MODERN CONTRACEPTIVE USE AMONG APPRENTICES IN IBADAN NORTH LOCAL GOVERNMENT AREA, IBADAN, OYO STATE

BY

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ABSTRACT

Family planning is a key factor to achieving the Sustainable Development Goal but it is relatively low in Nigeria. The socio-cultural and religious views on contraception poses a barrier to contraceptive use and this results to poor knowledge and low contraceptive use. Although studies have been carried out among in school adolescents, however few studies have been carried out among youths in the artisan group as regards contraceptive use. Thus, this study was aimed at investigating the modern contraceptive use among apprentices in Ibadan North Local Government area.

This was a cross-sectional study that used a three stage sampling technique to select 320 youths from tailors, hairdressers, traders, mechanics and carpentry group of artisans in their shops. Data were collected using both quantitative and qualitative methods. Quantitative data were collected using a validated semi-structured interviewer administered questionnaire. The questionnaire contained questions on the use of contraceptives, knowledge and attitudinal disposition of respondents to contraceptive use. Contraceptive use was measured in frequency and percentages, Knowledge was measured on a 21-point scale; score of 0<7 was classified as poor, ≥7<14 as fair and ≥14≤21 was classified as good. The attitude of the respondents was measured using a Likert scale. Concurrently, qualitative data were collected from consenting family planning service providers at primary health care centre and State coordinator for family planning services, using a Key informant interview (KII) guide. Quantitative data were analysed using descriptive and inferential statistics at $p<0.05$ while qualitative data were analysed thematically.

The contraceptive use among those who currently have sex was (94.5%) in this study. The mean age was 19.5±2.5 years and (64.7%) were mostly females. Most of the respondents (72.8%) had a fair knowledge on modern contraceptive with a mean score of 11.9±3.0. Slightly above half of the respondents (56.9%) have had sex and Condom (54.4%) and pills (51.7%) were the most used contraceptives by the respondents, this was corroborated with the KII were condoms and pills were mostly used by youths. Most (55.0%) of the respondents sometimes use any of the two methods. Socio demographic factors that

influenced contraceptive use were age (X^2=23.9 p-value=0.0), sex (X^2=7.0 p-value=0.0) and artisan group (X^2=14.8 p-value=0.0). Knowledge was found to influence contraceptive use (X^2=11.3 p-value=0.0). Attitudes of health care worker was also significantly associated with contraceptive use by youths (X^2=5.9 p-value=0.0). The KIIs revealed that there is a need to integrate the parents into educating their youths on contraceptives and its importance and to create more enabling environments for contraceptives among the apprentices.

Majority of the respondents had fair knowledge on contraceptives but their contraceptive use was quite high among those who currently have sex, however their sex and age and artisan group influence their use. Health Education strategies such as, advocacy and use of workplace setting should be used to design educational intervention and training aimed at empowering each youth to informed decision about contraceptive use. Positive attitude from family planning service provider is also recommended to address these gaps on youth's contraceptive use.

Keywords: Modern contraceptive use, apprentices, Knowledge, artisans

Word count: 496

DEDICATION

I dedicate this project to God Almighty for keeping and sustaining me throughout the MPH programme and for giving me the grace to execute this work successfully.

To my parents Mr. and Mrs. Akinade and my siblings, Tomiwa and Segun Akinade, Timilehin Bello for their love and care and support.

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Tomisin AKINADE

CERTIFICATION

I hereby certify that this research work was carried out by Victoria Oluwatomisin AKINADE in the Department of Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan.

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LIST OF ABBREVIATIONS

WHO:	World Health Organization
UNFPA:	United Nation Population Fund
NPC:	National Population Commission
ICF	International Coach Federation
CPR:	Contraceptive prevalence Rate
IUD:	Intra-uterine Device
NDHS :	National Demographic Health Survey
NURHI:	Nigerian Urban Reproductive Health Initiative
NGO:	Non-Governmental Organization
SC	State coordinator
KII	Key informant interview
SFH	Society for Family Health
HCP	Health Care Provider
PHC	Primary Health Care

OPERATIONAL DEFINITION OF TERMS

Youths: Unmarried apprentices that are aged 15 to 24 years

Apprentice: Tailors, hairdressers, carpenters, traders and mechanics who are aged between 15 and 24 years who has been with his/her boss for more than 3 months

Modern Contraceptive: Any method of family planning designed using technological advancement such as condoms, vasectomy, pills, implants, Injectable, Intra uterine device, spermicides

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

According to the (Nigeria Demographic Health Survey, 2013) the contraceptive prevalence among women in Nigeria is 15 percent and the statistics shows that 50.3% of sexually active adolescent girls aged 15–19, are not using any modern method of contraception. This average usage is not far-fetched from various factors that pose as barriers to the use of modern contraceptive by women and particularly adolescents because adolescents face more challenges than adults to accessing contraceptives. Although the contraceptive services are available and free, unmarried adolescents find it difficult to access the contraceptives due to the restrictive socio cultural barriers in Nigeria. They also have the fear of confidentiality breach when visiting clinics for contraception even if they are youth friendly as well as the stigma associated with early sexual debut (United Nation Population Fund, 2016). Globally, 63% of women of reproductive age, use a modern contraceptive method with less than half of them in West Africa and middle Africa (United Nations, 2017).

Urbanization has brought about changes that creates barrier for the extended families and elders who often took the responsibilities of preparing adolescents for sexuality and parenthood due to geographical, language, and cultural differences. Thus, when they get matured and become sexually active with little or no factual information and access to appropriate health services, more adolescents face a series of health risks including unintended early pregnancies and sexually transmitted diseases (Gandisa, 2004). A study in Ghana explains that adolescents face many social barriers to contraceptive use because of the close connection our social and cultural has with our sexual activities. Some of these social and cultural factors are: interpersonal relationships from peers and parents, community influences in terms of perceived norms about acceptability of adolescent sexual activity and its consequences as regards pregnancy and abortion, religious teachings on abstinence to premarital sex, lack of comprehensive sex education, and limited access to confidential quality sexual reproductive health care affects the willingness and ability of young

adolescents to use family planning methods and services (Challa, Manu, Morhe, Dalton, Loll, et al, 2017). Some other socio-cultural barriers are from the health workers or lack of willingness to acknowledge adolescents' sexual health needs (World Health Organisation report, 2018).

In addition, Adolescents' religious beliefs and connection to religious institutions are often developed within the family environment Manlove, Logan, Moore, and Ikramullah (2003). Therefore, as morbidity and mortality among adolescents increase as a result of teenagers' unprotected sexual activity, low contraceptive use, rising pregnancy rates and dependence on unsafe abortion practices has become a focus of research and policy initiatives in developing countries (Dehlendorf, Greene, Bocanegra, Bradsberry, and Darney, 2007).

1.2 Problem Statement

The prevalence of adolescents with unmet need for family planning is 35.3% which is the highest of the age distribution in the need and demand for family planning (Nigeria Demographic Health Survey, 2013). It was also corroborated by a study in Nairobi that 91.4% of the adolescents do not use contraceptive methods (Marston and King, 2006). According to the global trend, sexual activity among never married adolescents increases with level of education and wealth in Burkina Faso and Nigeria and over one third of ever-married adolescent females had sex before age 15 in Bangladesh (37%), Niger (37%), and Nigeria (38%) (Cortez, Quinlan-Davidson, and Saadaat, 2015). This is of concern because they make up one fifth of the world population and their potential impact in the future population growth will be enormous if the factors inhibiting their positive response to contraceptive use is not addressed (Gandisa, 2004). Teenage pregnancy imposes health problems for the mother and child and contributes to educational and socioeconomic disadvantages (Carvalho, Medeiros, Faria, Cotu, Will, Neves and Pontes, 2017). Unmarried pregnant adolescents face stigma or rejection by parents and peers and threats of violence and are more likely to experience violence within marriage or a partnership (WHO, 2018).

Stigmatization of sexual activity outside marriage is one of the main reasons cited for why adolescent women with unmet need are not using a method of contraception (Woog, Singh,

Browne and Philbin 2015). The challenge is accentuated by the unfamiliar excitement of sexual arousal, the attention connected to being sexually attractive, and the new level of physical intimacy and psychological vulnerability created by sexual experiences.

Adolescents' responses to these social challenges are profoundly influenced by the social and cultural context in which they live (Titiloye, et al 2017). These competing perspectives co-mingle, creating a situation where adolescents are exposed to sexual activities daily but not given adequate preparation to behave responsibly in sexual situation and social measures have not been able to fill the gap (Crockett, Raffaelli and Kristen, 2003). Furthermore, in a cross sectional study in Ojo military barrack, Lagos, it was reported that the most common barrier to contraceptive use as reported by 85.1% of respondents was being embarrassed to source for the contraceptive services and this shows that they do not have the self-efficacy to access family planning services because of the social environment (Chimah, Lawoyin, Lika and Nnebue, 2016).

Understanding the modern contraceptive use of youths who do not have access to enough educational materials or information on contraceptives and its benefits helps to provide services that meets their needs as regards the procurement and provision of services to these group of people. Although contraceptive services is targeted towards women of reproductive age however, youths in this category of age 15 to 14 are not usually captured adequately due to the socio-cultural barriers they face in their environment as regards contraceptive use which in turn results to high pregnancy and unsafe abortion rate. The study was therefore conducted to address this gap by looking into the youth's knowledge, attitude, practices and socio-cultural factors influencing the contraceptive use of youths in Ibadan North Local Government in Ibadan.

1.3 Justification of the study

The fertility rate of women who are aged 15-19 is 23% and the percentage of teenagers who have started child bearing decreases with educational level. This tells us that there is a high relationship between educational literacy and fertility (Nigeria Demographic Health Survey, 2013). The global population of adolescents continues to grow and projections indicate that

the number of adolescent pregnancies will increase globally by 2030, with the greatest proportional increase in West and Central Africa. Increasing the use of contraception by adolescents at risk of unintended pregnancy will avert 2.1 million unplanned births, 3.2 million abortions, and 5600 maternal deaths each year (Woog, Singh, Browne and Philbin, 2015).

In a study conducted in Ogbomoso, it revealed that teenage pregnancy is a significant risk factor for morbidity and mortality in the newborn. Newborns were admitted with the common indications for admission were birth asphyxia, prematurity, neonatal sepsis and neonatal jaundice. These newborns were children who belonged to teenage mothers (79.3%) with poor knowledge of contraception while majority of the mothers 22(75.9%) did not use contraceptives. These key findings were among children of artisans and apprentices and exposes the gaps that their literacy level on contraceptive matters influences their health decisions (Joel-Medewase and Aworinde, 2018). In Nigeria, the projection to 2030 on the 3rd Sustainable Development Goal of Good Health and Well-being's target is to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. In order to achieve this, one of the indicators is to reduce adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group (WHO, 2016**).** Levels of demand satisfied by modern methods less than 50 per cent are considered very low and a key aspiration of the 2030 agenda is ensuring that no one will be left behind (United Nation, 2016).

In many schools, sexuality education is taught and the sexuality education curriculum is reinforced but no provision is made available for out of school youths who do not have the privilege of being in the formal setting of a school (WHO, 2014). Others studies have assessed the implication of parent's educational level on contraceptive use, knowledge, attitude and practice of adolescents towards contraceptive use in other countries but few has focused specifically on modern contraceptive use among apprentices who are unmarried and have the tendency of not having any educational background in Nigeria. Thus, this research aims to investigate the modern contraceptive use by apprentices in terms of religion, health

care service, cost, peers and family influences, so that policy makers and programmes can address their unmet need in the Ibadan municipal and beyond.

1.4 Research Questions

1. What is the level of knowledge of the respondents on modern contraceptives?
2. What is the attitude of the respondents towards contraceptive use?
3. What is the practice of contraceptive use among the respondents?
4. What are the factors influencing contraceptive use among the respondents?

1.5 Broad Objectives

The broad objective of the study was to investigate the Modern Contraceptives use among apprentices in Ibadan North Local Government Area, Ibadan.

1.6 Specific Objectives

The specific objectives of this study were to:

1. Assess the level of knowledge of the respondents on modern contraceptives.
2. Determine the attitude of the respondents towards contraceptive use.
3. Determine the practice of modern contraceptive use among the respondents.
4. Identify the factors influencing contraceptive use among the respondents.

1.7 Research Hypotheses

The following hypotheses were tested:

Ho1. There is no significant relationship between the respondents' socio demographic (age, sex, apprentice group) and use of modern contraceptive.

Ho2. There is no significant relationship between the respondents' knowledge and use of modern contraceptive.

Ho3. There is no significant relationship between factors influencing modern contraceptive use and uptake of modern contraceptive among apprentices.

CHAPTER TWO

LITERATURE REVIEW

2.1 Knowledge of contraceptive among adolescents and youths

A Nigerian study conducted in the Southwestern part of Nigeria on contraceptive knowledge and usage amongst female secondary school students in Lagos, revealed that 77% of the 1500 research recruits had good knowledge on contraception with most of them knowing through television (45%) and radio (Tayo, Akinola, Babatunde, Adewunmi, Osinusi, and Shittu, 2011). This was quite different from the findings of a study in Kabarole District, Uganda whose objective was to examine the reproductive Health Behaviour among in-school and Out-of-school youth by (Ndiananbangi, Kipp and Diesfeld, 2007) reported that majority (63.2%) of the adolescents had no knowledge about contraceptives but just 36.8% of the adolescents knew contraceptives are used to limit pregnancy while 29.3% indicated that contraceptives are used to delay pregnancy but majority didn't know what contraceptives were. Most of the respondents (77.3%) indicated that contraceptives are used to prevent pregnancy. Condom was mostly known among in-school adolescents while less than half (42%) of the out-of-school youth were knowledgeable about condoms. The out-of-school adolescents' knowledge on modern contraceptive was low because of their understanding of oral contraceptives being a cause for malformation of newborns. The highest known modern contraceptive was also condom (74.8%) as compared to others where pills (56.2%) was the highest known contraceptive by the adolescents in another study in Northern Ghana which examined the socio cultural determinants of contraceptive use among adolescents by (Adadow, Shamsu-deen, Bavo and Ibn, 2015).

The level of knowledge among Adolescents in Taung community was also quite low among the adolescents in comparison to other studies. During an In depth interview session, a pregnant 17 year old grade 12 girl was asked to mention any kind of contraceptive she knows and she said *"So that one, I don't know anything about it"*. Teenagers knowledge varied in the number of contraceptive options that they knew about, although condoms (mentioned by nine out of the 12 pregnant teenagers), injection (eight girls) and pills (four girls) were most

frequently mentioned. Only three of the 12 girls had heard of emergency contraception (Kanku and Mash, 2010).

Furthermore, a systematic review on contraceptive use by adolescents reported that there is poor understanding of how contraceptives methods work and how they should be used leading to adolescents using them incorrectly and this is as a result of their poor knowledge in contraceptive (Chandra-mouli, Mccarraher, Phillips, Williamson and Hainsworth, 2014). In another study carried out among 238 in-school and out-of-school adolescents in Gomoa East in Ghana reported that the perceived benefits for contraceptives were to delay pregnancy in order to complete school/acquire skills (36%), marry before getting pregnancy (37%), to avoid teenage pregnancy (25%) or spoil pregnancy (2%) (Clottey, 2012).

2.2 Attitude of adolescents and youths toward modern contraceptive use

A study in Taung which conducted a focus group discussion and an in-depth interview among adolescents and young people aged 10-23 whose objective is to understand the attitudes and perceptions of teenagers regarding teenage pregnancy and to explore their understanding of sexuality and contraception usage found out that adolescents in this district do not see the need to use contraceptives because of the benefits of grants they receive from the Government and the fact that the responsibility of taking care of the child is not on them but on their parents or grand-parents (Kanku, and Mash, 2010). Another study in Kabarole District, Uganda whose objective was to examine the reproductive health behaviour among in-school and out of school Youth was of the same opinion that out-of-school youth had a less positive attitude towards the use of contraceptives with 67% of the participants reporting that they would use condoms, compared to 86% in the in-school youth (Ndiananbangi, Kipp and Diesfeld, 2007).

In a study in Northern Ghana, shyness towards purchasing contraceptive was statistically significant ($P<0.001$ and $X^2= 56.7$) as a barrier in using contraceptives (Adadow, Shamsu-deen, Bavo and Ibn, 2015). Similarly, Bell (2009) stated that embarrassment is a key risk factor in young people's sexual behaviour and it explains why engaging in protective sexual

behaviour and seeking information and advice, can be constrained by fear of embarrassment and concerns about how they are perceived by others.

2.3 Practice of contraceptive use among youths

In a recent study conducted in Southern Nigeria by Eze, Obiebi and Akpofure, (2018) on Sexual behaviour and patterns of contraceptive use among students of Tertiary Institutions in Southern Nigeria stated that Condoms were the most known, 159 (88.6%), and was mostly used 97 (31.4%) contraceptive method among the sexually active participants. This was corroborated by a study conducted among rural youths in South west Nigeria on contraceptive use by (Onajole, Sekoni and Onigbogi, 2017) where two-thirds (63.8%) reported condom as mostly used, and there was gender-based difference in condom use (P = 0.021). More male respondents (68.9%) reportedly used condoms compared to their female counterparts. In Nepal, a cross sectional household survey was conducted among urban areas of Kathmandu Valley with the aim of identifying key factors that are associated with current non use of contraceptives among sexually active youth aged 15-24 found out that young people who were not planning to have a child used modern contraceptives and condoms (48.0%) and were mostly used followed by injectables (19.0%) and contraceptive pills (5.0%) (Tamang, Raynes-greenow, Mcgeechan, and Black, 2017; Adadow, Shamsu-deen, Bavo, and Ibn, 2015).

In a study conducted in Lagos, very few 5% (58) participants out of the 1155 research recruits that have knowledge on modern contraception used any form of contraception. Condom was the highest mode of contraception use among the different contraceptive use. The reason for this low contraception use was as a result of a high number of non-sexual activities among the adolescents but 85% of the sexually active adolescents was because of their laicadesical attitude towards contraceptive use (Tayo, Akinola, Babatunde, Adewunmi, Osinusi and Shittu, 2011). In addition to these findings on practice towards contraceptive use, a study conducted in Kabarole Uganda on 300 in-school and 256 out-of-school adolescent on pattern of reproductive health behaviour reported that use of family planning methods was also significantly higher (61.0%) among in-school adolescents compared to only 33 (17.0%) of the sexually active out-of-school youth said they had ever used a family planning method

(p<0.001). The biggest difference in contraceptive methods used between the two groups was found in the rates for condom use. It was followed by the use of pills, safe period, withdrawal less than 0.001 except for injectables (p < 0.023) Ndiananbangi, Kipp and Diesfeld, (2007). Furthermore, another study conducted to examine the factors associated with unmet need for modern contraceptives in post conflict Liberia among young women aged 14-25 years reported that male condom was mostly used to prevent pregnancy followed by pills which was the second most commonly mentioned form of contraceptive use to prevent pregnancy (Park, McCarraher, Chen, Okigbo, Albert and Wambugu, 2016).A study conducted in South West Nigeria by Omokhodion and Balogun (2017) to determine the prevalence and predictors of contraceptive use, unwanted pregnancies and induced abortion among hairdressers found out that the male condom was the most (23.6%) used contraceptive. In contrast to these findings, contraceptive use was high (81.0%) among sexually active adolescents in another study in Ghana (Clottey, 2012). Also, these findings on condoms being the mostly used modern contraceptive differs from a study by Adadow, Shamsu-deen, Bavo and Ibn, (2015) in Northern Ghana which shows that injectables was the highest (61.0%) contraceptive to have been used while condom was the second highest (46.3%).

In Nigeria, the study carried out to identify the determinants of contraceptive use among female adolescents found a significant relationship with age and contraceptive use (X^2=373.38 p-value 0.000) which shows that the percentage of adolescents saying no to contraceptive use is high at age 15 and only 2% out of them said yes to using contraceptives This shows that the higher the age of the adolescents, the higher the use of their contraceptives (Onipede, Babalola, and Adetoro, 2014).

In the hypothesis testing of association of educational level of youths in Abuja metropolis and contraceptive use, there was a significant association between tertiary institutions and contraceptive use compared to the secondary school since chi-square value 346.525 was significant at 0.007 likewise that of knowledge and contraceptive use, the chi-square of 4494.56 was significant at 0.000 levels. This shows that the higher the knowledge of contraceptive methods, the more the use of contraceptives among youth (Ugwu, 2012).

2.4 Socio cultural factors that influence contraceptive use

Religiosity is conceptually defined as religious beliefs, practices, moral values and guidance, and involvement in a faith community. As part of that moral guidance, most mainline religions have taught that sexual intercourse is to take place between a man and woman within the context of marriage. For Catholics, the frequency of their church attendance was significantly associated with lower incidence of sexual activities while the conservative protestants' incidence of sexual activities was low as a result of increased sexual attendance and self-identification by church members was associated with lower incidence of pre-marital sex which in turn affects the rate of contraceptive use (Fehring and Ohlendorf, 2002). In Nepal, a cross sectional household survey conducted among urban areas of Kathmandu Valley with the aim of identifying key factors that are associated with current non use of contraceptives among sexually active youth aged 15-24 reported that Significant factor associated with current use of contraception was religion, revealing that Hindu youths having lower odds of use compared to young people who belonged to other religions 3.24 (95% CI: 1.39-7.56; P= 0.008) (Tamang, Raynes-greenow, Mcgeechan and Black 2017).

In addition to this finding, Onipede, Babalola, and Adetoro (2014) found out that there was a significant relationship between religion and the use of contraceptives (X^2=315.4 p-value=0.000). Among all the different religion, Christians use contraceptives more (86%) compared to traditionalists (96%) and Muslims (98%) although this is still comparatively low to the expected level of use of contraceptive in Nigeria. Using a two wave's data from the National survey of youth and Religion 2002 and 2005, a national probability sample of 3290 adolescents ages 13-17 was aimed at testing the association of religious involvement and delayed transitions into sexual activities. Studies consistently show that religious involvement is more strongly associated with the sexual and contraceptive behaviours of females especially. Although boys and girls are encouraged to refrain from sexual activities, virginity status may be especially important for girls (Burdette and Hill, 2009). However, a study conducted by Manlove, Logan, Moore, and Ikramullah (2003) using a longitudinal survey of youths from 1997 to 2003 which measured the associations between family religiosity assessed during early adolescence and contraceptive use reported a different view from previous findings that family religiosity was negatively associated with the adolescents

sexual activity, and this is as a result of the quality of the parent teenager relationship and negative peer behaviours. A family with high religious activities was indirectly associated with adolescents having fewer sexual partners (–0.03) and with the use of contraceptive (0.02).

2.5 Social norms influencing contraceptive use among Youths

A study conducted in Abuja by (Ugwu, 2012) on contraceptive use explained that "embarrassment to buy" is one of the major problems the tertiary students of Abuja face. This according to them is because asking for contraceptives shows that the person is wayward and not disciplined, and he/she is not from a good Christian/Moslem home. This was confirmed by a qualitative survey where a 20 year old undergraduate said:

"one day I went to buy a condom in a chemist shop and one of our fellowship leaders saw me. She reported me to our fellowship and after a lot of questions. I was suspended for a month".

A 19 year old hair dresser claimed *"youth faced a lot of problems while buying condoms, their problems are fear and shame to buy, humiliating by the sellers and refusal by partners and again where to keep the remaining after use.*

Human societies differ significantly in the cultural rules regulating their sexual behaviour and contraceptive behaviour and the dynamism with which they are enforced. Cultural values and attitudes regarding sexuality are provided through experiences in everyday social contexts. Interactions within families, peer groups, and other daily contexts can influence whether and when an adolescent will initiate sexual intercourse (Crockett, Raffaelli and Kristen, 2003).

A study conducted in Northern Ghana among adolescents to examine the socio cultural determinants of contraceptive use reported that, social belief was a factor that influences young the adolescents contraceptive use with a statistical significance of ($P< 0.64$ and $X^2 =0.43$) (Yidana, Ziblim, Azongo and Abass, 2015)

A systematic review of literature on contraception for adolescents in low and middle income countries: needs, barriers and access revealed that another factor that influences contraceptive use was social pressure even when contraception are obtained. This is because there is a stigma that surrounds contraception use among adolescents by the community at large and

they can also be perceived to be loose because they choose to use condoms or they have condom on them (Chandra-mouli, Mccarraher, Phillips, Williamson and Hainsworth,2014).

Furthermore, a systematic review of 268 qualitative studies of young people's sexual behaviour published between 1990 and 2004 developed a method of comparative thematic analysis in which each document was coded according to themes they contained. It found out that carrying or buying condoms can imply sexual experience and young people worry that asking for their partner to use a condom implies that they think their partner has a disease (Marston and King, 2006).

Also, a national representative survey of adolescents aged 12-19 that was conducted in Uganda, Burkina Faso, Ghana and Malawi corroborated this by showing the result of adolescents who are sexually active do not know of any source to obtain contraception due to embarrassment and fear of being tagged as a loose adolescent (Biddlecom, Munthali Singh and Woog, 2007)

2.6 Family influence on contraceptive use among youths

A study conducted by (Ugwu, 2012) in tertiary university in Abuja reported that parents' disapproval (14.6%) is the reasons why they didn't use contraceptives at their last sex intercourse. Parent–child relationships, communication, and parental control, have all been concerned in adolescent sexual behaviour (Crockett, et al., 2003). In a study conducted by (Adadow, et al, 2015) the discussions focused on the use of protection, societal expectations etc, it revealed that family was an important part of an adolescent's life that has a strong influence on adolescent sexual behaviour and contraceptive use. According to a study conducted by (Manlove, Logan, Moore and Ikramullah, 2003) using a longitudinal survey of youths from 1997 to 2003 which measured the associations between family religiosity assessed during early adolescence and contraceptive use reported that family religiosity was negatively associated with the adolescents sexual activity, and this is as a result of the quality of the parent teenager relationship and negative peer behaviours. Research shows that "abstinence only" programmes do not work and that comprehensive sex education programmes do. Teen mothers are less likely to complete school, less likely go to college, more likely to have large families, and more likely to stay single increasing the likelihood

that their children will live in poverty. Research shows that restricted access to reproductive health services and parental involvement mandates have negative consequences on teen health. Studies show that even parental consent for birth control would deter teens from seeking other reproductive health services, including testing and treatment for STIs (Pro choice America Foundation, 2017). Adadow et al. (2015) also reported that fear of parents was and hindrance to using contraceptives however it was not significantly associated with contraceptive use ($P< 0.42$ and $X^2 = 2.8$).

Furthermore, a study conducted in Kenya among 15-19 years adolescents which looked at the perceptions and barriers to contraceptive use reported that parental approval was significantly associated with contraceptive use at $p<0.01$. The use of contraceptive also increased from6.2% to 17.7% among adolescents whose parents would object to their contraceptive use. This was corroborated by a qualitative analysis of parental approval and contraceptive use. Few parents indicated they talked about contraceptives as their main focus of discussion while most parents indicated that they would be angry to find their children using contraceptives (Kinaro, Kimani, Ikamari and Ayiemba, 2015). A study conducted in Osogbo, Nigeria on the parental attitude towards the use of contraceptives by adolescents found out that there was a significant difference between gender and parental attitudes [r-cal = (0.272), r-tab= (0.098), P-value<(0.05)], towards the use of contraceptives by adolescents (Oyediran, Faronmbi and Ajibade, 2013).

2.7 Peer influence on contraceptive use among youths

A study conducted by (Ugwu, 2012) identified disapproval by partner (14.6%) as a reasons why respondents don't use any contraceptives. A study in Taung which conducted a focus group discussion and in depth interview among adolescents and young people aged 10-23 in other to understand the attitudes and perceptions of teenagers in Taung regarding teenage pregnancy and to explore their understanding of sexuality and contraception usage found out that friends or peers who have unprotected sex can strongly influence one's own behaviour. A young girl admitted that pregnant friends can influence ones' own behaviour because they convince their peers to have sex so they won't fall sick and this are usually done without contraceptives during the focus group discussion. It also explained that some teenagers are

forced by partners to have sex without contraceptives because they are being provided financial support by their male partners and they feel justified to give in to their partners demand (Kanku and Mash, 2010).

2.8 Socio-economic cost of contraceptives

Adadow, et al. (2015) reported that the poverty rate in adolescents family was statistically significant ($P<0.64$ and $X^2=0.43$), to their contraceptive use. The cost of purchasing the contraceptives also played a significant role in hindering their ability to use contraceptives with a cost of contraceptives ($P<0.001$ and $X^2=52.4$). The Socio-economic status of an individual influences contraceptive use based on the ability to purchase contraceptives and also to get to the source of the contraceptive providence 0r where they can get information on contraceptive information (Prince and Hawkins 2007). Onipede, Babalola, and Adetoro, (2014) corroborated the aforementioned findings by reporting a statistical significance ($X^2=145.7$ p-value=0.000) between wealth index and contraceptive use. The rich adolescents were more likely to use any method of contraceptives than the poor, in addition the middle class adolescents using contraceptives are also more than the poor who cannot afford nor access any method of contraceptives.

2.9 Gender and contraceptive use

Adolescents' sexual experiences and contraceptive use differ by gender. This gender differential may be due to the societal emphasis on controlling female adolescents' emerging Sexuality And to an underlying assumption that young women should act as responsible gatekeepers (Manlove, Logan, Moore and Ikramullah, 2003).

A study conducted in Indianapolis examined the influence of sex differences in barriers to contraceptive use by using a national sample of 4539 participants from The National Longitudinal Study of Adolescent Health found out that boys were significantly more likely than girls to believe that using birth control interferes with pleasure during intercourse, is difficult to obtain, is morally wrong, is expensive, is bothersome, involves too much planning, and makes people think they are seeking sex (Pesa, Turner, and Matthew, 2001).

2.10 Attitude of health care service provider

The negative attitude of the youth friendly health service providers resulted in the non-use of contraceptives with a statistical significance of ($P< 0.001$ and $X^2=41.3$) (Adadow, et al, 2015). A systematic review of literature on contraception for adolescents in low and middle income countries: needs, barriers and access revealed that even when there are no laws restricting adolescents from using modern contraceptives, health workers in many places refuse to provide these unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity and when it is being provided it is often limited to condoms because of the wrong believes that hormonal methods and intra uterine devices are inappropriate for women who have no children yet (Chandra-mouli, Mccarraher, Phillips, Williamson and Hainsworth, 2014). In another study carried out among 238 in school and out of school adolescents in Gomoa East in Ghana by Clottey (2012) which looked at the social barriers that affect the non-use of contraceptives among adolescents found out that there was a high (81%) usage of contraceptive among the adolescents. Adolescents find it difficult to use contraceptives because of the unfavorable environment in clinics because service providers discriminate against them due to age. According to an in depth interview with an adolescent, he reported that

"It is hard to go and buy contraceptives from the shops because when they look at you and see that you are young they won't give you." Kinaro, Kimani, Ikamari and Ayiemba (2015). This is also corroborated by Clottey, (2012) who reported negative attitudes of health workers (10.6%) as a barrier to contraceptive use by adolescents.

A study in South west Uganda identified cost as a barrier for contraceptive use among in-school users 37(77.1%) (OR=2.6, 95% CI=1.7-5.4) while Stigma surrounding sexual activity was a barrier to out-of school youths 25 (58.1%) (OR=0.4, 95% CI=0.2-0.8). However, Out-of school with secondary education 37(84.1%) were more likely to use contraceptives (OR=0.2, 95% CI=0.1-0.5) (Batwala, Nuwaha, Mulogo, Bagenda, Bajunirwe and Mirembe, 2006).

2.11 Contraceptive policy for youths

A systematic review of literature on contraception for adolescents in low and middle income countries: needs, barriers and access revealed that contraceptive methods are not available to adults and adolescents because of laws and policies which prevent the provision of contraceptives to unmarried adolescents or to those under a certain age (Marston and King, 2006).

2.12 THE ECOLOGICAL MODEL EXPLAINING THE FACTORS INFLUENCING CONTRACEPTIVE USE AMONG APPRENTICES

INTRAPERSONAL LEVEL: This explains the age, religion, knowledge, attitude contraceptive use behavior that is exhibited by the youths. Specific personal characteristics such as religion, type of occupation and family background also gives more explanation to the personal factors that can influence their contraceptive use. This describes the influencing factors that is peculiar to that individual and this influences their behavior towards contraception

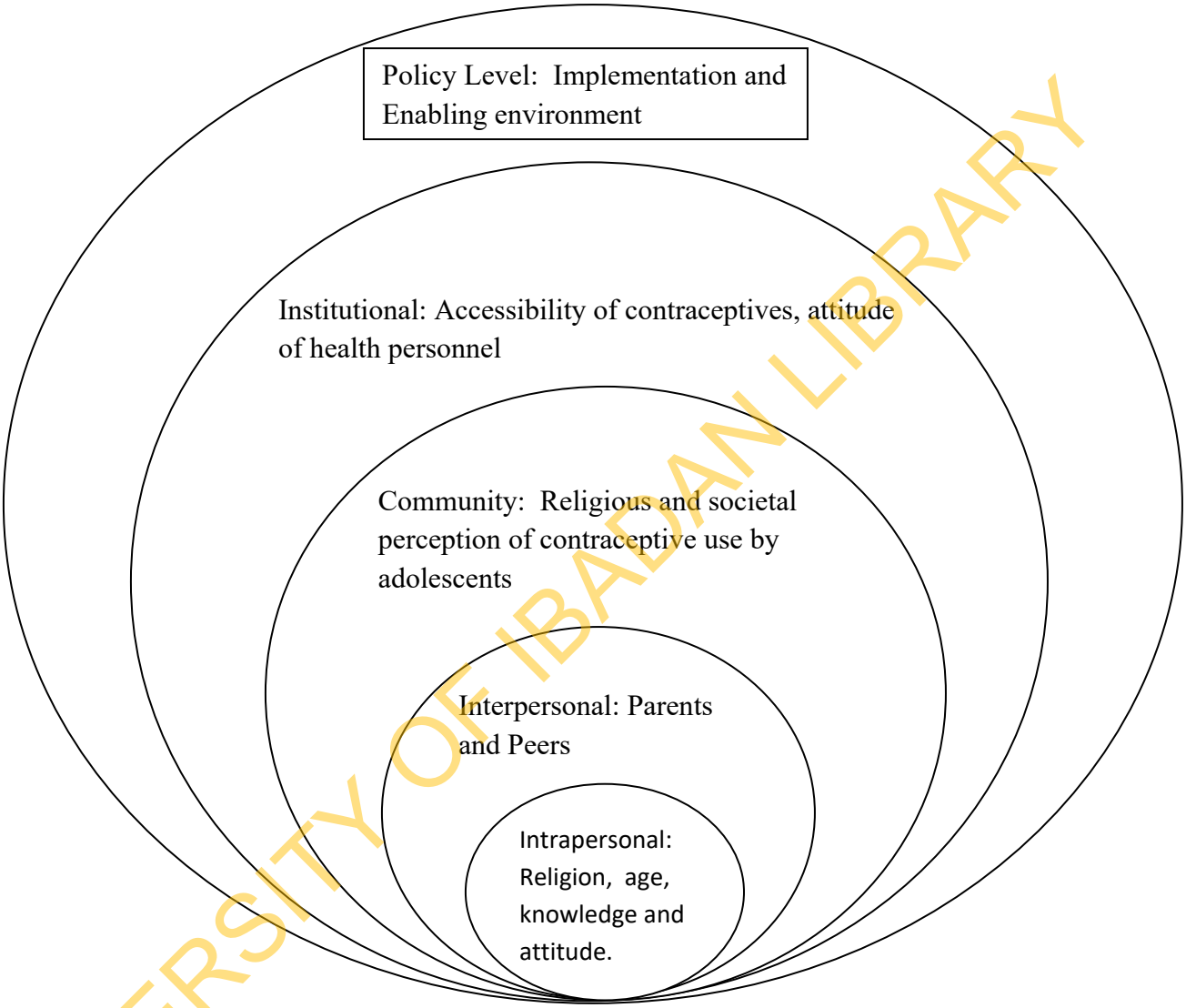
INTERPERSONAL LEVEL: These are the relationships the youths have with their peers and family which in turn influences their behavior of contraceptive use. The usage of contraceptives by peers can also influence contraceptive use while parental guidance on their sexuality can influence a positive attitude towards contraceptive use. The family plays an important role in the contraceptive behavior of youths. Therefore the family background is a valid variable to measure this.

COMMUNITY LEVEL: The community plays a vital role to the use of contraceptive use by youths. There is a general culture of ensuring female youths remain virgins till their marriage while nothing is done towards the male adolescents as regard this, this makes them to engage in sexual activity but the fear of being known to be sexually active prevents them from accessing or purchasing contraceptives. This is a double standard for female and male youths as regards denying youths the right to make the reproductive and sexual health choices.

INSTITUTIONAL LEVEL: This can be related to the health care system in terms of contraceptive services provided by staff. Although, the contraceptive service is free and readily available according to the reproductive health policy but the attitude and approach of the family planning service providers might influence their contraceptive use either positively or negatively. A positive attitude without discrimination of youths using contraceptive can encourage them to use contraceptives. This is another influencing factor.

POLICY LEVEL: Policy involves statements of intent or goals towards a particular course and also the means to achieve them. There is a Reproductive health policy which emphasizes the meeting of reproductive health needs of adolescents and unmarried youths without discrimination

Theoretical Framework



THE ECOLOGICAL MODEL FOR CONTRACEPTION USE AMONG APPRENTICES

CHAPTER THREE

METHODOLOGY

3.1 Study Design

The study was descriptive cross-sectional in design. This cross sectional study design was used to investigate the modern contraceptive use among apprentices aged 15-24 years in 6 wards in Ibadan North Local Government Area, Ibadan, Nigeria.

3.2 Study Population

The study population were youths in Ibadan North Local Government Area, Ibadan

Inclusion Criteria

Apprentices who gave consents and are aged 15 to 24 years who has been with his/her boss for more than 3 months

Exclusion Criteria

Apprentices who are married or above the age of 25 years old and those who didn't consent to be a part of the study will not be eligible.

3.3 Description of Study area setting and Study sample

Ibadan North Local Government area, is one of the five local Government carved out of the defunct Ibadan Municipal Government in 1991 with the youth population of 128,563. According to the National Bureau of statistics, the age distribution of adolescents aged 10 – 29 was 128,563. The Local Government Area covers a landmass of 132.500 square kilometers with a population density of 2,626 persons per square kilometer. The 2010 estimated population for the Local Government area is put at 308,119 as at 2006 census. It is bounded by Akinyele and Lagelu local Government to the North and to the East by Egbeda local Government. Ibadan North West and Ibadan North East bounds it to the South. There are no serious farming activities however trading and other commercial activities are predominant in this area and this makes it an urban area. It is also a home for small, medium and large scale industries. It was also characterized by the population of the highest

concentration of virtually all ethnicity and tribe in Nigeria subdivided into twelve wards (ibadanland.com).

3.4 Study Sample

This study was carried out among youths aged 15 to 24 who are apprentices and not married in Ibadan North Local Government Area, Ibadan, Nigeria.

3.5 Sample Size and Sampling Technique

The sample size was calculated using Cochrane formula (1977) for sample size determination in health studies:

$$n=\frac{z^2pq}{d^2}$$

Where n = sample size;

z = the standard normal deviation which corresponds to the 95% confidence level (1.96);

p = current use of any modern contraceptive in Oyo state, Nigeria was 24.4%. This prevalence is derived from NDHS 2013 (NPC and ICF International, 2014)

$q = 1 - p$ $(1 - 0.244 = 0.756)$;

d = (0.05) degree of accuracy desired

Therefore $n = \frac{1.96^2 \times 0.244 \times 0.756}{0.05^2}$

= 289 apprentices that are youths

Where non response rate is 10% of the sample size n ÷ (1-10%)

289 ÷ (1-0.1) = 289 ÷ 0.9

= 320

Therefore the new sample size was 320

The sampling technique that was used for this study is a three stage sampling technique among apprentices.

1st STAGE

Six out of the twelve wards was randomly selected using the ballot method. The wards randomly selected were Oke Are, Gate, Basorun, Sango, Old Bodija and Agbowo.

2nd STAGE

Five major artisan associations were purposefully identified for the research and this cut across the 6 wards because they usually have more number of members which constituted participants for the research. These associations includes the Hair dressers, Mechanics, Tailors, Carpenter and Traders.

3rd STAGE

The apprentices were approached through their boss at various shops. A simple random system through the ballot system was used to pick one research respondents in a shop if they are more than one present in a shop and they must meet the inclusion criteria to partake in the study.

3.6 Instruments for the Data Collection

The questionnaire used was a semi-structured questionnaire and it was interviewer administered.

The questionnaire was structured into five Sections in order to measure the variables that were identified according to the ecological model and literature search.

Section A: Demographic information

These were age (as at last birthday), ethnicity, religion, artisan group, family background, level of education etc. The responses were analyzed based on frequencies of the respondents.

Section B: Knowledge Section

The questions asked measured their knowledge on modern contraceptives and the knowledge questions asked had multiple options with correct and incorrect options which was ticked based on the knowledge of the respondents.

Section C: Attitude towards contraceptive use

This section measured the intrapersonal variable of the research. Questions were asked using a Likert scale to measure the extent of their agreement or disagreement to using modern contraceptives.

Section D: Practice of Contraceptive use

This section focused on knowing the contraceptive method that is mostly used and how often it is used.

Section E: Factors influencing contraceptive use

This section focused on the factors that influence contraceptive use. The questions were asked based on different sub themes adapted from other studies: socio cultural factor, Peers and family relationship, attitude of Health care workers.

Questions were asked to measure the socio cultural barriers to contraceptive use, six questions for peer relationships, and six questions for health workers attitude.

Qualitative Instrument

Questions were asked on the programmes and policies that guide contraceptive use by youths from the State coordinator for family planning and on the quality of the service provider, how often youths visit the health facility for family planning services and barriers that the adolescent face in accessing these family planning services from the Health service providers on Family planning using the interview guide.

3.7 Validity of the Instrument

The instrument went through different stages of validation.

The questionnaire was validated by reviewing relevant literatures to design the questionnaire.

Appropriate research questions and objectives were formulated in order to address the research topic.

It was also validated by making sure the items under each section of the questionnaire measure the variable construct in each formulated research questions and objectives.

Also the questionnaire was given to the supervisor and other researchers and lecturers within the Health Promotion department for thorough review.

3.8 Reliability of the Instrument

The questionnaire were pretested among apprentices of the same artisan group in Ibadan North East local Government area because it has the same characteristics with the purposed sample population of Ibadan North being urban Local Governments. As mentioned above, 10% of the total sample size was administered and tested through measures of internal consistencies using the Cronbach's alpha. A co-efficient analysis of > 0.70 confirmed its reliability being greater than > 0.5.

3.9 Data collection procedure

The administration of the questionnaire was carried out over the period of three weeks for the quantitative study and a week for the qualitative study. The Questionnaire was interviewer administered in Yoruba, a local dialect in the western part of Nigeria in their shops. An informed consent was sought from all the apprentices that took part in the study. The anonymity and confidentiality of the respondents were kept safe by the researcher and the research assistants. The questionnaire was tagged with number for accountability of the questionnaire and it was conducted in a conducive environment where the respondents' privacy was respected in answering the questions. The questionnaire was read out to the youths so they can provide answers to the questions being read to them. After the completion of the questionnaire, it was kept in a safe place and coded for analysis through the use of a coding guide.

A qualitative data collection procedure was performed by the researcher by conducting a Key Informant interview to the State family Planning Coordinator and the facility family planning providers in each ward to know if there is a policy or programme that favours apprentices use of modern contraceptives and the availability and accessibility of the services was asked from the health care providers on family planning service respectively. A voice recorder was used to record the interview session with the state family planning coordinator and the health service providers which was transcribed and analyzed.

3.10 Data Management and Analysis

Each of the questionnaire were reviewed to ensure completeness. The investigator checked the data collected each day to make sure that questionnaire are properly filled. A coding guide was developed to facilitate data entry and entered into a computer.

The analysis was done by using statistical package for the social scientists of version 21 (SPSS). The data collected was subjected to statistics which are Chi square analysis was used to test for the hypotheses stated and regression analysis was used to analyze the factors influencing contraceptive use using the information obtained.

The Key informant interview was analyzed using the content analysis to generate nodes (the themes and child-nodes (subtheme) using Nvivo version 12 which helped to corroborate and give a different view from the quantitative responses from the research respondents.

3.11 Ethical considerations

Ethical clearance was obtained from the Oyo State Ethics Review Committee (Appendix VII) before the study is conducted. After this, the purpose and the procedures of the study was explained to the respondents in Yoruba which is a language they can understand. Verbal or written consent were obtained from all respondents from both the quantitative and qualitative arm in order to ensure adherence to the fundamental ethical principles of; respect for persons, non-maleficence, beneficence, justice and confidentiality of the responses. Anonymity of the respondents were ensured by the removal of all identifiers during the data collection activities.

CHAPTER FOUR

RESULTS

4.1 Respondents socio-demographic characteristics

Three hundred and twenty artisans were interviewed for this study, five artisan groups represented in this study: tailor (31.6%), hairdresser (23.8%), carpenter (10.3%), mechanic (14.7%) and trader (19.7%) (Figure 4.1). Age of respondents ranged from the age of 15 years to 24 years with a mean age of 19.5 ± 2.5, more than half of the respondents were of the age range of 20-24 (51.9%). Majority (64.7%) of the respondents were females while most of the respondents were predominantly of Yoruba ethnic background (88.1%), followed by Igbo (7.5%) and Hausa r`(3.8%), there were respondents who claimed Igala (0.3%) and Edo (0.3%). Christianity is the most prominent religion practiced by the respondents (61.6%) (Table 4.1).

There were two hundred and twelve (66.3%) respondents who had secondary education, however, a small proportion of the respondents (2.5%) do not have any form of formal education. More than half of the respondents (52.5%) live with their parents, compared to (11.9%) who live alone, furthermore, (16.6%) of the respondents live with their partners while (6.6%) live with friends. Most of the respondents nevertheless come from a nucleus family (68.4%) while (19.1%) come from a polygamous family (Table 4.1).

4.2 Respondents knowledge on modern contraceptives

The level of knowledge of modern contraceptives is high among respondents with (98.4%) of the respondents claiming “yes” to “having heard about modern contraceptive before” while (1.6%) said “no” to having heard about modern contraceptive. Among the modern contraceptives identified, level of awareness was measured: condoms (84.7%), oral contraceptives (43.8%), injectable (30.0%), implants (25.6%), intra uterine devices (8.8%), vasectomy (11.6%) and tubal ligation (4.1%) (Figure 4.2).

Majority (86.4%) of the respondents had knowledge of using modern contraceptive to prevent unwanted pregnancy, (58.4%) as being used to space children while (44.4%) knew it

can be used to stop child birth when needed. Among the different benefits of using modern contraceptive known by the respondents, prevention of unplanned pregnancy had the highest frequency (86.0%) known by the respondents and followed by its knowledge of it being used to prevent contraction of STI, although a high percentage (75.6%) do not know it can be used to reduce poverty in the home when childbearing is regulated through the use of Modern contraceptive. Amongst the risk involved identified by the respondents, unplanned pregnancy (80.6%) had the highest being identified followed by the contraction of sexually transmitted disease as the second highest (71.6%) risk in engaging in unprotected sex (Table 4.2).

The overall knowledge score of respondents on modern contraceptive was determined to be fair (72.8%) with a mean score of 11.9 ± 2.9 and with the range of 0-21. Furthermore, 6.6% respondents had a poor level of knowledge of modern contraceptive while (20.6%) of the respondents have good knowledge of modern contraceptives (Table 4.3).

Respondents were assessed on their source of information for modern contraceptive and it was found that television (59.7%) was the highest source of information, followed by radio (56.2%), friends (46.7%) and Social media (46.0%). Other sources include: newspaper (21.0%), parents (21.0%), health care staff (22.2%), course education (10.5%), posters (1.6%) and seminar talks (1.0%) (Figure 4.3).

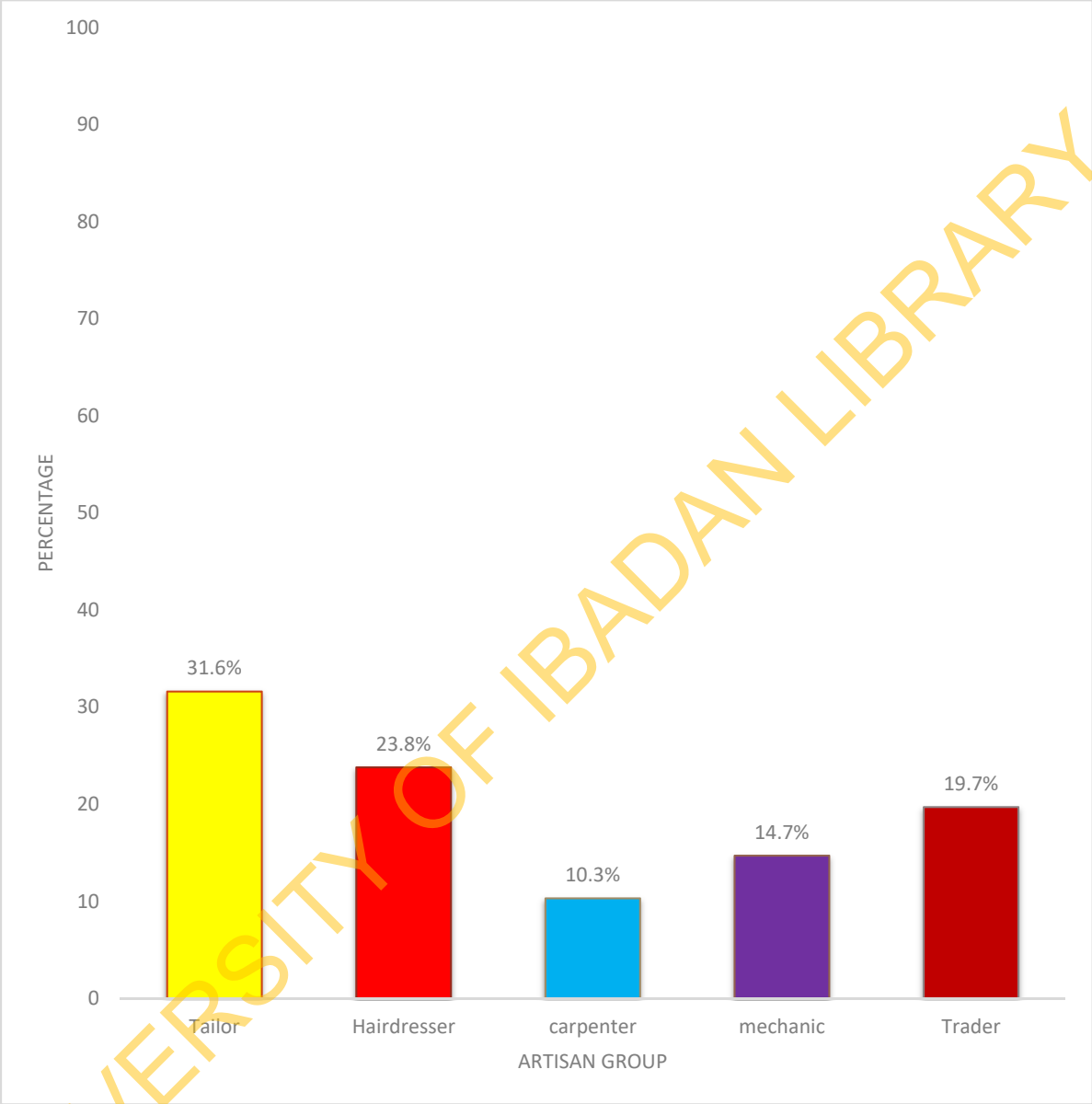


Figure 4.1: Respondents' artisan groups

Table 4.1: Respondents socio-demographic characteristics (N=320)

Socio demography	Frequency	Percentage%
Age		
15-19	154	48.1
20-24	166	51.9
Sex		
Male	113	35.3
Female	207	64.7
Ethnicity		
Yoruba	282	88.1
Hausa	12	3.8
Igbo	24	7.5
Igala	1	0.3
Edo	1	0.3
Religion		
Christianity	197	61.6
Islam	121	37.8
Traditional	2	0.6
Education		
No formal education	8	2.5
Primary	55	17.2
Secondary	212	66.3
Tertiary	45	14.1
Living arrangement		
Alone	38	11,9
with partner	53	16.6
With parents	168	52.5
With guardians	40	12.5
With friends	21	6.6
Family structure		
Nuclear	219	68.4
Polygamous	61	19.1
Single parenting	40	12.5

***Mean age 19.5± 2.5years**

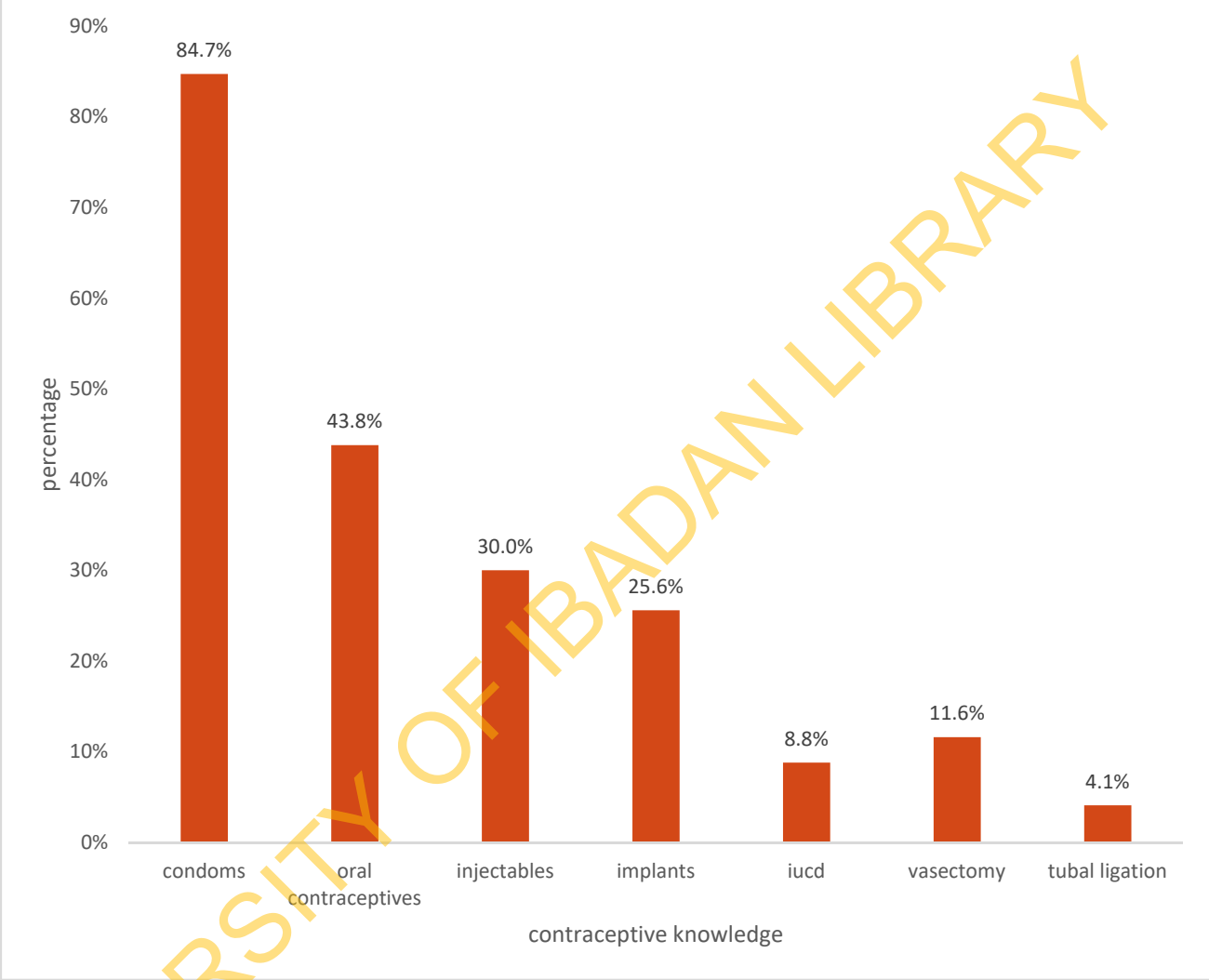


Figure 4.2: Respondents knowledge about types of modern contraceptives n = 315

Table 4.2: Respondents Knowledge on modern contraceptives (n=315)

variable	Yes (%)	No (%)
Truth about modern contraceptives		
They prevent unplanned pregnancy	272(86.4)*	43(13.6)
Used to space children	184(58.4)*	131(41.6)*
Used to stop child bearing at when decided	140(44.4)*	175(55.6)
Causes infertility	80(25.4)	235(74.6)*
IUD is a modern contraceptive that prevents STI	71(22.5)	244(77.5)*
Benefits of Modern Contraceptives		
Prevents unplanned pregnancy	271(86.0)*	44(14.0)
Helps to initiate abortion in an unplanned pregnancy	51(16.2)	264(83.8)*
Prevents against STIs	207(65.7)*	113(34.3)
Helps to reduce poverty	77(24.4)*	238(75.6)
Risks involved in engaging in unprotected sex		
Unplanned pregnancy	254(80.6)*	61(19.4)
Contraction of STI	226(71.7)*	89(28.3)
Unsafe abortion as a result of unplanned pregnancy	146(46.3)*	169(53.7)
There is no risk involved	45(14.3)	270(85.7)*

***correct responses**

Table 4.3: Respondents overall knowledge score of modern contraceptive (N= 320)

Score	Frequency	Percentage (%)
Poor 0 -7	21	6.6
Fair 8- 14	233	72.8
Good 15-21	66	20.6

Mean=11.9±3.0

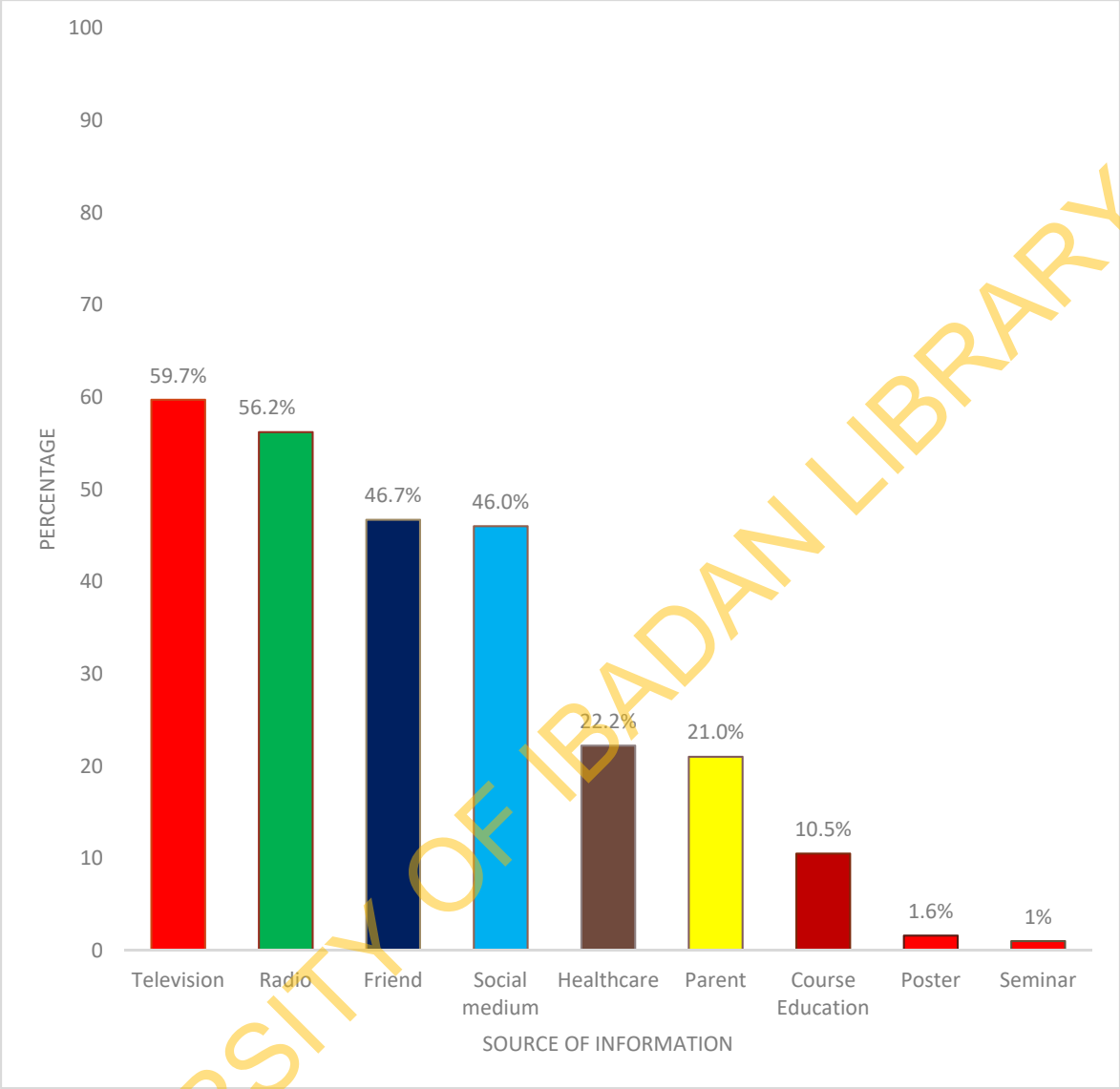


Figure 4.3: Respondent sources of information on modern contraceptives

4.3 Respondents attitude towards contraceptive use.

There were ninety six (30%) respondents who 'disagreed' to the statement that 'I am not comfortable using modern contraceptive, however most respondents (49%) 'Agreed' and 'strongly agreed'. Also most of the respondents 'disagreed' to the statement that 'I cannot use modern contraceptives to prevent pregnancy' while a small proportion (15.9%) of the respondents 'strongly agreed' to the statement. The statement that 'I cannot buy contraceptives because it is embarrassing' was 'agreed' to by most of the respondents (27.8%) while 'strongly disagreed' to by sixteen respondents (5%). Majority of the respondents (31.9%) 'Disagreed' to the statement that 'I detest youths who use modern contraceptives because they are morally bad people' and 13.8% of the respondents 'strongly agreed'. There were ninety seven respondents (30.3%) who 'agreed' that 'I can encourage any unmarried youth to use modern contraceptive to prevent pregnancy' even though a small proportion (12.2%) 'Strongly disagreed'. A cumulative percentage of 45.5% 'agreed' and 'strongly agreed' that 'I don't feel comfortable using modern contraceptives because I am not married'. Finally, the statement that 'I am shy to purchase contraceptives because of what people will think about me' was 'agreed' to by most of the respondents (35%) (Table 4.4).

Table 4.4: Respondents Attitude towards contraceptive use (N=320)

Statements	Strongly Agree (%)	Agree (%)	Undecided (%)	Disagree (%)	Strongly Disagree (%)
I'm not comfortable using modern contraceptive.	67 (20.9)	90 (28.1)	49 (15.3)	96 (30.0)	18 (5.6)*
Cannot use modern contraceptives to prevent pregnancy.	51 (15.9)	75 (23.4)	46 (14.4)	100 (31.3)	48 (15.0)*
Cannot buy contraceptives because it is embarrassing	49 (15.3)	89 (27.8)	83 (25.9)	83 (25.9)	16 (5.0)*
Detest youths who use modern	44 (13.8)	77 (24.1)	51 (15.9)	102 (31.9)	46 (14.4)*
Can encourage any unmarried youth to use modern contraceptive	76 (23.8)*	97 (30.3)	45 (14.1)	63 (19.7)	39 (12.2)
Don't feel comfortable using modern contraceptives because I am not married.	61 (19.1)	84 (26.3)	84 (26.3)	65 (20.3)	26 (8.1)*
I'm shy to purchase contraceptives because of what people will think about me.	65 (20.3)	112 (35.0)	67 (20.9)	53 (16.6)	23 (7.2)*

***multiple response**

4.4 Practice of Contraceptive Use

Findings revealed that more than half of the respondents (56.9%) have had sex before. Among the respondents that have had sex before, most of the respondents (33.8%) have had sex within the past month, followed by (7.8%) who have been sexually active for two months. Among those who have had sex, (94.5%) claimed to have ever used modern contraceptives.

Respondents' use of modern contraceptives was measured and it was found out that: condoms (54.4%), Pills (51.7%), intra-uterine device (7.1%), injectable (5.0%) and implants (1.7%) were used by respondents, however, female sterilization was not used by any of the respondents (Figure 4.5).

This section derived qualitative information regarding the contraceptive choices used by youths from the health care service providers. The findings from the interview among the respondents showed that condoms is the most used modern contraceptive among the youths which corroborates with the quantitative findings from the adolescents while other choices include; injectable contraceptives (depo povera and noristerat), oral contraceptives, implants, spermicide tubes and postinor 2. Some of the quotes from the respondents are illustrated in table below.

"Injectable are used by females and males use more of condoms." ***"-(KII 1 Female, HCP 1, PHC service provider)***

*"Pills and condoms are used"-****(KII 2 Female, HCP 2, PHC service provider)***

*"Pills and condoms are mostly used "-****(KII 6 Female, HCP 6, PHC service provider)***

During the respondents' last sexual engagement, condom was the most used of all the identified modern contraceptives (54.4%), followed by pills (25.8%) and intra-uterine device (7.1%), other contraceptives used by respondents include injectable (5.0%) and implants (1.7%). Nonetheless, there were 6.0% of the sexually active respondents who did not use any of the modern contraceptives but have had sex before (Figure 4.6).

On assessing frequency of modern contraceptive use, it was found that (55.0%) of the respondents sometimes use modern contraceptives while there were (39.5%) of the respondents always use modern contraceptives, and there were (5.5%) respondents who never used modern contraceptive but have had sex (Table 4.5).

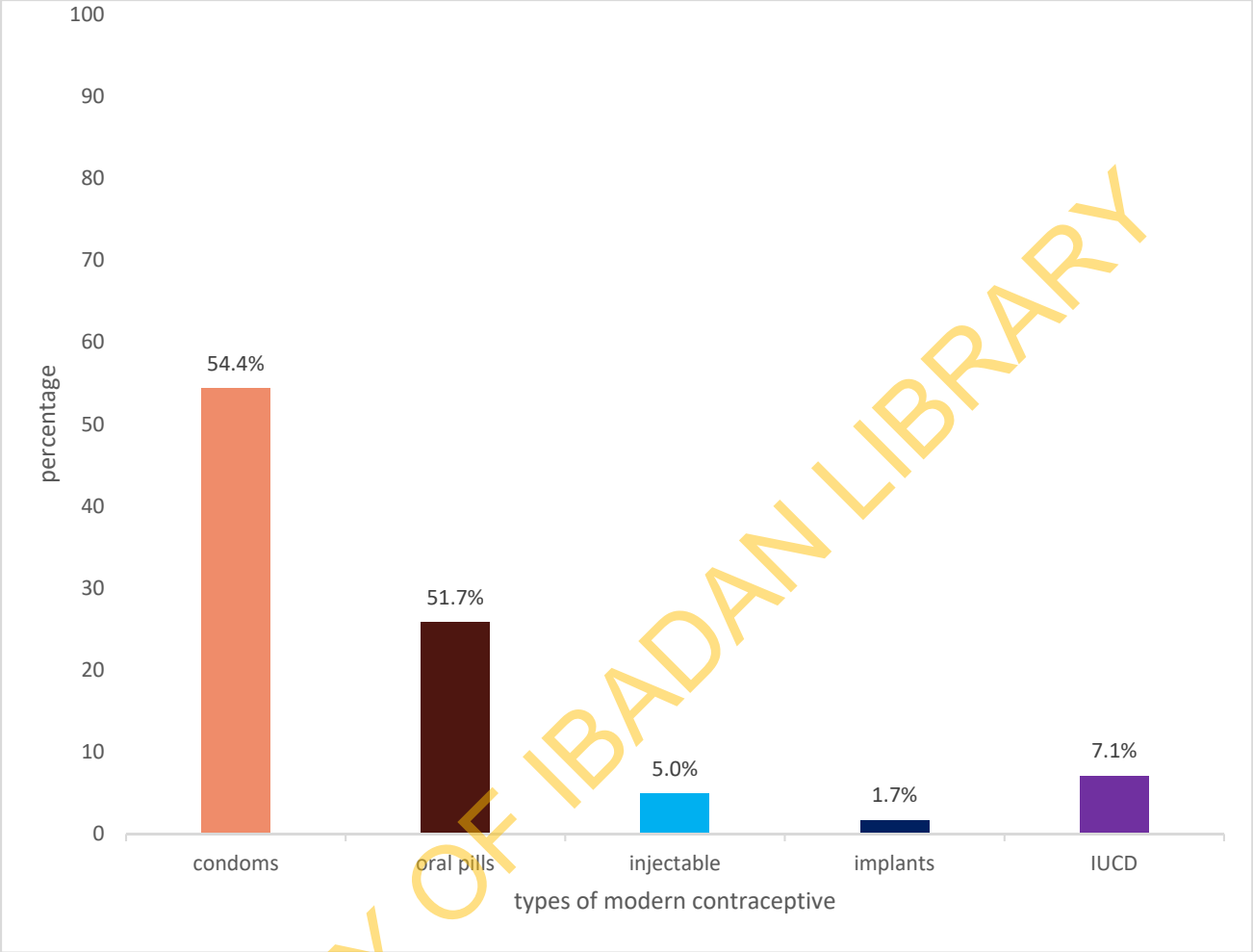


Figure 4.4: Respondents Contraceptive methods ever used (n=172)

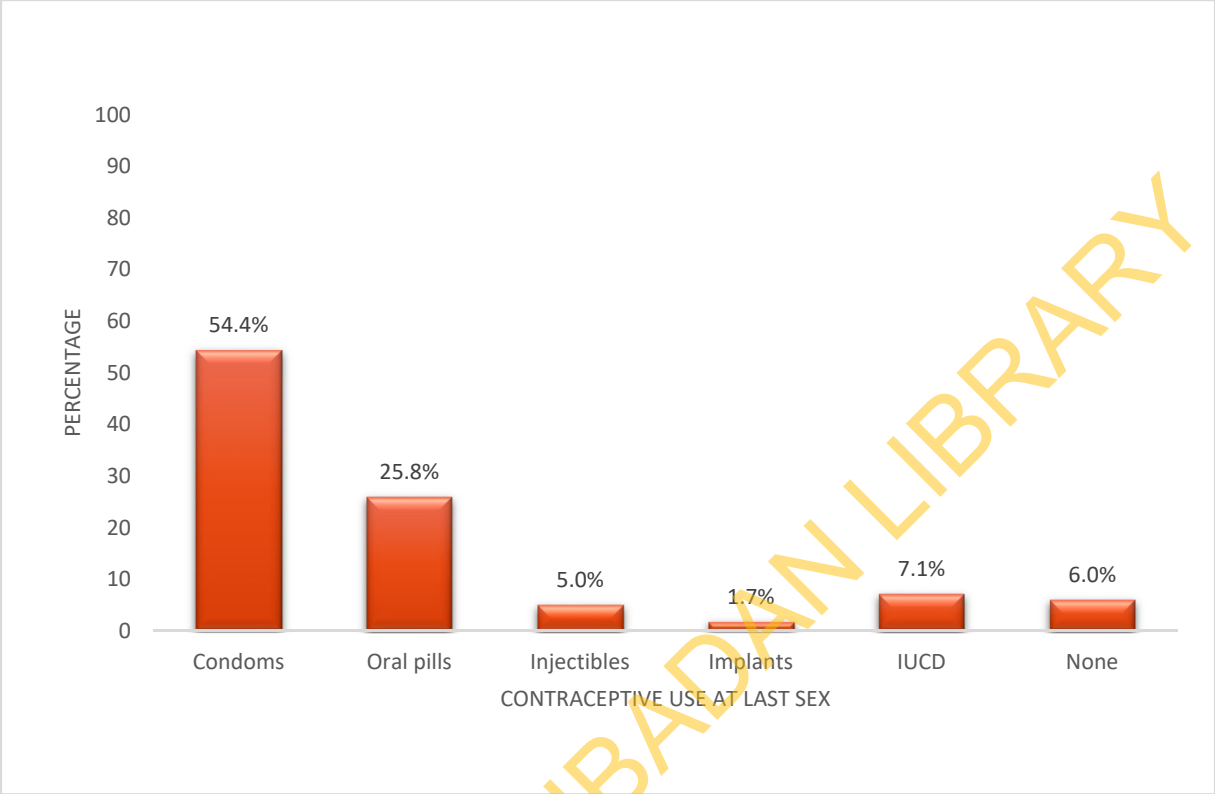


Figure 4.5: Respondents contraceptive use at last sexual Engagement (n= 182)

Table 4.5: Frequency of modern contraceptive use by respondents (n= 182)

Frequency of Contraceptive Use	Frequency	Percentage (%)
Always	72	39.5
Sometimes	100	55.0
Never	10	5.5

4.5 Factors influencing Contraceptive Use

There were one hundred and twenty eight (40.0%) respondents who agreed that people around them don't think modern contraceptives are meant for young people. Assessing the socio-cultural factors, majority of the respondents (36.6%) agreed that their society feels that it is dangerous to use modern contraceptives when not married while a small proportion (3.8%) strongly disagreed. Additionally, (26.9%) of the respondents agreed that their society thinks the use of modern contraceptives in early youthful age will cause infertility later in life. Likewise, more respondents (33.1%) agreed that their society tag those who use modern contraceptives as promiscuous people.

Also, there were one hundred and one (34.7%) who agreed that their society believes youths should not be sexually active. There were one hundred respondents (31.3%) who agreed that their religion does not permit them to use contraceptives. In addition, most of the respondents (28.1%) agreed that preventing unwanted pregnancy is a sin in their religion and on the other hand, the largest proportion of respondents (35.3%) strongly agreed that it is an abomination to use contraceptives in their religion as an unmarried youth (Table 4.6).

Assessing Peers/ Family Relationship factors, it was determined that more than half of the respondents (58.4%) selected 'no' to the statement that 'I can't use contraceptives because my friends do not use contraceptives' while half of the respondents (50.6%) did not feel their friends encourage them to use modern contraceptives. Further, most respondents (62.8%) did not feel their brothers and sisters encourage them to use contraceptives. Most of the respondents (61.6%) replied 'yes' that their parents will never support them to use contraceptives as an unmarried youth. On the other hand, half of the respondents replied 'no' to the statement that 'my boy/girlfriend frowns at using modern contraceptives' and more respondents (63.8%) felt that their parents must not see them use any form of contraceptives because they are still young (Table 4.7).

Attitude of Service Providers on family Planning was assessed as factor influencing modern contraceptive use, it was determined that a small proportion of the respondents (18.1%) have visited the health facility where they provide family planning service.

The qualitative study carried out among the health care centres family planning service providers explained that very few adolescents actually go to these health centres for family planning uptake and this corroborated the quantitative study findings of those who have gone

to the health care centre to utilize the family planning service. The respondents reported that majority of those who utilize the facility are married men and women of reproductive age while very few adolescents age 15 years and above utilizes the centres. Few of the comments from the respondent are quoted below

"*Youths starting from age 16 upwards and adults".* ***(KII 1, Female, HCP1, PHC service provider)***

"Married women, women of multiparity and hardly adolescents come for the family planning centre- ***(KII2, Female, HCP 2, PHC service provider)***

*"Men and women and few youths"-****(KII 5 Female, HCP 5, PHC service provider)***

From the number of respondents who visited the facility, 24.1% of them admitted that the family planning service providers shout at them when addressing them. Nevertheless, more of the respondents (55%) admitted that the service providers have respect for them when they requested for family planning services

The qualitative aspect report corroborates the quantitative responses that some of the adolescent rarely use the centres and this is due to; feelings of shame, low level of awareness on right to contraceptive use, misconception about cost of contraceptive service, societal norms and values, peer pressure, low educational status, low socioeconomic status, social and family perception on contraceptive possession by adolescents. The health care worker also reported that some adolescents also engage in using un-prescribed emergency contraceptives and some feel stigmatized.

The following quotes from some of the respondents illustrates the narratives:

"Some of the adolescents feel ashamed of their single status coming to use family planning. They are not informed that they have the right to use family planning since they are sexually active. They are shy of coming to the health centre because they don't want people to be aware of their sexual activeness".....

"Some are also shy of people knowing them coming to the health centre because our socio-cultural factor. They don't want to be called prostitute (ashewo). For example some lie about their real address and some lie about their real names."- ***(KII 1 Female, HCP 1, PHC service provider)***

"During the counseling session, we observed that poverty is a factor that hinders them. Some come from far places and it's difficult to get back home because of financial challenges. Also,

some say their religion don't accept it, some also have a misconception that to access the service is expensive whereas it is free for everybody. "-***(KII 4 Male, HCP 4, PHC service provider)***.*

The quality of service provided to the adolescent at the health care centres showed that majority of the respondents chorused that they provide quality contraceptive services to the adolescent at their respective health care facilities. More reported that; a high level of self-efficacy based on prior training, they have no discrimination rule against their adolescent clients, presence of quality equipment, availability of funding from government and private Non-Governmental Organisations such as Nigerian Urban Reproductive Health Initiative for contraceptive support materials such as drugs and pills

*"We give them full service, no discrimination irrespective of your age. Our materials are always ready and our staff are well trained in attending to people as regards family planning."****"-(KII 1 Female, HCP 1, PHC service provider)***

"We thank State Government, they normally provide us all the goods that are needed based on our request and we are supplied at the end of the month." ***"-(KII 4 Male, HCP 4, PHC service provider)***

Additionally, (36.2%) of respondents selected 'no' when replying to the statement that 'the family planning service providers are not friendly to me', it was also determined that more than half of respondents (56.9%) denied family planning service providers discouraging them from using modern contraceptives when they go for the service. Finally, most respondents (77.7%) denied that the service providers laugh at them for wanting to buy/use the modern contraceptives. The qualitative study also looked at the cost of the contraceptives from the health care service perspective as an influencing factor for contraceptive use in terms of socio economic influence. Findings from the health care providers on the cost of family planning services among at the facilities revealed that the family planning services are completely free, however, some reported that they sometimes pay a token between #50 to #200 to buy some materials such as gloves, cotton wool and some other deliverables if exhausted.

"It is free. However, if the deliverables provided is finished like Pregnancy test kit is exhausted, we ask the client to bring a token of 50 naira to buy what is needed but if all

materials are available there is no need to pay anything"-***(KII 1 Female, HCP 1, PHC service provider)***

"Maximum of 200" "-***(KII 3 Female, HCP 3, PHC service provider)***

Table 4.6: Socio Cultural factors influencing contraceptive use (N=320)

Socio- cultural factors	Strongly Agree (%)	Agree (%)	Undecided (%)	Disagree (%)	Strongly Disagree(%)
People don't think modern contraceptives are meant for young people.	75 (23.4)*	128 (40.0)	44 (13.8)	56 (17.5)	17 (5.3)
It is dangerous to use modern contraceptives	74 (23.1)	117 (36.6)	52 (16.3)	65 (20.3)	12 (3.8)*
Use of modern contraceptives will cause infertility	58 (18.1)	86 (26.9)	87 (27.2)	78 (24.4)	11 (3.4)*
Those who use modern contraceptives as promiscuous people	87 (27.2)	106 (33.1)	42 (13.1)	69 (21.6)*	16 (5.0)
Youths should not be sexually active.	93 (29.1)	111 (34.7)	59 (18.4)	42 (13.1)	15 (4.7)*
Religion forbids me to use contraceptives	84 (26.3)	100 (31.3)	70 (21.9)	47 (14.7)	19 (5.9)*
Preventing unwanted pregnancy is a sin	72 (22.5)	90 (28.1)	80 (25.0)	57 (17.8)	21 (6.6)*
It is an abomination to use contraceptives	113 (35.3)	87 (27.2)	55 (17.2)	44 (13.8)	21 (6.6)*

***correct response**

Table 4.7: Peers/ Family factors influencing contraceptive use

Peers/family factors	Yes (%)	No (%)	Don't know (%)
I can't use contraceptives because my friends do not use contraceptives	71 (22.2)	187 (58.4)*	62 (19.4)
Friends encourage me to use modern contraceptives	119 (37.2)*	162 (50.6)	39 (12.2)
Brothers and sisters encourage me to use contraceptives	61 (19.1)*	201 (62.8)	58 (18.1)
Parents will never support me to use contraceptives as an unmarried youth	197 (61.6)	87 (27.2)*	36 (11.3)
Boy/girlfriend frown at using modern contraceptives	103 (32.2)	166 (51.6)*	51 (15.9)
Parents must not see me use any form of contraceptive because I am still young.	204 (63.8)	79 (24.7)*	37 (11.6)

*correct response

Table 4.8: Attitude of Service Providers on family Planning factors influencing Contraceptive use (n=58)

STATEMENTS	Yes (%)	No (%)
Family planning service providers shout at me.	14(24.1)	44 (75.9)*
Service providers have respect for me when I request for family planning services.	32(55.2)*	26 (44.8)
Family planning service providers are not friendly to me.	21(36.2)	37 (63.8)*
Family planning service providers discourage me from using modern contraceptives.	25 (3.1)	33 (56.9)*
Service providers laugh at me for wanting to buy/use modern contraceptives.	13 (20.7)	45 (79.3)*

*correct response

4.6 Test of Hypotheses

Hypothesis One: There is no significant relationship between socio-demographic (sex, age and use of modern contraceptive among apprentices.

Chi square test (X^2) was used in testing this hypothesis at 95% confidence interval ($p<0.05$). It was found that there is statistical relationship between respondents' use of contraceptive and artisan groups(X^2=14.832 p-value=0.0), age (X^2=23.875 p-value 0.000), sex (X^2=6.980, p-value 0.008).Therefore the null hypothesis is hereby rejected (Table 4.9).

Hypothesis Two: There is no significant relationship between knowledge and the use of modern contraceptive among apprentices. Table 4.10 indicates the cross tabulation of respondents knowledge and use of modern contraceptive at 95% confidence interval ($p<0.05$). Respondents' knowledge has a significant influence (X^2=11.337, p-value = 0.003) on the use of modern contraceptive. Consequently, the null hypothesis was rejected (Table 4.10)

Hypothesis Three: There is no significant relationship between factors influencing modern contraceptive use and use of modern contraceptive among apprentices. Chi square (X^2) at confidence interval of ($p<0.05$) was used to test the statistical significance of different factors at different levels and contraceptive use (Table 4.11). The perceived societal thoughts of modern contraceptive at an early youthful age and its cause for infertility later in life was significantly associated with contraceptive use (X^2=6.466, p-value = 0.011) , inability to use contraceptives because friends do not use was also significantly associated with contraceptive use (X^2=12.294, p-value = 0.000), friends encouragement to contraceptives was significantly associated to contraceptive use (X^2=40.362, p-value = 0.000), boyfriend or girlfriend support of contraceptive use was statistically significant to contraceptive use (X^2=30.001, p-value = 0.000), discouragements from family planning service providers to youths contraceptive use was significantly associated with contraceptive use (X^2=5.909, p-value = 0.015) and family planning service providers' mockery of youths for wanting to use the family planning service was statistically significant to their contraceptive use (X^2=6.851, p-value = 0.009) Linear regression was further used in testing the strength between factors influencing modern contraceptive use practice of modern contraceptive. There was no significant association between the factors influencing modern contraceptives and its utilization among the artisan youths (Table 4.11).

Table 4.9 Relationship between respondent's contraceptive use and socio-demographic Characteristics

Variable	Ever use Contraceptive		Total	X^2	df	p-value
	Yes (%)	No (%)	100%			
Artisan Group						
Tailor	47(46.5)	54(53.5)	101(100)	14.8	4	0.005*
Hairdresser	32 (42.1)	44(57.9)	76(100)			
Carpenter	19(57.6)	14(42.4)	33(100)			
Mechanic	33(70.2)	14(29.8)	47(100)			
Trader	41(65.1)	22(34.9)	63(100)			
Age						
15-19	61(39.6)	93(60.4)	154(100)	23.9	1	0.000*
20-24	111 (66.9)	55(33.1)	166(100)			
Sex						
Male	72(63.7)	41(36.3)	113(100)	7.0	1	0.008*
Female	100(48.3)	107(51.7)	207(100)			
Ethnicity						
Yoruba	149(52.8)	133(47.2)	282(100)	2.5	4	0.794
Hausa	8(66.7)	(33.3)	12(100)			
Igbo	13(54.2)	(45.8)	24(100)			
Igala	1(100)	0(0.0)	1(100)			
Edo	1(100)	0(0.0)	1(100)			
Religion						
Christianity	103(52.3)	94(47.7)	197(100)	2.6	2	0.075
Islam	69(57.0)	52(57.0)	121(100)			
Traditionalist	0(0.0)	2(100)	2(100)			
Education						
No formal education	7(87.5)	1(12.5)	8(100)	6.9	3	0.075
Primary	34(61.8)	21 (38.2)	55(100)			
Secondary	105(48.5)	107(50.5)	212(100)			
Tertiary	26(57.8)	19(42.2)	45(100)			
Living arrangement						
alone	20 (52.6)	18(47.4)	38(100)	7.8	4	0.099
With partner	29(54.7)	24(45.3)	53(100)			
With parents	81(48.2)	87(51.8)	168(100)			
With guardian	27(67.5)	13(32.5)	40(100)			
With friends	15(71.4)	6(28.6)	21(100)			
Family structure						
Nuclear	113(51.6)	106(48.4)	219(100)	4.5	2	0.107
Polygamous	40(21.3)	21(34.4)	61(100)			
Single parenting	19(47.5)	21(52.5)	40(100)			

***significant**

Table 4.10: Relationship between Knowledge and Respondents' use of Modern Contraceptives

Variable	Ever use contraceptive		Total	Chi	df	p-value	Hypotheses
	Yes (%)	No (%)	N%	square			
Knowledge about contraceptive							
poor	8(38.1)	13(61.9)	21(100)	11.3	2	0.003	rejected
fair	117(50.2)	116(49.8)	233(100)				
Good	47(71.2)	19(28.8)	66(100)				

Table 4.11a Relationship between different factors influencing contraceptive uptake by respondents

Variable	Contraceptive use		Total	X^2	df	p-value	Null Hypothesis
	Yes (%)	No (%)	N(%)				
People around me don't think contraceptive are for young people							
Yes	109(53.7)	94 (46.3)	203(100)	0.0	1	0.979	Fail to reject
No	63 (53.9)	54 (46.1)	117(100)				
It's dangerous to use modern contraceptive when single							
Yes	48 (62.3)	29 (37.7)	77(100)	3.0	1	0.083	Fail to reject
No	124(51.0)	119(49.0)	243(100)				
Use of modern contraceptive in early years will cause infertility later in life							
Yes	58(68.2)	31(31.8)	85(100)	6.5	1	0.011	reject
No	114(48.5)	117(51.5)	235(100)				
Those who use modern contraceptives are promiscuous people							
Yes	53 (62.4)	32 (37.6)	85(100)	3.5	1	0.063	Fail to reject
No	119(50.7)	116 (49.3)	235(100)				
Youth should not be sexually active							
Yes	34 (59.7)	23 (40.3)	57(100)	0.9	1	0.324	Fail to reject
No	138(52.5)	125 (47.5)	263(100)				
Religion does not permit me to use contraceptives							
Yes	29 (43.9)	37 (56.1)	66(100)	3.2	1	0.073	Fail to reject
No	143(56.3)	111(43.7)	254(100)				

Table 4.11b Relationship between different factors influencing contraceptive uptake by Respondents

Variable	Contraceptive use		Total	Chi square	df	p-value	Null hypothesis
	Yes (%)	No (%)	N%				
Preventing pregnancy is a sin in my religion							
Yes	40(51.3)	38(48.7)	78(100)	0.3	1	0.615	Fail to reject
No	132(54.5)	110(45.5)	242(100)				
Using modern contraceptives is an abomination in my religion							
Yes	38 (58.5)	27 (41.5)	65(100)	0.7	1	0.393	Fail to reject
No	134(52.6)	121(47.4)	255(100)				
Can't use contraceptives because my friends do not use contraceptive							
Yes	119(63.6)	68 (36.4)	187(100)	12.3	1	0.000	reject
No	28 (39.4)	43 (60.6)	71(100)				
friends encourage me to use modern contraceptives							
Yes	91 (76.5)	28 (23.5)	119(100)	40.4	1	0.000	reject
No	62 (38.3)	100(61.7)	162(100)				
Brothers and sisters encourage me to use contraceptives							
Yes	39 (63.9)	22 (36.1)	61(100)	6.5	1	0.011	reject
No	91(45.5)	110(54.7)	201(100)				
Parents will never support my use of contraceptives as an unmarried youth							
Yes	53 (60.9)	34 (39.1)	87 (100)	2.5	1	0.116	Fail to reject
No	95(48.2)	102(51.8)	197(100)				

*significant

Table4.11c Relationship between different factors influencing contraceptive uptake by respondents

Variable	Contraceptive use		Total	X^2	df	p value	Null Hypothesis
	Yes (%)	No (%)	N(100%)				
Boy/girlfriend frown at using modern contraceptive							
Yes	119(71.7)	47 (28.3)	166(100)	30.0	1	0.000	reject
No	39 (37.9)	64(62.1)	103(100)				
parents must not see me use any form of contraceptive							
Yes	45 (57.0)	34 (43.0)	79(100)	0.6	1	0.449	Fail to reject
No	106(52.0)	98 (48.0)	204(100)				
Family planning service providers shout at me							
Yes	29 (65.9)	15 (34.1)	44(100)	0.8	1	0.575	Fail to reject
No	11 (78.6)	3 (21.4)	14(100)				
The service providers have respect for me							
Yes	25 (78.1)	7 (21.9)	32(100)	2.8	1	0.094	Fail to reject
No	15 57.7)	11 (42.3)	26(100)				
The family planning service providers are not friendly to me							
Yes	23 (75.7)	9 (24.3)	37(100)	2.1	1	0.143	Fail to reject
No	13 (57.1)	9 (42.9)	21(100)				
Family planning service providers discourage me from using modern contraceptive							
Yes	27 (81.8)	6 (18.2)	33(100)	5.9	1	0.015	reject
No	13 (52.0)	12 (48.0)	25(100)				
The service providers laugh at me for wanting to buy/use the modern contraceptives							
Yes	35 (77.8)	10 (22.2)	45(100)	6.9	1	0.009	reject
No	5(38.5)	8 (61.5)	13(100)				

Table 4.12: Relationship between different factors and contraceptive use

Model	Sum of Squares	Df	Mean Square	Sig.	R Square	Null hypothesis
Regression	4.355	12	0.363			
Residual	4.534	23	0.197	1.841	0.101	Rejected
Total	8.889	35				

Model	Unstandardized Coefficients		Standardized Coefficients
	B	Std. Error	Beta
Constant	1.785	0.958	
Age	-0.405	0.173	-0.407
Total knowledge score	0.052	0.182	0.055
Total Attitude score	-0.123	0.223	-0.103
Artisan group	-0.073	0.079	-0.177
Societal thought on contraceptive use causing infertility	-0.035	0.173	-0.033
Friends negative influence on contraceptive use	0.034	0.200	0.034
Friends encouragement on contraceptive use.	0.226	0.176	0.255
Siblings encouragement on contraceptive use	0.032	0.216	0.031
Parents non-support of use of contraceptives by unmarried youths	-0.099	0.206	-0.089
Girl/boy friend frown at contraceptive use	-0.301	0.286	-0.296
Family planning service providers discouragement of youths to contraceptive use	0.015	0.206	0.014
Service providers mockery of youths as clients	0.530	0.263	0.478

4.7 Report of the Key informant Interviews Conducted among Health care workers and state personnel on Modern Contraceptives use among apprentices in Ibadan North Local Government Area.

Seven participants were engaged for the Key informant interview. All health care workers were recruited at the six (6) health care facility in Ibadan, Oyo state. The study was conducted to help give insight to the use of Modern Contraceptives use among youth apprentices and identify the factors that are affecting adolescent contraceptive uptake in Ibadan North Local Government Area.

All the participants had a tertiary education and were married. They were Community Health Extension Officer, some were family planning officer, matron and state coordinator. This information is represented in the table 4.13 below

QUALITATIVE ANALYSIS OF THE KEY INFORMANT INTERVIEW ON MODERN CONTRACEPTIVE USE BY ADOLESCENTS AND YOUTHS

Table 4.13 Socio-Demographic Profile of Respondents

S/N	Age (In years)	Gender	Education Level	Marital Status	Designation	Code	Ethnicity
1	38	Female	Tertiary	Married	Community Health Officer	HCP 1	Yoruba
2	35	Female	Tertiary	Married	Assistant Family Service Provider	HCP 2	Igbo
3	42	Female	Tertiary	Married	Family Planning Service Provider	HCP 3	Yoruba
4	45	Male	Tertiary	Married	Community Health Extension Worker	HCP4	Yoruba
5	37	Female	Tertiary	Married	Community Health Extension Worker	HCP5	Yoruba
6	50	Female	Tertiary	Married	Chief Matron	HCP6	Yoruba
7	48	Female	Tertiary	Married	State coordinator for family planning	SC	Yoruba

Key; HCP-Health Care Provider, SC- State Coordinator

Table 4.14: Socio-Demographic Profile of Respondents

Key Informant Interview		Profile of respondent
Key Informant Interview 1	-	CHEW, Female, 38 years
Key Informant Interview 2	-	CHEW, Female, 35 years
Key Informant Interview 3	-	FP. service provider, Female, 42 years
Key Informant Interview 4	-	CHEW, Male, 45 years
Key Informant Interview 5	-	CHEW, Female, 37 years
Key Informant Interview 6	-	Matron, female, 50 years
Key Informant Interview 7	-	State coordinator, Female, 48years

4.8 Comments on improving Adolescent contraceptive uptake

When queried on how best to ensure an increase in adolescents and youth contraceptive uptake in Ibadan about half, respondents suggested health educating the parents of the adolescent to come along with their adolescents during clinic visitations, use of mass campaign both within the community and religious centres to overcome the socio-cultural and religious constraints and raise the level of awareness on the importance of contraceptive use for unplanned pregnancy prevention among the adolescents in the community. Some of the respondents suggested that the service providers should be more youth friendly during service delivery and that such efforts should be coupled with the provision of quality information on contraceptive usage in order to allow the adolescent to open up. Other suggestions by few of the respondents include; resilience in the use of diverse approach, use of community mobilizers, ending stigmatization and discrimination against adolescents who use contraceptives, and guiding them to make the right choices.

The following are quotes from some respondents:

"I think it is by health educating them, you are ignorant of what you are not aware of. But when we are telling them even in the church, Mosque and this is against our culture, our culture do not support sex before marriage. For example, because of this culture it will inhibit my daughter from opening up that she is sexually active if not because I am a health provider……

*Also the service provided should be more youth friendly because it is very crucial in this place in rendering services." "-**(KII 2 Female, HCP 2, PHC service provider)***

*"We encourage their parents to talk to them and bring them along. where educational level is low the Government should create more awareness in this regard at church, mosques, traditional birth attendants since most of them visit these places for services so they can counsel them on what to do and where to get these modern contraceptive methods." "-**(KII 5 Female, HCP 5, PHC service provider)***

"Also the service provided should be more youth friendly because it is very crucial in this place in rendering services……

*We can encourage them by not stigmatizing them and educating them on the need to make wise decisions in using family planning methods when they are not ready to bear children. We should not relent in creating this awareness." **-(KII 6 Female, HCP 6, PHC service provider).***

However some respondents have a different opinion about how best to improve the adolescent contraceptive uptake. Some reported that some don't listen to advice and that there is little they could do. This points to a significant negative tone on the part of the health care service provider. To illustrate this, respondents have these to say:

"There is nothing more we can do, after all we can't force them to use what they don't want. The only thing is that we can keep telling them to use contraceptives to prevent pregnancy." "- ***(KII 3 Female, HCP 3, PHC service provider)***

4.9 Policy provision on contraceptive use by youths and Adolescents

When the respondents queried on the existence of policy with the state on adolescent contraceptive usage confirmed the absence of the provision of such with the law which points to a significant negative within the reproductive health policy in the state. To illustrate this the respondent put it this way:

"When it comes to adolescents or… youth program in the State, talking about contraceptive use, there is no policy guiding it for now, there is no written policy guiding it for now. As a matter of fact, the Reproductive Health and Family Planning Policy for the State will be going for Public hearing on Wednesday, 17th Oct 2018……. Although there are written policies as regards contraceptive use for youths and adolescents by the Federal Ministry of Health (FMOH)" ***- (KII 7 Female, SC).***

4.10 Availability of programmes For Youths and Adolescents

Findings from the study showed an abysmally low levels of youth friendly centres within the state thus making such programmes to be plagued by poor government funding and heavy dependent on donor agencies to champion the core affairs of the youth population within Ibadan

Quotes from the respondents are illustrated below;

"It's not that we really have structured youth friendly services for now. The only activities I am aware of are the activities being carried out by partners, partners like ehh SFH (Society for Family Health), they have a grant from Bill and Melinda Gate foundation to execute a program called adolescent 360 also known as ***Naija*** *Girls….targeted towards adolescent girls between 13-19 where they give them counseling on contraceptives and some of them take up a*

*method …… State, currently there has no structured activity for different youth services…….just the general treatment or general family planning services that we normally render for them" -**(KII 7 Female, SC).***

4.11 Educational provision for the adolescents

The respondent reported that there are few youth friendly centres cited outskirt the town to ensure privacy, easy access and that such centres are run by the primary health care facilities across the state. The findings from the study revealed that though the approach left much to be desired there are plans for improvement on the services.

Below is a quote from the respondent:

*"Some of these youth Friendly centres are situated outskirt of the town like those of Youth friendly centres integrated into the Primary Health centres ….. they are planning on scaling it up but I haven't heard anything from there" - **(KII 7 Female, SC).***

4.12 Challenges towards youth engagement

Findings from the study revealed that diverse challenges such as poor funding from the government, limited number of youth friendly centres, inadequate health workforce, stigmatization against the adolescents and poor infrastructures are some of the key identified challenges.

Below is a comment from the respondent;

*"We have only two Local Government (Akinyele and Ibadan North Local Government) that has a Youth friendly integrated Health centres, and to reach to youths and adolescents we need a platform….. a youth friendly centre where an adolescent boy or girl can walk in not ashamed or not feeling anybody can talk to me anyhow, we can't reach out to them when there no facilities in place…..a lack of fund……. inadequate man power, in the whole state, apart from the two local Government that we have the Society for Family Health operating in, we don't have any local Government officers in charge of adolescents'' - **(KII 7 Female, SC).***

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study explores the Modern Contraceptives use among apprentices. This chapter explains the result presented in the previous chapter. The demographic characteristics of the respondents, their knowledge on modern contraceptives, attitude towards modern contraceptives, practice of modern contraceptive use and factors influencing modern contraceptives use were investigated. The implication of the findings of this study to health promotion and education was discussed and recommendations were made at the end of this report.

5.1 Respondents Socio-demographic characteristics

The study artisan groups comprises of Tailor, Hairdresser, Carpenter, Mechanic and Trader, with the most number of the study participants being apprentices in the Tailoring group and Hairdressing group, this can be attributed to the higher proportion of female apprentices recruited for this study as tailoring and hairdressing are female dominated vocations. Age of respondents for this study ranged from 15 years old to 24 years old and according to the WHO definition of youth, this category of respondents can be classified as youths.

In a similar study conducted by Chimah et al. (2016) in South West Nigeria, he reported that most of the respondents were early adolescents (10-13 years of age) which was quite different from this study where more than half of the respondents were of age range 20-24. This might be attributed to their physical engagement in their apprenticeship with signs of maturity in them understanding whatever apprenticeship they have chosen.

In a Yoruba geographical area like Ibadan, it is expected that the population of residents will be dominated by the Yoruba ethnic group, this study was no exception with most of the respondents being of Yoruba ethnicity. Christianity is the most prominent religion practiced by the respondents and this is corroborated by the study conducted by Ajibola et al (2017) where Christianity was predominantly practiced but this is contrary to a study by Adadow et al. (2015) where Islam was the predominant religious affiliation.

On marital status, more of the youths were single while few were cohabiting and this is relatively low according to Adadow et al., 2015 compared to this study which shows that more respondents cohabit with their partner even though they are not married. This shows a form of freedom these adolescents have to engaging in unprotected sex.

According to Adadow et al., (2015) a test of association between the socio-demographic characteristics of respondents and their use of contraceptives showed that respondents' age has a significant relationship with the use of contraceptives. As the age of respondent increases, the likelihood of contraceptive use also increases. However, in this study, it was found that there is a statistical association between respondents' age and sex had an influence on their practice of modern contraceptives. Furthermore, a similar study conducted among out of school youths in Nigeria by Atere et al., (2010) corroborated the findings of this study by the socio demographic significant association with age and sex.

Additionally, most of the respondents had secondary school education as their highest form of educational qualification and more than half of them still live with their parents. This shows parental dependence among respondents financially and emotionally which may play significant role in decision making and socio-economic status of respondents.

The qualitative arm revealed that, all the participants had a tertiary education and were married. They were Community Health Extension workers, some were family planning officer, matron and state coordinator. This findings is similar to a study conducted by Paul *et al.* (2016) in Ghana where all the respondents were doctors and midwives who were involved in Post Abortion care provision and contraceptive counselling or emergency obstetric care at their respective facilities. Also a study conducted among family planning service providers in Ibadan and Kaduna by Hebert *et al*. (2012) had pharmacists, nurses, midwives as respondents.

5.2 Respondents knowledge on modern contraceptives

Findings from this study showed a high level of awareness of modern contraceptives by respondents, however, detailed exploration suggested that level of awareness of individual modern contraceptives was not very high with the most popularly known modern contraceptives among respondents being condoms and oral contraceptives. Level of awareness was however low for contraceptives like: implants, intra uterine devices,

vasectomy and tubal ligation among respondents. This pattern is similar to a study conducted in Uganda where condoms were the most known contraceptives among adolescents (Adadow *et al.*, 2015) and the most mentioned by respondents, this can be attributed to the general availability and reduced cost of procuring condoms and oral contraceptives (Kanku *et al.,* 2010).

Respondents' knowledge of modern contraceptive was found to be fair, this was similar to the study conducted by Ndiananbangi *et al.*, (2007) where majority of the adolescents had no knowledge about contraceptives. The respondents' knowledge on the benefits of using modern contraceptives was good, contrary to Ndiananbangi *et al.*, (2007) where a small proportion of respondents knew the benefit of contraceptives. Attributed to the poor knowledge of contraceptive is it being a cause for malformation of newborns (Adadow *et al.*, 2015). Contributing to the poor level of knowledge, according to Chandra-mouli *et al.* (2014) is poor understanding of how contraceptives methods work and how they should be used.
It was also found in this study that the mass media (television and radio) contributed the highest source of information on modern contraceptive, followed by friends and social media, other sources included parents and print media. In a study conducted in south west Nigeria, almost all the respondents had heard of family planning with health workers being the commonest source of information Ajibola *et al.,* (2017).

However, while parental influence on contraceptive may not have been explored overtime, family was an important part of an adolescent's life that has a strong influence on adolescent sexual behavior and contraceptive use (Adadow *et al.,* 2015). This was corroborated by a qualitative analysis of parental approval and contraceptive use. Few parents indicated they talked about contraceptives as their main focus of discussion while most parents indicated that they would be angry to find their children using contraceptives (Kinaro *et al.,* 2015).

5.3 Respondents' attitude toward modern contraceptive use

A study done by Kanku *et al.* (2010) in South Africa where respondents were documented not to see the need to use contraceptives because of the benefits of grants they receive from the Government and the fact that the responsibility of taking care of the child is not on them but on their parents or grand-parents. Additionally, within this study, the feeling of embarrassment procuring contraceptives and feeling shy to buy it because of societal perception contributed to the negative attitude recorded by respondents, similar to Bell's (2009) finding that embarrassment is a key risk factor in young people's sexual behavior and it explains why engaging in protective sexual behaviour and seeking information and advice on contraceptives is less.

5.4 Practice of Modern Contraceptive Use

With more than half of the respondents living with their parents and the statistical significant influence parents have on adolescents' modern contraceptive use and literature suggesting parental influence on sexual activity (Adadow *et al.,* 2015), findings from this study highlighted that more than half of respondents have had sex and half of the sexually active respondents have had sexual intercourse within the past one month.

In this study, use of modern contraceptives among respondent was high, indicating for every 10 respondents, 9 respondents ever used modern contraceptives, a higher modern contraceptive use was recorded in a study in Ghana where overall use of modern contraceptive was documented at 81% (Clottey, 2012), however, a lower usage rate was recorded by Adadow *et al.* (2015). In a study by Pesa *et al.* (2001), low use of contraceptives was attributed to believe that using birth control interferes with pleasure during intercourse, is difficult to obtain, it's morally wrong, it's expensive, it's bothersome, involves too much planning and makes people think they are seeking sex.

The most used contraceptive in this study was determined to be condoms and pills similar to a study in Nepal where condoms were mostly used followed by injectable and contraceptive pills (Tamang *et al.,* 2017) and another study in South West Nigeria by Omokhodion *et al.* (2017) where condoms were recorded to be the most used contraceptives. Similarly in Liberia, male condom was mostly used, followed by pills which were the second most commonly

mentioned form of contraceptive used (Park *et al.,* 2016). On the frequency of use, more than half of the respondents do not use contraceptives always at sexual engagements.

Similarly to Onipede *et al.* (2014) that the higher the age of the adolescents, the higher the use of contraceptives, this study also determined that the higher the age of respondents the higher the use of contraceptives with respondents age. Choice of contraceptive was found to differ across sex, as stated by interviewed Community Health Extension Officers, consensus of the interview revealed that condoms is the preferred choice among males while the females preferred choice includes; injectable contraceptives, oral contraceptives, implants, spermicide tubes and postinor 2 (emergency pills).

5.5 Factors influencing Contraceptive Use

According to Tamang *et al.,* (2017) and Fehring *et al.,*(2002), religions (Catholic and Hinduism) have taught that sexual intercourse is to take place between a man and woman within the context of marriage and this has lowered incidence of pre-marital sex which in turn affects the rate of contraceptive use. This finding was also similar to that of Onipede *et al.,* (2014) where there was a significant relationship between religion and the use of contraceptives but this study contrasted the previous studies revealing that religion was not statistically significant with contraceptive use.

Societal perception of sexual activity among youths was found to be a strong influencer of contraceptive use by respondents when most believed the society's view of contraceptives using youth as promiscuous defer them from use, this view was also shared by respondents in a study by Yidana *et al.* (2015) that social belief was a factor that influences their contraceptive use. Chandra *et al.* (2014) further explored this factor that stigma that surrounds contraception use among adolescents by the community at large perceiving them to be loose because they choose to use condoms or they have condom on them has negative effect on use. From the interview conducted, it was gathered that adolescent rarely use the centres due to feelings of shame, low level of awareness on right to contraceptive use, misconception about cost of contraceptive service, societal norms and values, peer pressure, low educational status, low socioeconomic status, social and family perception on contraceptive possession by adolescents. This was also corroborated by another qualitative result conducted by Paul *et al.*

(2016) where the participants agreed that few of the sexually active young people would not seek advice from the healthcare system due to the existing social stigma although in this study the family planning health care providers reported to have been trained. This shows a headway in the campaign to re orient the health care workers to providing family Planning service to whoever needs it irrespective of the age as it is a human right. Interestingly, most respondents do not visit the health facility for family planning and procurement of contraceptive because of fear of being seen going into the centre for family planning; however, data showed that a sizeable of proportion of the respondents admitted that family planning service providers discourage them from using modern contraceptives when they go for the service. The few respondents who identified going to the health care services corroborates the report of the health care providers for family planning when they reported very few youths come to the health centres to access the services even when they are trained to meet the youths need of providing contraceptive services.

However, this is a different case in Ghana when participants, especially the doctors, considered themselves to lack the appropriate counselling skills to effectively communicate with young clients and to provide accurate contraceptive advice. The participants found it difficult to address sex among young people in an appropriate way, and several felt uncomfortable discussing sex with young people (Paul *et al.,* 2016). Furthermore, the discrepancy in this study and a study conducted by revealed, most providers had not received any training in family planning (Hebert, Schwandt, Boulay, and Skinner, 2012). Findings in this study further revealed that family planning services are free except in situations where there is need to procure deliverables if it is exhausted, however, uptake of these services is low, it is however health educating the parents of the adolescent to come along with their adolescents during clinic visitations, use of mass campaign both within the community and religious centres to overcome the socio-cultural and religious constraints and raise the level of awareness on the importance of contraceptive use for unplanned pregnancy prevention among the adolescents in the community was suggested. The absence of policy guiding the use and promotion of modern contraceptive for youths and adolescents was found to be a cause for concern which is compounded with the low numbers of youth friendly centres within the state of Oyo. There are only two Local Government (Akinyele and Ibadan North

Local Government) that has a Youth friendly integrated Health centres, and to reach to youths and adolescents there is need to increase these integrated youth friendly health centres in Oyo State.

5.6 Implication of the study findings for health promotion and education

This study has provided an exploration of modern contraceptive use among apprentices in Ibadan, with emphasis laid on knowledge, attitude, use and factors influencing use of contraceptives. Knowledge has been establish to the preceding factor for practice, a reduced knowledge influences low practice or wrong practice, within the context of this study, respondents had fair knowledge of modern contraceptives despite a high level of awareness and an observed negative attitude towards contraceptive use, this was also reflected in the low usage of the family planning clinics.

Efforts needs to made towards improving use of modern contraceptive by youth in prevention of unintended pregnancy and the increasing overpopulation of Nigeria, it is necessary that it is directed at increasing the knowledge of apprentices on contraceptives and correct use. Using the workplace setting is an added advantage at designing and implementing educational intervention which can be implemented across different artisan groups. Additionally, with most of the respondents being female, there may be a need for a female focused educational intervention aimed at empowering female youth in procuring and use of contraceptive independent of their partner's decision.

5.7 Conclusion

The prevalence of adolescents with unmet need for family planning is 35.3% in Nigeria, this is of concern because they make up one fifth of the world population and their potential impact in the future population growth will be enormous if the factors inhibiting their positive response to contraceptive use is not addressed.

This study has brought to limelight areas where efforts need to be focused on. The level of knowledge of respondents on modern contraceptives was fair and this was reflected in the show of negative attitudinal disposition towards contraceptive use. The study showed that contraceptive use is low among apprentices with condoms and pills being the most used. Age,

sex artisan group were found to be major predictors of contraceptive use among respondents and contraceptive use reduces with increased age of respondents. The lack of a supportive society towards contraceptive use by youth was documented to mitigate use of contraceptive among respondents. Additionally, the low number of youth friendly in Ibadan may be a contributing factor to the reduced utilization of the services provided despite being free.

5.8 Recommendation

In view of the findings, the following recommendations were made:

1. This study has highlighted age and sex as a major factor influencing usage of contraceptives. It is recommended that the youths should be provided with unbiased access to these contraceptives by Oyo State health initiatives on family planning as this will influence youth in practice of safe sex.
2. Most importantly, there is need for creation and implementation of policies by the policy makers on adolescent Sexual and Reproductive health initiatives which encourages contraceptive use by youth free of stigmatization and victimization.
3. As this study revealed a fair knowledge in contraceptives, the youths should be provided with health education services at their work settings in order to increase their knowledge on what contraceptive information entails by Organisations such as NURHI
4. Parents should be encouraged to educate and inform their wards on the danger of unprotected sex and how they can protect themselves from unwanted pregnancy through the use of contraceptives.
5. Family service providers should provide professional, adequate and unbiased information to anyone who comes to the health centres irrespective of their age and economic status.
6. Peer education should be taught by those focusing on family planning such as Nigeria Urban Reproductive Health Initiative among these group of people across the artisan group after being trained by trained personnel on family planning.

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INFORMED CONSENT FORM

INFORMED CONSENT FORM FOR MODERN CONTRACEPTIVE USE AMONG APPRENTICES IN IBADAN NORTH LOCAL GOVERNMENT, OYO STATE, NIGERIA

IRB Research Approval Number:

This approval will elapse on:

Title of research: **Modern Contraceptive use among apprentices in Ibadan North Local Government, Oyo state, Nigeria**

Name of researcher: This study is being conducted by Akinade Oluwatomisin Victoria who is a postgraduate student in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine University of Ibadan.

Purpose of research: The purpose of this study is to investigate the Modern contraceptive use among out of school youths in Ibadan North local Government, Ibadan, Oyo State, Nigeria.

Sample size and procedure for data collection: A total of 322 respondents would be recruited for this study using a multi stage sampling procedure to select eligible respondents.

Expected duration of the research and participant(s) involvement: The process of this study will last for one month. The expected time to spend with each participant in filling the questionnaire is fifteen to twenty minutes. You are to provide answers to the questions contained in the questionnaire

Risk(s): There are no physical risks in participating in this study. Also, each participants will be given their privacy to fill the questionnaire based on the sensitivity of sexual experience of the young adolescents and youth.

Cost to participating of joining the research: Participation will cost nothing financially to the participants. It will however take a little of your time.

Benefit: At the end of the research, findings will be useful in the design of interventions or strategies aimed at meeting unmet needs of family planning.

Confidentiality: All information collected in this study will be given coded numbers. Names of participants will not be written on the questions. In addition, names or any other identifiers will not be used in any publication or report emancipating from this study.

Voluntariness: Your participation in this research is entirely voluntary.

Consequences of participants' decision to withdraw from the research and procedure for orderly termination of participation: You can choose to withdraw from the research at any time without any penalty. Please also note that some of the information that has been obtained about you before you choose to withdraw may have been used in reports and publications.

Statement of Person Obtaining Inform Consent

I have fully explained the nature and scope of the research to _____ and have provided sufficient information to him/her which is needed by him/her to make informed decision.

Date _____

Signature _____

Name _____

Statement of Person Giving Consent

I have read the description of the research and the research has been explained to me in a language I understand or have been translated into a language I understand. I understand that my participation is voluntary. I know enough about the purpose, methods, risk, and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. Finally, I have received a copy of this consent form and additional information sheet to keep for myself.

Date _____

Signature _____

Name _____

Detailed contact information including contact address, telephone, fax, email and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Oyo State Research Ethical Review Committee and the chairman of this committee can be contacted at Ministry of Health, Secretariat, Ibadan. In addition, if you have any question about your participation in this research, you can contact the principal investigator,

Date _____

Phone _____

Name _____

Signature _____

Name: Akinade Oluwatomisin Victoria

Department: Health Promotion and Education

Phone: 08026209385

Email: victoriaakinade5@gmail.com

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT

FỌỌMU IFOHUNSI TI ṢALAYE LILO IFETOSOMO BIBI IGBALODE LAARIN AWON OMO EKOSE NI IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE

IRB iwadi ìtẹwọgbà nọmba:

Itẹwọgbà yii yoo kọja ni:

Akole ti iwadi: **lilo ifeto somo bibiigbalode laarin awon omo ikose ni Ibadan North Local Government, Ibadan.**

Orukọ ti oluwadi: Iwadi yi ti waye nipasẹ Akinade Oluwatomisin Victoria, omoIle-ẹkọ giga ti Ibadan ni ẹka Igbelaruge Ilera ati Ẹkọ

Idi iwadi: Awọn idi ti iwadi yi ni lati se iwadi nipa ifeto somo bibi igbalode laarin awon omo ikose ni Ibadan North Local Government.

Iwọnatiilana fun gbigba data: Lapapọ odunrunlemejilelogun awon odo ti won je omo ekose ni yiokopa ninu iwadi yi ni Ibadan North Local Government area yoo wa nikopa fun iwadiyi lilo ilanaimupeseipeletiọpọlọpọlatiyanawọneniyanti o yẹ

Akokoti a yẹ fun iwadi: Ilanayiiyooṣiṣe fun osukan. O nilatipeseidahunsiibeereti o waninuiweibeerenaa. Awọnibeeretiwani o tiṣeyẹlatipariniogunisẹju

Ewu: Kosi awọn ewu ti ara nikikopa ninu iwadi yii. Sibẹsibẹ, awọn ibeere kan wa lori awọn abuda-ti-ara-ẹni-ara ati ihuwasi ibalopọ ti diẹ ninu awọn olufisun yoo kolati ma ledahun.

Awọ niye owo lati kopa ninu didapọ mọiwadiyii: kopayoona o ohunkohun. O yoo, sibẹsibẹ, ya diẹ ninu akokorẹ.

Anfaani: Ni opin iwadi naa, awọn awari yoo wulo ni idamo awọn ogbonimo ati ki o ṣe idiwọ idaamu ti aini alaye ti o to lori lilo ifeto somo bibi igbalode laarin awon omo ekose ni Ibadan North Local Governent.

Asiri: Gbogbo awọn alaye ti a gbani iwadi yii ni a o fun ni nọmba. Awọn orukọ ti awọn eniyanti o idahun kii yoo walori awọn ibeere. Ni afikun, orukọ rẹ tabi awọn ami idanimọ miiran kiiyoo lo ni eyikeyiki yoo walori iwe tabi iroyin.

Iyọọda: ikopa ninu iwadi yini o šee igbọ kan le ati nuwa.

Awọn abajade ti ipinnu awọn olukopa lati yọ kuro ninu iwadi ati ilana fun létòletò ifopinsi: O le yan lati yọ kuro ninu iwadi ni eyikeyi akoko laisi ijiya kankan. Jọwọ ṣe akiyesi

pe diẹ ninu awọn alaye ti a ti gba lati ọdọrẹ ṣaaju ki o to yan lati yọ kuro ni a le lo ninu awọn iroyin ati awọn iwe aṣẹ.

GbólóhùntiÈnìyàn

Mo ti ṣe alaye ni kikun tii se daa ti darapọ mo iwa di naa fun _____ ati wipe mo ti pese alaye ti o to fun

Ọjọ _____ **Ibuwọlu** _____

Oruko _____

GbólóhùntiÈnìyànti fi asesiiwadi

Mo ti ka apejuwe ti iwadi naa atipe a tiṣe alaye fun mi ni ede ti o ye mi. Mo mo wipe ikopa mi jẹ ati nuwa. Mo mọ nipa idi, awọnọna, ewu, ati awọn anfani ti iwadiyi lati darapo ati ṣe alabapin ninu rẹ. O ye mi pe mo le ma tẹsiwaju ninu iwadiyi. Níkẹyin, Mo ti gba fọọmu iwadi ìtẹwọgbà ati iwe ifowosi alayefun ara mi.

Ọjọ _____ **Ibuwọlu** _____

Oruko _____

QUESTIONNAIRE

Serial no _____

Dear respondent,

I am a Masters student of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Oyo State. This questionnaire is designed to gather information about modern contraceptive use among apprentices in Ibadan.

Please you are requested to provide complete and sincere information to the following questions. Be assured that all information will be treated with utmost confidentiality; this questionnaire is solely for research purpose.

_____

Signature/ Thumbprint

Thank you.

Section A: Socio Demographic Characteristics

ARTISAN GROUP _____

Please tick the correct option rightly using this symbol (✓)

1. Age as at last birthday _____ (in years)
2. Sex: 1. Male [ ] 2. Female [ ]
3. Ethnicity: 1. Yoruba [ ] 2. Hausa [ ] 3. Igbo [ ] 4. others specify _____
4. Religion: 1. Christian [ ] 2. Muslim [ ] 3. Traditional worshipper [ ].
5. Level of Education: 1. No formal education [ ], 2. Primary education [ ], 3. Secondary education [ ] 4. Tertiary education [ ]
6. Living arrangement: 1. alone [ ], 2. With partner [ ], 3 with parents [ ] 4. With guardians [ ] 5. With friends [ ]
7. Family structure: 1. Nuclear family [ ], 2. Polygamous family [ ] 3. Single Parenting [ ] 4.others specify_____

SECTION B: Knowledge Questions

Please tick the appropriate option(s) in the spaces provided [✓]

8. Have you heard about modern contraceptive before? 1. Yes [ ] 2. No [ ]

9. Tick the **TYPES** of modern Contraceptive that you know using this symbol (✓). Multiple choices can be taken

i.	Condoms	[ ] ii. Oral contraceptives	[ ] iii. Injectables	[ ]
iv.	Implants	[ ] v. Intra uterine Devices	[ ] vi. Vasectomy	[ ]
vii	Tubal Ligation	[ ] viii others _____		

10. Which of the following is **TRUE** about modern contraceptives?

i. They prevent unplanned pregnancy. [ ]

ii. It is used to space children and also used to stop child bearing as at when decided [ ]

iii. It causes infertility [ ]

iv. IUD is a modern contraceptive that prevents sexually transmitted diseases [ ]

11. What are the **BENEFITS** of using modern contraceptives? **Multiple choice answers**

i. Prevent unwanted pregnancy [ ]

ii. It causes abortion [ ]

iii. Prevent against Sexually Transmitted Disease [ ]

iv. It helps to reduce poverty in the home [ ]

Multiple choices are allowed

12. What are the risks involved in engaging in unprotected sex?

i. Unplanned pregnancy [ ]

ii Contraction of Sexually transmitted Disease [ ]

iii Prevent against Sexually Transmitted Disease [ ]

iv There is no risk involved in practicing unprotected sex [ ]

13. What is your source of information on modern contraceptives? **Multiple choice selections**

i. Radio [ ] ii. Television [ ] iii Newspaper [ ] iv. Social media [ ]

v. Friends [ ] vi. Parents [ ] vii. Health care staff [ ] viii. Course Education [ ] ix other source (mention)_____

SECTION C: Attitude towards contraceptive use. Please tick your response with this sign (✓)

S/N	STATEMENTS	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
14	I am not comfortable using modern contraceptive.					
15	I cannot use modern contraceptives to prevent pregnancy.					
16	I cannot buy contraceptives because it is embarrassing					
17	I detest youths who use modern contraceptives because they are morally bad people					
18	I can encourage any unmarried youth to use modern contraceptive to prevent pregnancy					
19	I don't feel comfortable using modern contraceptives because I am not married.					
20	I am shy to purchase contraceptives because of what people will think about me.					

SECTION D:Practice of Contraceptive Use

21. Have you had sex before? 1 Yes [ ] 2 No [ ]

If yes to question 21,

22. When was the last time you had sex? _____ (in months)

23. Have you ever used modern contraceptives before? 1. Yes [ ] 2. No [ ]

24. Which modern contraceptive method have you or your partner used before? You can tick as many as possible

1. Pill [ ] 2. Intra-uterine device [ ] 3. Injectables [ ] 4. Condom [ ] 5. Female sterilization [ ] 6. Implants [ ] 7. Other method (mention) _____

25 Which modern contraceptive did you use during your last sexual engagement?

1. Pill [ ] 2. Intra-uterine device [ ] 3. Injectables [ ] 4. Condom [ ] 5. Female sterilization [ ] 6. Implants [ ] 7. Others methods (mention) _____

26Which modern contraceptive did your partner use during your last sexual engagement?

1. Pill [ ] 2. Intra-uterine device [ ] 3. Injectables [ ] 4. Condom [ ] 5. Female sterilization [ ] 6. Implants [ ] 7. Others methods (mention) _____

27. How often do you use modern contraceptives?

1. Always [ ] 2. Sometimes [ ], 3. Never [ ]

SECTION E: Factors influencing Contraceptive Use

Socio Cultural factors. Please tick your response with this sign (X)

S/N	Variable	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
28	People around me don't think modern contraceptives are meant for young people.					
29	My society feels that it is dangerous to use modern contraceptives when not married.					
30	My society thinks the use of modern contraceptives in early youthful age will cause infertility later in life					
31	My society tag those who use modern contraceptives as promiscuous people					
32	My society believes youths should not be sexually active.					
33	My Religion does not permit me to use contraceptives					
34	Preventing unwanted pregnancy is a sin in my religion					
35	It is an abomination to use contraceptives in my religion as an unmarried youth					

Peers/ Family Relationship influencing contraceptive use by youths. Please tick your response with this sign (✓)

S/N	Statements	Yes	No	I dont know
36	I can't use contraceptives because my friends do not use contraceptives			
37	My friends encourage me to use modern contraceptives			
38	My brothers and sisters encourage me to use contraceptives			
39	My parents will never support me to use contraceptives as an unmarried youth			
40	My boy/girl friend frown at using modern contraceptives			
41	My parents must not see me use any form of contraceptive because I am still young.			

Attitude of Service Providers on family Planning. Please tick your response with this sign (✓)

s/n	STATEMENTS	Yes	No	Not applicable
42	Have you ever visited the health facility where they provide family planning service?			
43	The family planning service providers shout at me when addressing me.			
44	The service providers have respect for me when i request for family planning services.			
45	The family planning service providers are not friendly to me.			
46	Family planning service providers discourage me from using modern contraceptives when i go for the service.			
47	The service providers laugh at me for wanting to buy/use the modern contraceptives			

IWE IBEERE **Nomba_____**

Oludahun mi owon,

Mo je akeekoo gboye keji ni eka igbeleke ilera ati eto eko, eka eko ilera ara ilu, koleji ti iwosan ni eko giga ifasiti ti ilu Ibadan ni ipinle Oyo.KII is yi ni lati se **iwadi nipa ifeto somo bibi igbalode laarin awon omo ikose ni Ibadan.**Abajade ise yii yoo ṣe ranwọ lati ṣe eto ati abadofin ti yoo ran idagbasoke lilo ifetosomo bibi igbalode. Iwadii yii ko ni gbaju iṣẹju mẹwaa lọ lati dahun ati wi pe, ẹwẹ, ikopa kii ṣe dandan. ko si ewu ninu kikopa ninu iwadii yii, ti o ba si pinu lati kopa, aridaju wa wi pe a o ṣe aabo fun idanimọ rẹ

E jowo e ba mi pese idahun otito si awon ibeere yi. Mo fe ki e mo wipe ako niba enikeni so ohun ti e ba so fun wa. Lati ma je ki enikeni da yin mo, a ko ni lo oruko yin ninu iwadi yi, nomba ti a o ko sori iwe ibeere ni a o lo. Esi t e ba fun wa yio ran wa lowo lati le mo iru ifeto somo bibi igbalode ti awon omo ekose maan n lo.

Ninu iwadi yii, a o ma beere n owo yin nipa imo nipa ifeto somo bibi igbalode, ihuwasi awon omo ikose si ifeto somo bibi igbalode, lilo ifeto somo bibi igbalode laarin awon omo ikose ati awon ohun t o n se okunfa lilo ifeto somo bibi igbalode.

Nigba ti mo ti mo gbogbo nkan ti iwadi yii ko sinu ti o si ti ye mi yekeyeke, mo se tan lati kopa ninu iwadi yi

_____

Ibowolu/ ika tite Olukopa

Ese pupo.

Abala A:ìbeereabuda eni ajemo awujo

Egbe Onise owo_____

E mu esi ibeere yin pelu amin yi (X)

1. kini ojo ori re in ojo ibi ti o koja _____ (ni odun)
2. Ako abi abo1. Ako [ ] 2. Abo [ ]
3. Eya: 1. Yoruba [ ] 2. Hausa [ ] 3. Igbo [ ] 4. Eso omiran ti e mon _____
4. Esin: 1. Kristiani[ ]2. Musulumi [ ]3. Esin abalaye [ ].
5. Ipele Eko: 1. N ko kawe rara[ ], 2 Eko iwe mefa [ ], 3. Eko sekondiri [ ]

4. Eko ile iwe giga [ ]

6 Eeto gbigbe: 1. Mo n dagbe [ ], 2. pelu ololufe [ ], 3 pelu obi [ ] 4. Pelu alagbato 5. Pelu ore [ ]

7. Eeto ebi: 1. Baba, iya ati awon omo[ ], 2. Ile olorogun [ ]3. Baba/iya nikan[ ]4. E so eto gbigbe miran ti e mo ti e n se_____.

Abala B: Ibeere nipa Imo ifeto si omo bibi igbalode

E jowo, e mu esi ti o ba dara julo fun ibeere ti e o dahun si. E fi ami yi [X] se idahun si ibeere wonyi.

8. N je e ti gbo nipa ifeto somo bibi igbalode ri? 1. Beeni [ ] 2. Beeko [ ]

9 Ti idahun yin ba je beeni si ibeere kewa, e mu orisi ifetosomobibi igbalode ti e bam o nipa lilo afihan yi (X). E le mu ju idahun kan lo

i. Roba idabobo [ ] ii. Ogun lilo [ ] iii. Alabeere [ ] iv. Alafisapa [ ] v. Alafibo enu ile omo [ ]

vi. sise abe fun nkan omokunrin [ ] vii sise abe fun inu ile omo obinrin [ ] viii omiran _____

10. E wo ni o je ooto nipa ifeto somo bibi igbalode?

i. Won maa n dina oyun nini [ ]

ii. Won ma n fi se aala si arin omo bibi [ ]

iii. Won maa n fi da omo bibi duro nigba ti won ba fe [ ]

iv. O maa n fa airomobi [ ]

iv. Alafibo enu ile omo je ifetosomobibi igbalode ti o n dena kiko aarun ibalopo [ ]

11.Ki ni anfaani to wa ninu lilo ifeto somo bibi igbalode ?**E le mu idahun to ju eyo kan lo**

i. O ma n dina oyun ti a ko lero [ ]

ii. O ma n fa ki oyun jabo lara nigba ti a ba loyun airotele [ ]

iii. O ma n dina aarun ibalopo[ ]

iv. O maa n dekun ise at osi ninu idile [ ]

12. Ki ni awon ewu to ro mo sise ibalopo lai lo idabobo? **E le mu idahun to ju eyo kan lo**

i. Oyun airotele [ ]

ii Nini aarun ibalopo [ ]

iii oyun sise ni ona to lewu fun ilera latipase oyun airotele [ ]

iv Ko si ewu to ro mo nini ibalopo lai lo roba idabobo [ ]

13. Nibo le ti gbo nipa ifeto somo bibi igbalode? **E le mu idahun to ju eyo kan lo**

i. Redio [ ] ii. Ero Mohun maworan (T.V) [ ] iii iwe iroyin [ ] iv. Eero ayelujara [ ]

v. Ore [ ] vi. Obi [ ] vii. Awon osise ni ile iwosan [ ] viii. Ile eko [ ] ix ona miran _____

Abala C: Ihuwasi odo si ifeto somo bibi igbalode. E mu esi ibeere yin pelu aamin yi (X)

S/N	ORO	Mo gba gan	Mo gba	N o mo	Mi o gba	Mi o gba rararara
14	Mo fara mo lilo ifetosomo bibi igbalode					
15	Mi o le lo ifeto somo bibi igbalode lati dena oyun nini					
16	Mi o le ra ifeto somo bibi nitori wipe o maa n ti mi loju					
17	Mo koriraki odo lo ifeto somo bibi igbalode nitori won kii se iwa omoluabi					
18	Mo le gba odo niyanju ki won lo ifetosomo bibi igbalode lati fi dena oyun airo ti tele					
19	Ara mi ko fi bee ya si lilo ifeto somo bibi igbalode nitori n ko ti se igbeyawo					
20	Oju maa n ti mi lati ra/tabi se ifeto somo bibi nitori n ko mo oun ti awin eniyan o so nipa mi					

SECTION D:Sise/ lilo ifeto somo bibi igbalode

21. N o ti ni ibalopo ri? 1 Beeni [ ]2 Beeko[ ]

Ti idahun yin baa je beeni si ibeere kokanlelogun 21,

22. Nigba wo le ni ibalopo keyin ? _____

23. Se eti lo ifeto somo bibi igbalode ri? 1 Beeni [ ]2 Beeko[ ]

24. Ewo ninu awon ifeto somo bibi igbalode yi le ti lo ri ?**E le mu idahun to ju eyo kan lo**

i. Roba idabobo [ ] ii. Ogun lilo [ ] iii. Alabere[ ]iv. Alafisapa [ ]

v. Alafibo ile omo (IUD) [ ] vi. Ise abe fun ifeto somo bibi [ ] viii so omiiran _____

25.Ewo ninu awon ifeto somo bibi igbalode yi le lo ni igba ti eni ibalopo keyin?

i. Roba idabobo [ ] ii. Ogun lilo [ ] iii. Alabere[ ]iv. Alafisapa [ ]

v. Alafibo ile omo (IUD)[ ] vi. Ise abe fun ifeto somo bibi [ ] viii so omiiran _____

26.Ewo ninu awon ifeto somo bibi igbalode yi ni eni ti e ba ni ibasepo lo nigba ti eni ibalopo keyin?

i. Roba idabobo [ ] ii. Ogun lilo [ ] iii. Alabere[ ]iv. Alafisapa [ ]

v. Alafibo ile omo (IUD)[ ] vi. Ise abe fun ifeto somo bibi [ ] viii so omiiran _____

27. Bawo le se ma n lo ifeto somo bibi si?

1. Nigbagbogbo[ ] 2. Leekookan [ ] 3. N o lo ri [ ]

SECTION E: **Awon ohun ti o n sokunfa lilo ifeto somo bibi igbalode**

Asa ati ise awujo ibi ti a n gbe. **E mu esi ibeere yin pelu aamin yi (X)**

S/N	Oro	Mo Gba Gan	Mo gba	N o mo	Mi o gba	Mi o gba rara
28	Awon to wa lawujo mi o ro pe ifeto somo bibi igbalode wa fun awon odo					
29	Awon eeyan lawujo mi lero wipe lilo ifeto somo bibi lai ti se igbeyawo le lewu fun odo ti o ba n lo					
30	Awujo mi ro wipe lilo ifeto somo bibi igbalode lati igba ewe le fa airomobi ni ojo iwaju.					
31	Awujo mi ti so awon odo ti o n lo ifeto somo bibi igbalode lenu ni onisekuse.					
32	Awujo mi gbagbo wipe ko ye ki odo ti maa ni ibalopo.					
33	Esin mi ko gba mi laye lati lo ifeto					

	somo bibi igbalode.					
34	Ese ni didena oyun nini ni esin mi.					
35	Nkan abami ni lati dina ise Olorun nipa oyun nini nipa lilo ifeto somo bibi igbalode.					

IbasepoEgbe/Ebi ti o n sokunfa lilo ifeto somo bibi igbalode laarin awon odo. E mu esi ibeere yin pelu aamin yi (X)

S/N	Oro	Beeni	Beeko	N ko mo
36	Mi o lelo ifeto somo bibi igbalode nitori awon ore mi kii lo.			
37	Awon ore mi maa n fun mi ni iwuri lati lo ifeto somo bibi igbalode.			
38	Awon egbon ni lokunrin ati lobirin maa n lo ifeto somo bibi won I maa n fun mi ni iwuri lati lo ifeto somo bibi igbalode pelu.			
39	Awon obi yio faramo ki n lo ifeto somo bibi igbalode ju ki n loyun airotele lo.			
40	Awon ore mi koro oju si lilo ifeto somo bibi igbalode			
41	N ko le lo ifeto somo bibi igbalode nitori awon obi mi o gbodo mon wipe mo ti n ni ibalopo.			

Ihuwasi awon osise eleto ilera fun ifeto somo bibi .E mu esi ibeere yin pelu aamin yi (X)

s/n	Oro	Beeni	Beeko	Ko kan mi
42	Nje o ti lo si ile iwosan ti won ti n fun ni ifetosomo bibi ri?			
43	Awon osise eleto ilera fun ifeto somo bibi maa n pariwo mo mi ti won ba n bamisoro.			
44	Awon osise eleto ilera ma n bowo fun mi ti mo ba lobe fun lilo ati gbigba ifeto somo bibi.			

45	Awon osise eleto ilera o kin se oyaya simi ti mo ba lo gba eto ifeto somo bibi igbalode.			
46	Awon osise eleto ilera fun ifeto somo bibi o kin se iwuri funmi lati lo ifeto somo bibi igbalode ti mo ba lo si ibe.			
47	Awon osise eleto ilera fun ifeto somo bibi maa n fimi se yeye ti mo ba lo si odo won lati lo ifeto somo bibi			

HEALTH CARE PROVIDERS KEY INFORMANT INTERVIEWER GUIDE

To be read by the interviewer: The questions to be asked are meant to understand the Family Planning Service offered at this Health Care centre and also to know about the challenges faced by youths and adolescents in using the facility's service on modern contraceptives. Family planning services can be actual provision of contraceptive methods or counseling about these types of method. These methods include condoms, pills, injections, IUCDs, implants or surgical procedures such as tubal ligation or vasectomy.

Today's Date: …….

Facility Name: …….

Ward Number: …….

Interviewee Title or role: ……

QUESTIONS

Who provides Family planning services at the clinic?

1. What category of people visit this Family planning service centre?
2. How often do youths visit the Family Planning Clinic?
3. What services are usually sought by youths as regards modern contraceptives?
4. What do you think prevents youths to using modern contraceptives?
5. How much does it cost to acquire the modern contraceptive methods?
6. What do you think about the quality of service in terms of attention provided and the materials used while providing Family Planning services to users especially unmarried youths?
7. How can we encourage youths to use modern contraceptives?

STATE COORDINATOR FOR FAMILY PLANNING KEY INFORMANT INTERVIEWERS GUIDE

Date …….

Name: ……

Office Held ……..

1. What written policies guide the contraceptive use for youths in Oyo State?
2. What programmes are made available for out of school youths as regards their contraceptive use?
3. What educational programmes are created by the family planning coordinators in the state to reach the out of school youths considering their inability to go to school?
4. If there are educational programmes created for these youths, how are they implemented?
5. What are the challenges faced when it comes to reaching out to youths?

ETHICAL APPROVAL

TELEGRAMS.....

TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to
the Honorable Commissioner quoting
Our Ref. No. AD 13/479/907

17th September, 2018

The Principal Investigator,
Department of Health Promotion and Education,
African regional Health Education Centre,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Akinade Oluwatomisin

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Modern Contraceptive Use among Apprentices in Ibadan North Local Government, Oyo State" has been reviewed by the Oyo State Ethics Review Committee.

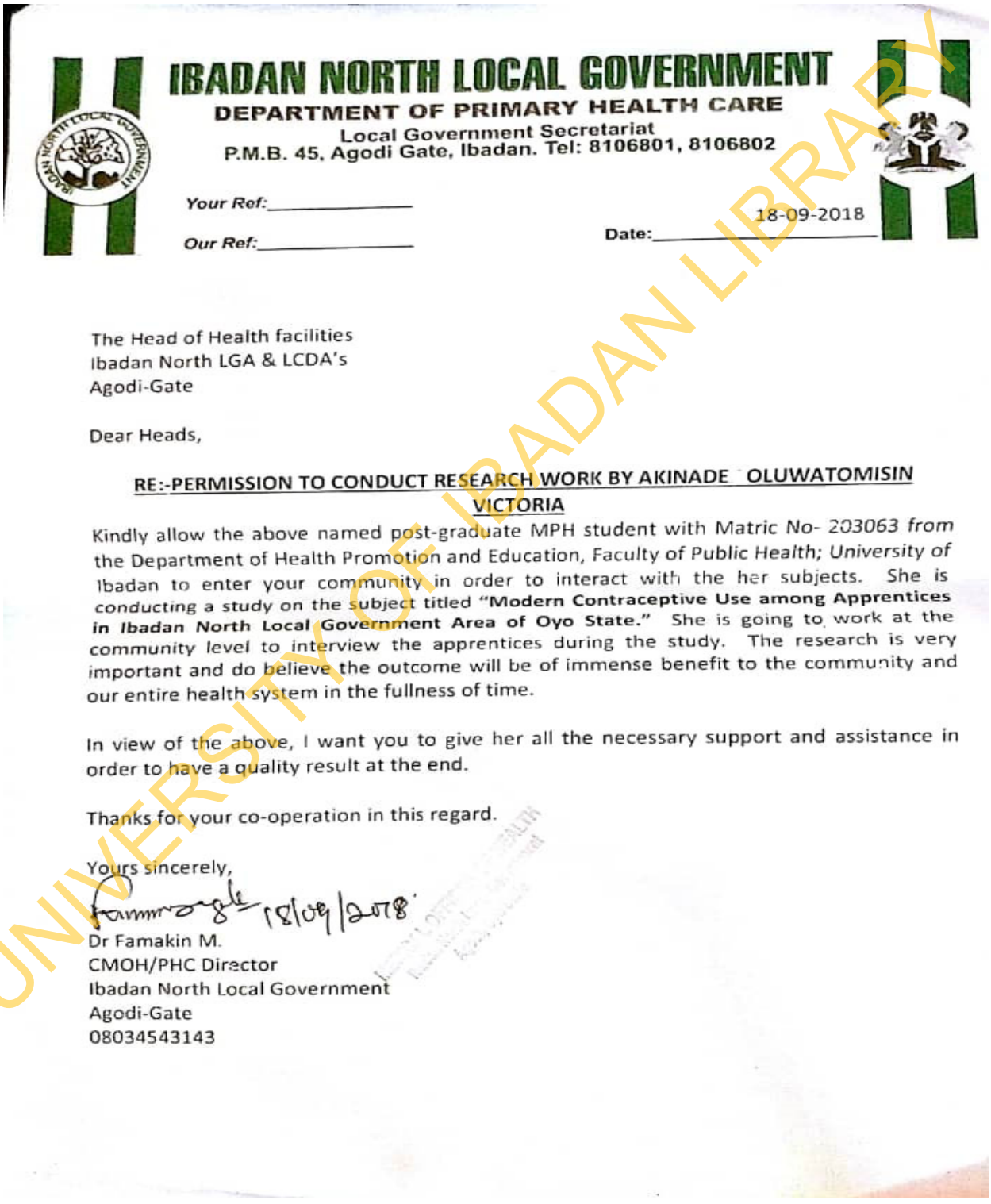
2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee

LOCAL GOVERNMENT APPROVAL LETTER



IBADAN NORTH LOCAL GOVERNMENT
DEPARTMENT OF PRIMARY HEALTH CARE
Local Government Secretariat
P.M.B. 45, Agodi Gate, Ibadan. Tel: 8106801, 8106802

*Your Ref:*_____

*Our Ref:*_____

Date: 18-09-2018

The Head of Health facilities
Ibadan North LGA & LCDA's
Agodi-Gate

Dear Heads,

RE:-PERMISSION TO CONDUCT RESEARCH WORK BY AKINADE OLUWATOMISIN VICTORIA

Kindly allow the above named post-graduate MPH student with Matric No- 203063 from the Department of Health Promotion and Education, Faculty of Public Health; University of Ibadan to enter your community in order to interact with the her subjects. She is conducting a study on the subject titled **"Modern Contraceptive Use among Apprentices in Ibadan North Local Government Area of Oyo State."** She is going to work at the community level to interview the apprentices during the study. The research is very important and do believe the outcome will be of immense benefit to the community and our entire health system in the fullness of time.

In view of the above, I want you to give her all the necessary support and assistance in order to have a quality result at the end.

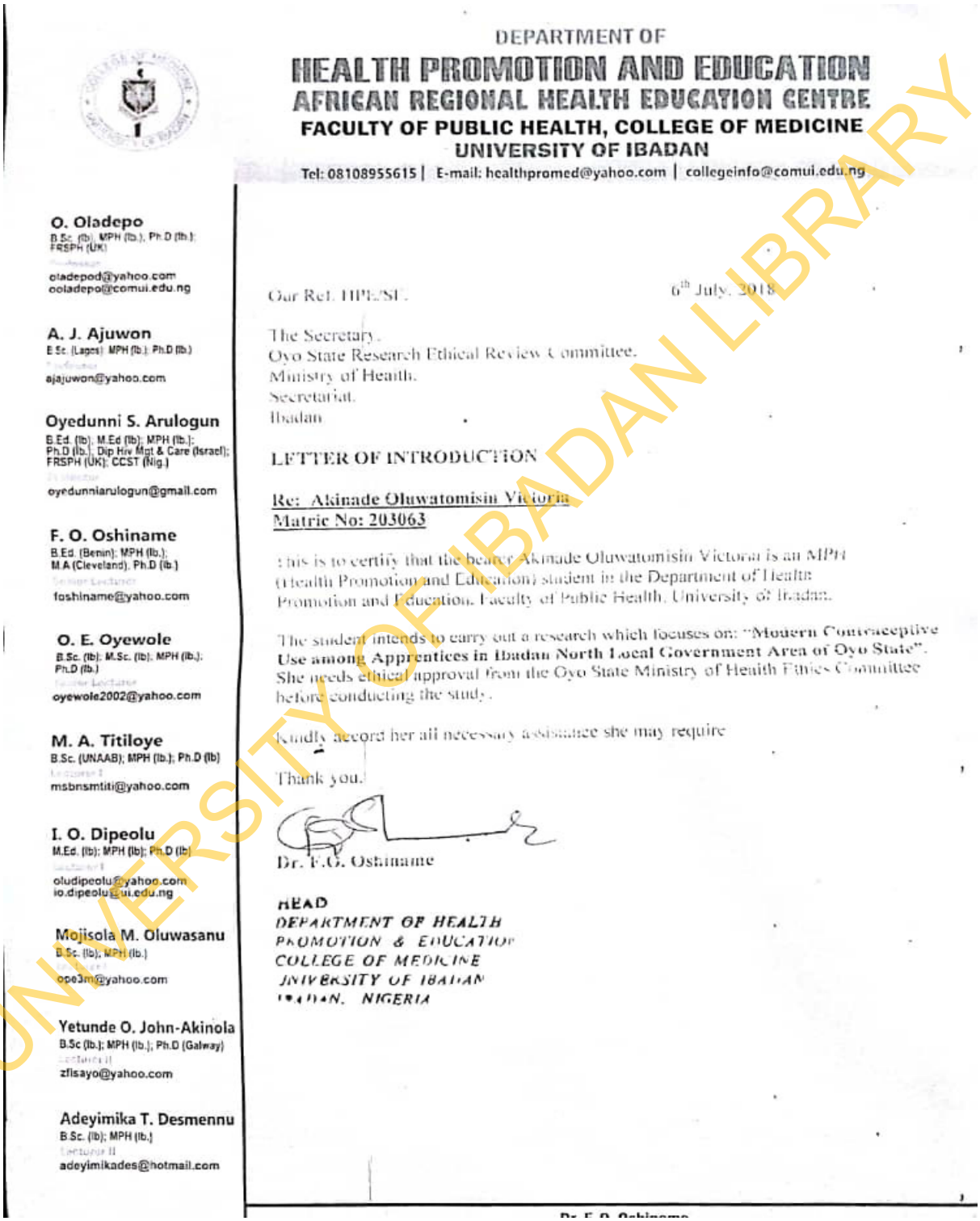
Thanks for your co-operation in this regard.

Yours sincerely,

18/09/2018

Dr Famakin M.
CMOH/PHC Director
Ibadan North Local Government
Agodi-Gate
08034543143

LETTER OF INTRODUCTION



DEPARTMENT OF
HEALTH PROMOTION AND EDUCATION
AFRICAN REGIONAL HEALTH EDUCATION CENTRE
FACULTY OF PUBLIC HEALTH, COLLEGE OF MEDICINE
UNIVERSITY OF IBADAN
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6th July, 2018

The Secretary,
Oyo State Research Ethical Review Committee,
Ministry of Health,
Secretariat,
Ibadan

LETTER OF INTRODUCTION

Re: Akinade Oluwatomisin Victoria
Matric No: 203063

This is to certify that the bearer Akinade Oluwatomisin Victoria is an MPH (Health Promotion and Education) student in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.

The student intends to carry out a research which focuses on: "**Modern Contraceptive Use among Apprentices in Ibadan North Local Government Area of Oyo State**". She needs ethical approval from the Oyo State Ministry of Health Ethics Committee before conducting the study.

Kindly accord her all necessary assistance she may require

Thank you.

Dr. F.O. Oshiname

HEAD
DEPARTMENT OF HEALTH
PROMOTION & EDUCATION
COLLEGE OF MEDICINE
UNIVERSITY OF IBADAN
IBADAN, NIGERIA