
Which of the contraceptive method do you prefer?		
Condom	122	61.4
Pills	35	17.6
Diaphragm	17	8.5
Injectable	19	9.5
COCs	6	3.0
Do you face any difficulty in accessing contraceptives?		

Yes	22	11.1
No	177	88.9
Where do you go to access contraception or sexual health service?		
Hospital	129	64.8
Schools	14	7.0
Friends	27	13.6
Others (specify)	29	14.6
Total	**199**	**100.0**

Source: author's construct 2018

4.1.3 Distribution of Respondents by factors influencing contraceptive knowledge

Results in Table 4.3 below showed factors influencing adolescent contraceptive knowledge. It was reported that adolescents that strongly disagree had greater percentage by 34.7%, disagree by 26.1%, strongly agree is reported by 23.1%, the least is adolescents who agree by 19.1%. Adolescents who strongly disagree and disagree that religion affect knowledge about contraceptive is reported by 29.7% respectively, strongly agree by 22.1%, and strongly disagree by 18.6%. Adolescents that agree that their parents use to enlighten them about contraceptive is reported by 34.2%, strongly disagree is reported by 26.6%, strongly agree by 19.6% and disagree by 19.1%. It was reported that adolescents that strongly agree that they have been taught about contraceptive in school have the highest percentage by 35.2%, agree by 34.7%, strongly disagree by 16.2% and the least were disagree by 14.1%. Also, adolescents that

strongly agree that contraceptive is a way to prevent pregnancy is reported by 50.3%, agree by 37.2%, strongly disagree by 7.0%, and disagree by 5.5%. It was reported that adolescents that agree that they have good knowledge on contraceptive have highest percentage by 40.7%, strongly disagree by 34.7%, disagree by 12.6%, the least is strongly disagree by 12.1%. Adolescents that strongly disagree were reported by 54.8%, agree by 29.2%, strongly disagree by 11.1%, and disagree by 5.0%.

Table 4.1.3: Distribution of Respondents by Neighborhood factors influencing contraceptive knowledge by Weighted Percentage.

VARIABLES	RESPONSE (%)			
	Strongly Agree	**Agree**	**Strongly disagree**	**Disagree**
Does the environment you live affect your knowledge about contraceptive?	20.1	19.1	34.7	26.1
Does your religion affect your knowledge about contraceptive?	22.1	18.6	29.7	29.7
My parents use to enlighten me about contraceptive?	19.6	34.2	26.6	19.1
I am been taught about contraceptive in my school?	35.2	34.7	16.2	14.1
Contraceptive is a way to	50.3	37.2	7.0	5.5

prevent pregnancy?				
I have a good knowledge on contraceptive?	34.7	40.7	12.1	12.6
Adolescents need to know about contraceptive?	54.8	29.2	11.1	5.0

Source: author's construct

FIGURE 1: NEIGHBORHOOD FACTORS ON ADOLESCENT'S CONTRACEPTIVE KNOWLEDGE

Neighbourhood Factors on Adolescent Contraceptive Knowledge

	Strongly Agree	Agree	Strongle Disagree	Disagree
Environmental factors	20.1	19.1	34.7	26.1
Religious factors	22.1	18.6	29.7	29.7
Parental factors	19.6	34.2	26.6	19.1
School factors	35.2	34.7	16.2	14.1
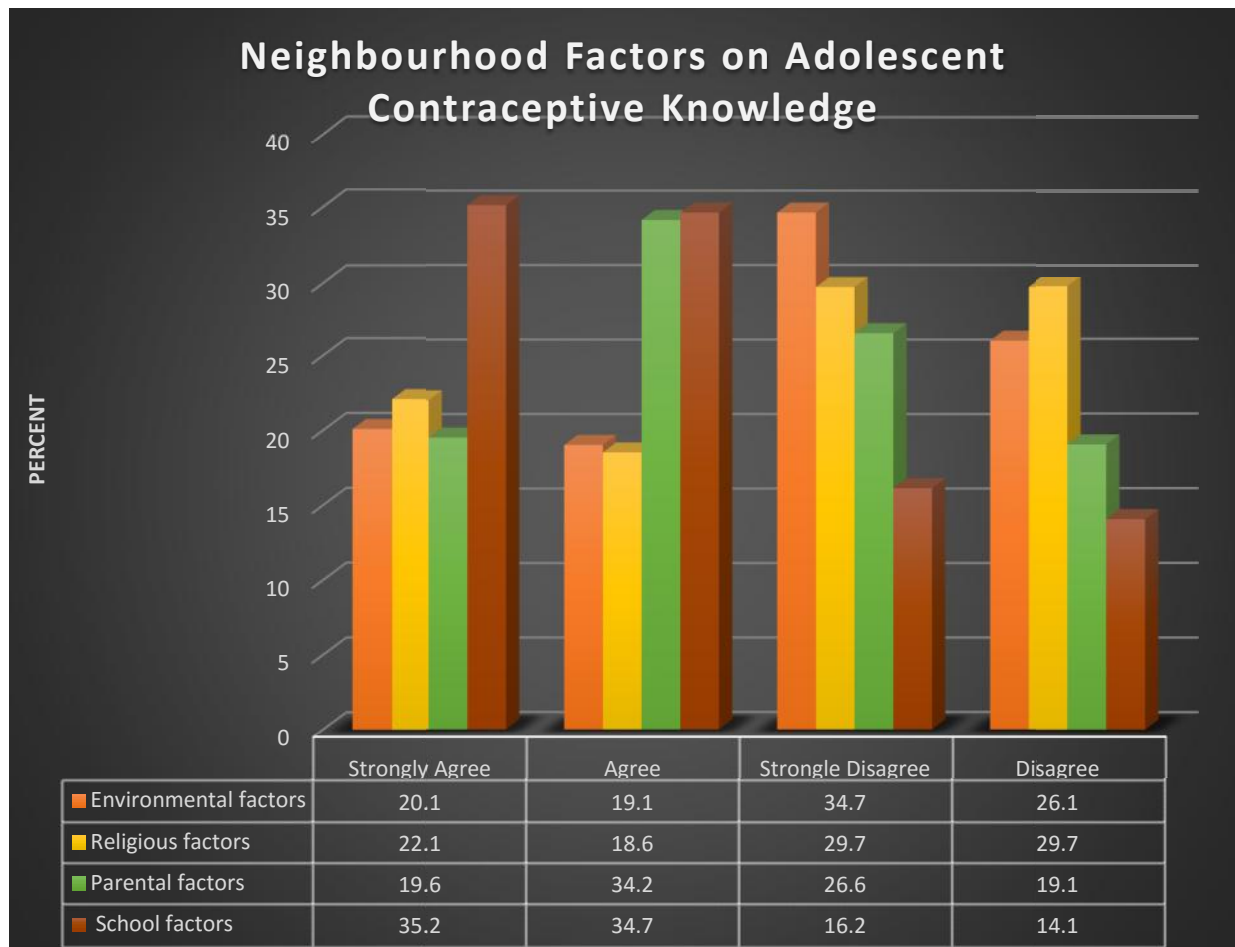
FIGURE 2: PERCENTAGE DISTRIBUTION OF THE TYPES OF CONTRACEPTIVE

Types of Contraceptives

Legend: Condom, Pills, Diaphragm, Injectable, Cocs
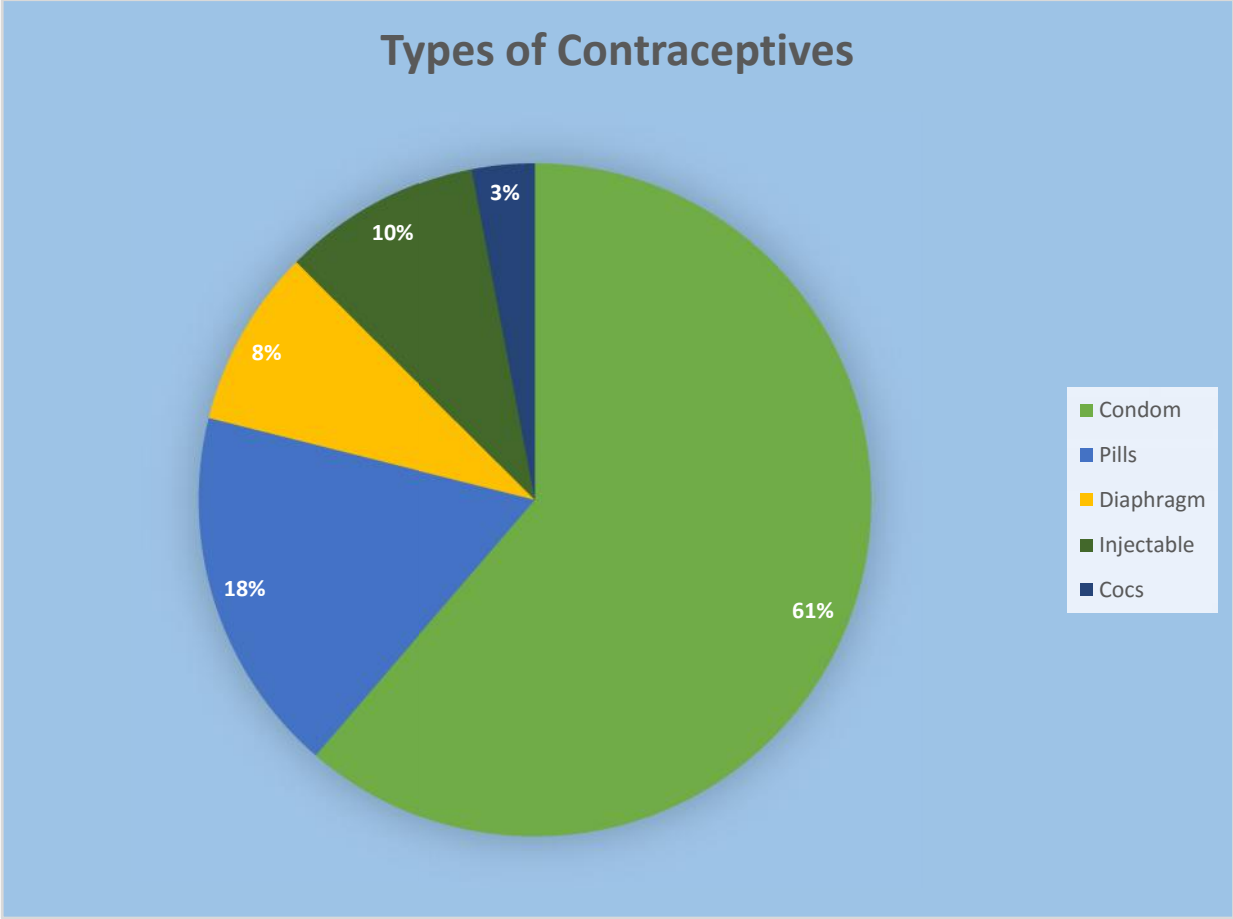
FIGURE 3: PERCENTAGE DISTRIBUTION OF RESPONDENT'S ACCESS TO CONTRACEPTIVE

Access to Contraceptives
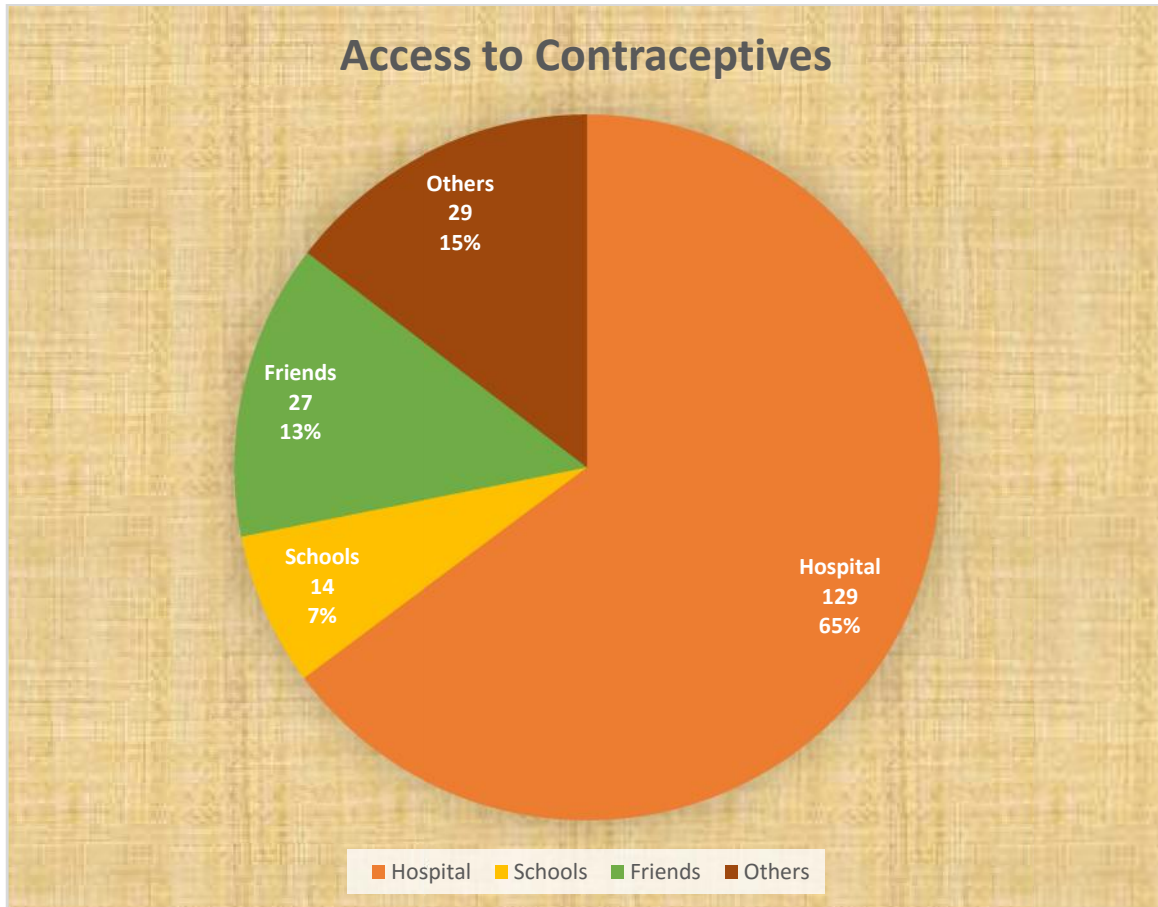
4.2 BIVARIATE ANALYSIS

4.2.1: Distribution of Respondents by Socio-Economic Characteristics and Adolescent Contraceptive Knowledge.

The table below revealed the level of significant association of family background and adolescent contraceptive knowledge (P<0.05). There is significant relationship between age of respondents and knowledge of contraceptives (X^2= 5.32, Pr= 0.021) age group 15-19 years heard more about contraceptive knowledge by 82.9% and age 10-14 years by 17.1% compare to adolescent that never heard about contraceptive knowledge. The result between level of education and knowledge of contraceptive is statistically significant (X^2= 13.16, Pr=0.004) students in part 1 had contraceptive knowledge by 54.3%, SS2 students by 21.3%, SS3 by 18.9% and JSS 3 were least by 5.5% in relation to those that had no knowledge about contraceptives. The result between place of residence and knowledge of contraceptive is statistically significant (X^2=4.23, Pr=0.040) adolescent from urban area had contraceptive knowledge by 76.8% and rural area by 23.2% in relation to those that had no knowledge about contraceptives. There is significant relationship between father's education and contraceptive knowledge (X^2=7.98, Pr=0.047), adolescent whose father attended high school had contraceptive knowledge by 57.3%, secondary education by 31.1%, primary education by 6.7% and father with no formal education by 4.9% compare to adolescents that had no knowledge about contraceptives.

Table 4.2.1: Distribution of Respondents by Socio-Economic Characteristics and Adolescent Contraceptive Knowledge.

Background Characteristics	Contraceptive Knowledge		Statistics
	Yes	No	
Sex			
Male	85 (51.8)	19 (54.3)	X^2= 0.069
Female	79 (48.2)	16 (45.7)	Pr=0.792
Age			
10 – 14 years	28 (17.1)	12 (34.3)	X^2= 5.32
15-19 years	136 (82.9)	23 (65.7)	Pr= 0.021
School attended			
St. mulumba	43 (26.2)	14 (40.0)	X^2= 9.54
Ife city	32 (19.5)	12 (34.3)	Pr= 0.009
OAU	89 (54.3)	9 (25.7)	
Class/level of respondent			
JSS 3	9 (5.5)	6 (17.1)	X^2=13.16
SS 2	35 (21.3)	8 (22.9)	Pr=0.004
SS 3	31 (18.9)	12 (34.3)	
Part 1	89 (54.3)	9 (25.7)	
Religion Affiliation			
Christianity	108 (65.9)	28 (80.0)	X^2= 3.13
Islam	47 (28.7)	5 (14.3)	Pr= 0.209
Traditional	9 (5.5)	2 (5.7)	

Residence			
Urban	126 (76.8)	21 (60.0)	X^2= 4.23
Rural	38 (23.2)	14 (40.0)	Pr= 0.040
Are you living with your parents?			
Yes	124 (75.6)	26 (74.3)	X^2= 0.2648
No	40 (24.4)	9 (25.7)	Pr=0.876
Father's education			
No formal education	8 (4.9)	5 (14.29	X^2= 7.98
Primary school	11 (6.7)	5 (14.29)	Pr=0.047
Secondary school	51 (31.1)	6 (17.14)	
High school	94 (57.3)	19 (54.3)	
Mother's education			
No formal education	9 (5.5)	5 (14.3)	X^2= 3.52
Primary school	7 (4.3)	1 (2.9)	Pr=0.319
Secondary school	59 (35.9)	12 (34.3)	
High school	89 (54.3)	17 (48.6)	
Father's employment status			
Full time	92 (56.1)	15 (42.9)	X^2= 6.69
Part time	25 (15.2)	6 (17.1)	Pr=0.082
Unemployed	11 (6.7)	7 (20.0)	
Retired	36 (21.9)	7 (20.0)	
Mother's employment status			
Full time	96 (58.5)	16 (45.7)	X^2= 4.9830

Part time	31 (18.9)	8 (22.9)	Pr=0.173
Unemployed	17 (10.4)	8 (22.9)	
Retired	20 (12.2)	3 (8.6)	

Source: author's construct

4.2.2: Distribution of Respondents by Neighborhood Factors and Adolescent Contraceptive Knowledge.

There is significant relationship between taught about contraceptive in my school and contraceptive knowledge (X^2=27.39, Pr=0.000), adolescent that support this agree by 76.8% and disagree by 23.2% compare to adolescents that had no knowledge about contraceptives. There is significant relationship between contraceptive is a way to prevent pregnancyand contraceptive knowledge (X^2=18.83, Pr=0.000), adolescent that support this agree by 92.1% and disagree by 7.9% compare to adolescents that had no knowledge about contraceptives. There is significant relationship between good knowledge on contraceptiveand contraceptive knowledge (X^2=35.23, Pr=0.000), adolescent that support this agree by 83.5% and disagree by 16.5% compare to adolescents that had no knowledge about contraceptives. There is significant relationship between adolescents need to know about contraceptiveand contraceptive knowledge (X^2=35.18, Pr=0.000), adolescent that support this agree by 90.3% and disagree by 9.7% compare to adolescents that had no knowledge about contraceptives.

Table 4.2.2: Distribution of Respondents by Neighborhood Factors and Adolescent Contraceptive Knowledge.

Background Characteristics	Contraceptive Knowledge		Statistics
	Yes	No	
Does the environment you live affect your knowledge about contraceptive?			
Strongly Agree	32 (19.5)	8 (22.9)	
Agree	31 (18.9)	7 (20.0)	X^2= 1.62
Strongly Disagree	60 (36.6)	9 (25.7)	Pr=0.655
Disagree	41 (25.0)	11 (31.4)	
Does your religion affect your knowledge about contraceptive?			
Strongly Agree	34 (20.7)	10 (28.6)	
Agree	30 (18.3)	7 (20.0)	X^2= 5.03
Strongly Disagree	54 (32.9)	5 (14.3)	Pr= 0.169
Disagree	46 (28.1)	13 (37.1)	
My parents use to enlighten me about contraceptive?			
Strongly Agree	34 (20.7)	5 (14.3)	
Agree	61 (37.2)	7 (20.0)	X^2= 7.64
Strongly Disagree	41 (25.0)	12 (34.3)	Pr= 0.106
Disagree	27 (16.5)	11 (31.4)	
I am been taught about contraceptive in			

my school?			
Strongly Agree	60 (36.6)	10 (28.6)	
Agree	66 (40.2)	3 (8.6)	X^2=27.39
Strongly Disagree	23 (14.0)	9 (25.7)	Pr=0.000
Disagree	15 (9.2)	13 (37.1)	
Contraceptive is a way to prevent pregnancy			
Strongly Agree	87 (53.1)	13 (37.1)	
Agree	64 (39.0)	10 (28.6)	X^2=18.83
Strongly Disagree	8 (4.9)	6 (17.1)	Pr= 0.000
Disagree	5 (3.0)	6 (17.1)	
I have a good knowledge on contraceptive			
Strongly Agree	63 (38.4)	6 (17.1)	
Agree	74 (45.1)	7 (20.0)	X^2= 35.23
Strongly Disagree	15 (9.2)	9 (25.7)	Pr=0.000
Disagree	12 (7.3)	13 (37.1)	
Adolescents need to know about contraceptive?			
Strongly Agree	101 (61.6)	8 (22.9)	
Agree	47 (28.7)	11 (31.4)	X^2= 35.18
Strongly Disagree	13 (7.9)	9 (25.7)	Pr=0.000
Disagree	3 (1.8)	7 (20.0)	

Source: author's construct

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 INTRODUCTION

This chapter is devoted to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research study. The overall objective of this study is to explore theneighborhood factors influencing contraceptive knowledge among adolescent in Ile-Ife, Osun State, Nigeria. The study was based on the sample size of 199 respondents of adolescent ages in the study area.

5.1 SUMMARY OF THE FINDINGS

With respect to socio-demographic characteristics of adolescent perception on contraceptive knowledge. The adolescents socio-economic and demographic characteristics were revealed that age 10 - 14 years had greater percentage than age 15 - 19 years. Female and male adolescent were reported. Adolescent from OAU reported were higher than those reported from St. Mulumba and Ife City. It was reported that adolescent in part 1 have the highest percentage than those in SS 2, SS 3 and JSS 3. Christian adolescent reported more than Muslim and Traditional religion in the study area. Also, adolescents from urban area are greater than those in the rural area. It was reported that adolescent living more with their parents have highest percentage than those reported not living with parent.

More so, based on adolescents contraceptive knowledge. It was reported that adolescents that have heard about contraceptive before, had greater percentage than those who have not heard about contraceptive before. Adolescents who heard about contraceptives more in school followed by media, parents, friends, and the lowest were other means of contraceptive knowledge. Adolescents that knows condom is reported to be higher than other contraceptive

methods Adolescents that has used any contraceptive is lower than those whohave not used any method. Adolescents that are not using contraceptive currently is reported mostly to higher than those that are using. Adolescent preference for contraceptive were reported to be condom followed by pills, injectable, diaphragm, and Combined Oral Contraceptives. Adolescents that did not face any difficulty in accessing contraceptive is reported to be greater than those who face difficulty in accessing contraceptive. Those who would go to hospital to access contraception is higher than other options (like friends, schools and others)

Furthermore, to show the neighborhood factors influencing adolescent contraceptive knowledge. It was strongly disagree by adolescent that the environment they lived affect their knowledge about contraceptive followed by those that disagree and adolescent were less reported to strongly agree and agree. Adolescents strongly disagreed and disagreed that their religion affect their knowledge about contraceptive than those that strongly agreed and agreed.

Furthermore, to show the level of significant association between family background and adolescent contraceptive knowledge, there is significant relationship between age of respondents and knowledge of contraceptives where age group 15-19 years heard more about contraceptive knowledge than age 10-14 years compare to adolescent that never heard about contraceptive. The result between place of residence and knowledge of contraceptive is statistically significant, adolescent from urban area had more contraceptive knowledge than those from rural area in relation to those that had no knowledge of contraceptives. There is significant relationship between father's education and contraceptive knowledge, showing that adolescents whose father attended high school had the highest contraceptive knowledge than those their father had secondary education, followed by primary education and fatherswith no formal education compared to adolescents that had no knowledge of contraceptives.

There is significant relationship between been taught about contraceptive in school and contraceptive knowledge, adolescent that agreed to been taught in school had greater percentage than those that disagreed compared to adolescents that had no knowledge about contraceptives. There is significant relationship between contraceptive is a way to prevent pregnancyand contraceptive knowledge, adolescent that agreed to this had more percentage than those that disagreed compared to adolescents that had no knowledge of contraceptives. There is significant relationship between adolescents need to know about contraceptiveand contraceptive knowledge, adolescent that support this had greater percentage than those that disagreed compared to adolescents that had no knowledge of contraceptives.

5.2 DISCUSSION OF FINDINGS

According to Williamson et al (2009), states that among the identified limits to contraceptive use by adolescents include lack of knowledge, limited sex education and access to services and negative social norms around premarital sex and pregnancy. Several participants in this study expressed negative perception on use of contraceptives (Williamson et al, 2009). Most participants described use of contraceptives by the teenagers as harmful and those using them are exposed to risks such as excessive bleeding or may not be able to have children in future. Once a teenage has reached puberty, methods that are physiologically safe for adults, they are physiologically safe for adolescents. However, the decision making consideration of more than just medical safety just like it is with adults and before discussing contraceptives options, adolescents must be given an opportunity to express their needs and to freely decide whether they want protection against pregnancy, HIV-Aids or even other sexually transmitted diseases (STDs). Once they have decided, sexually active adolescents should be presented with options that if used consistently and correctly, will cater for individual needs and circumstances, (WHO

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2004). For instance, adolescent who professed one kind of religion (Christian, Muslims and traditional) were unlikely to utilize contraceptives. Religion teaches and advocates for sex within marriage therefore respondents who professed one kind of religion were unlikely to engage in premarital sex and thus the lack of need to use any form of contraceptive.

Based on the findings of this study, there is need to improve sex education amongst teenagers. This is in regard to the curricular of subjects and things that our society, religion and traditions demands that should be taught or not taught. As recommended by the World Health Organization, teenagers should be provided with sufficient knowledge regarding sex. They should also be given an opportunity to decide freely on methods of contraceptives including abstinence based on accurate knowledge and not misperceptions. This finding is contrary to Jones and Dreweke, (2011) who showed high proportion of both married and unmarried religious women using contraceptive (Jones and Dreweke, 2011). Further compared to students who stayed with parents, those who stayed alone showed a higher likelihood of utilization of contraceptives. This was probably because of the access of contraceptives and freedom to choose what to do (Wangima, 2016).

5.3 CONCLUSION

This study conclude that based on the facts from the result that some factors such as age, school attended, class of respondent, place of residence and father's level of education profound a significant association with the prevalence of teenage pregnancy where p-value less than five percent level of significant. Neighborhood factors influencing uptake of contraceptive knowledge included access to contraceptive knowledge in school, contraceptive as way of

preventing pregnancy, good knowledge and adolescent needs to know about contraceptives greatly influence contraceptive knowledge and acceptability.

5.4 RECOMMENDATION

The findings suggest that there should more attention on adolescent contraceptive knowledge.

Adolescents requires enhanced continuous health education on sexuality and proper use of contraceptives aimed at improving their attitude towards contraceptive awareness and hopefully uptake. Also, Sex education in all educational levels should be enhanced by the ministry of education in conjunction with ministry of health to improve acceptability and utilization of services. Introduce policies that improve young people's demand and access to modern contraceptive methods;

- Provision of information about contraceptive should include possible sources of contraceptives, especially where it could be accessed without embarrassment by the providers.
- Adolescents should be provided with basic knowledge of sexuality and contraception before the age they are likely to engage in sexual activities.
- Education is a way of empowering adolescents. Hence, adolescents' knowledge as shown in the study should be encouraged.

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APPENDIX

Faculty of Social Science

Department of Demography and

social science

Federal University Oye-Ekiti

Ekiti State.

Dear Respondents,

The researcher wishes to elicit information on neighborhood factors influencing contraceptive knowledge among adolescents in Ile Ife, Osun State. Please be honest in supplying the information, as it is true of you and your person. The information collected shall be treated with utmost confidentiality. The researcher is an undergraduate student of the above school. Your co-operation, sincerity and honesty are solicited for.

Thank you.

Yours sincerely,

AdegunAdenike Grace.

QUESTIONNAIRE CODE NUMBER:-

QUESTIONNAIRE TITLE: - NEIGHBORHOOD FACTORS INFLUENCING CONTRACEPTIVE KNOWLEDGE AMONG ADOLESCENTS IN ILE IFE.

SECTION A: - SOCIO-DEMOGRAPHIC VARIABLES

1. Gender (a) male (b) female

2. Age category (a) 10-14 (b) 15-19

3. School attended _____

4. Class/level of respondent _____

5. Religion (a) Christian (b) Muslim (c) tradition

6. Residence (a) Urban (b) Rural

7. Are you living with your parents? (a) Yes (b) no

8. Father's education (a) no formal education (b) primary school (c) secondary school (d) high school

9. Mother's education (a) no formal education (b) primary school (c) secondary school (d) high school

10. Employment status of father (a) full-time (b) part time (c) unemployed (d) retired

11. Employment status of mother (a) full-time (b) part time (c) unemployed (d) retired

SECTION B: - LEVEL OF CONTRACEPTIVE KNOWLEDGE AND USE AMONG ADOLESCENTS

1. Have you ever heard of contraceptive before? (a) Yes (b) no

2. Where did you hear about contraceptive? (a) parents (b) friends (c) school (d) media (e) others (specify) _____

3. Types of contraceptive you know?

   _____

4. Is contraceptive wrong? (a) Yes (b) no

5. Have you ever used any contraceptive method? (a) Yes (b) no

6. Are you currently using any contraceptive method? (a) Yes (b) no

7. Which of the contraceptive method do you prefer?

   _____

8. Why do you use contraceptive?

   _____

9. Reasons for contraceptive use?

   _____

10. Reasons for not using contraceptive?

   _____

11. What is your view about contraceptives?

   _____

   _____

12. Do you face any difficulty in accessing contraceptives? (a) yes (b) no

13. If yes, what are the difficulties?

   _____

   _____

   _____

14. Where would you go to access a contraception or sexual health service?

   (a) hospital (b) school (c) friends (d) others (specify) _____

SECTION C: - NEIGHBORHOOD FACTORS INFLUENCING CONTRACEPTIVE KNOWLEDGE

For the following statements state whether you Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD). Please tick (√) the appropriate response

S/N		SA	A	SD	D
1.	Does the environment you live affect your knowledge about contraceptive?				
2.	Does your religion affect your knowledge about contraceptive?				
3.	My parents use to enlighten me about contraceptive				
4.	I am been taught about contraceptive in my school				
5.	Contraceptive is a way to prevent pregnancy				
6.	I have a good knowledge on contraceptive				
7.	Adolescents needs to know about contraceptive				