

ENSIGN GLOBAL UNIVERSITY
ENSIGN GLOBAL UNIVERSITY, KPONG,
EASTERN REGION, GHANA

FACULTY OF PUBLIC HEALTH
DEPARTMENT OF COMMUNITY HEALTH

ACCESSIBILITY AND CONTRACEPTIVE PREFERENCES AMONG
ADOLESCENTS AND YOUNG ADULTS IN TEMA WEST
MUNICIPALITY, GHANA

BY

DR MARFOAAH TETTEY-AMLALO (257100344)

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DECLARATION

I hereby certify that, except for references to other people's work, which I have duly cited, this project submitted to the Department of Community Health, Ensign Global University, Kpong, is the result of my own investigation and has not been presented for any other degree elsewhere.

Name Of Candidate: Dr Marfoaah Tettey-Amlalo (257100344)



Signature: Date: 22/07/2026

Name of Supervisor: Dr. Alberta Teye Agudey

Signature: : Date:

Name of Head of Academic Program:

Signature: : Date:

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ABSTRACT

Background: Adolescent reproductive health remains a concern in Ghana, where increased availability of family planning services has not translated into corresponding utilisation among young people. Barriers such as limited youth-friendly services, concerns about confidentiality, and provider attitudes continue to affect access. In peri-urban areas like Tema West Municipality, gaps persist between service availability, accessibility, and adolescents' contraceptive preferences. This study examines accessibility and contraceptive preferences among adolescents in Tema West Municipality to inform targeted interventions.

Aim: The aim of the study was to examine the accessibility and Contraceptive Preferences among Adolescents in Tema West Municipality, Ghana

Methodology: A analytical cross-sectional design was employed, involving 264 adolescents aged 10–25 years. Data were collected using a structured questionnaire adapted from a validated instrument and analyzed using IBM SPSS version 25 for descriptive and bivariate analyses, while multinomial logistic regression was conducted in R to identify predictors of contraceptive preference. Statistical significance was set at $p < 0.05$.

Results: Among 264 adolescents and young adults, accessibility to family planning services was limited despite high awareness (92.8%), with only 64.0% able to identify a specific service delivery point and 89.4% reporting low perceived availability. While affordability (73.1%), confidentiality (75.0%), and proximity (76.2%) were rated moderately, structural barriers particularly inconvenient service hours (mean = 2.37 ± 1.00) constrained effective access, and pharmacies or chemical shops emerged as the main access points (12.1%). Contraceptive use was low, with 61.0% reporting no prior use and 75.0% not currently using any method. Barrier methods

were the most preferred (35.6%), followed by hormonal methods (15.5%), while 25.8% reported no clear preference and preference for long-acting reversible contraceptives remained low (4.5%). Convenience (25.4%) and perceived effectiveness (20.9%) were the primary drivers of method choice. Contraceptive use was significantly associated with age ($\chi^2 = 27.563$, $p < 0.001$), religion ($\chi^2 = 9.969$, $p = 0.019$), relationship status ($\chi^2 = 54.372$, $p < 0.001$), education ($\chi^2 = 23.075$, $p < 0.001$), schooling status ($\chi^2 = 16.715$, $p < 0.001$), living arrangement ($\chi^2 = 40.171$, $p < 0.001$), employment ($\chi^2 = 22.752$, $p < 0.001$), and income ($\chi^2 = 20.975$, $p < 0.001$), but not gender ($p = 0.280$). Multinomial regression showed that males had higher odds of preferring barrier methods (aOR = 4.13, 95% CI: 1.73–9.89) but lower odds of preferring modern methods (aOR = 0.15, 95% CI: 0.05–0.44), while being in a relationship and being out of school increased the likelihood of preference across method categories. Key influencing factors included media exposure (mean = 2.81 ± 0.72), limited family communication (mean = 2.78 ± 0.87), infertility concerns (mean = 2.61 ± 0.86), and fear of provider judgment (mean = 2.58 ± 0.87), whereas cost was less influential.

Conclusion: The study showed that, accessibility barriers are driven less by awareness and cost, and more by structural and social factors, including service convenience, provider attitudes, and communication gaps. The findings support the Andersen Behavioral Model, demonstrating that contraceptive behavior among adolescents and young adults is shaped by predisposing factors (age, education), enabling factors (service accessibility, provider attitudes), and perceived need, with social and informational influences playing a central role.

ABBREVIATIONS AND ACRONYMS

Acronym	Full Meaning
aOR	Adjusted Odds Ratio
ASRH	Adolescent Sexual and Reproductive Health
CHPS	Community-based Health Planning and Services
CI	Confidence Interval
FABM	Fertility Awareness-Based Methods
FP	Family Planning
GHS	Ghana Health Service
GSS	Ghana Statistical Service
IRB	Institutional Review Board
LARC	Long-Acting Reversible Contraceptive
NHIS	National Health Insurance Scheme
PNFP	Private Not-For-Profit
RH	Reproductive Health
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
TWMA	Tema West Municipal Assembly
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Adolescent reproductive health continues to challenge public health systems worldwide, and nowhere is this more acute than in low- and middle-income countries where adolescents make up a disproportionate share of unintended pregnancies and their consequences (Morris & Rushwan, 2015; Plesons *et al.*, 2019). Globally, adolescents aged 10–19 account for 11% of all births, with 95% of these occurring in low- and middle-income countries, a statistic that carries with it elevated risks of maternal mortality, school dropout, and deepening poverty (Ghose & John, 2017). In Sub-Saharan Africa, these rates are among the highest in the world, sustained by limited contraceptive access, cultural resistance to open discussions about adolescent sexuality, and entrenched socio-economic inequalities (Melesse *et al.*, 2020). Progress toward SDG 3.7 which is universal access to sexual and reproductive health services and Sustainable development goals (SDG) 5 on gender equality remains slow in this context.

Ghana sits squarely within this pattern. By 2014, adolescents accounted for 30% of all registered births, and 14% of girls aged 15–19 had already begun childbearing (Coughlin, 2016). The downstream effects are well-documented: higher maternal mortality, higher school dropouts, and cycles of poverty that are especially difficult to break in underserved communities. On paper, Ghana's modern contraceptive prevalence rate (mCPR) among adolescents now stands at 24.4% still well short of the national target of 30% by 2030 (Track20 Project, 2024). However, that aggregate figure obscures a more important question: which contraceptives are adolescents willing to use, and what determines that choice?

This is where existing research begins to thin out. Studies in Ghana consistently show that adolescents do not simply lack access to contraception in a technical sense; health facilities exist, contraceptives are stocked, and national policies mandate their provision (Agbenu et al., 2024; Ehiawey et al., 2024). The deeper problem is that adolescents often do not use those services, or do not use them consistently, because the services are not designed around how adolescents make decisions about contraception. Fear of stigma, concerns about confidentiality, negative provider attitudes, and a lack of youth-friendly environments all shape whether an adolescent walks through a clinic door and what method they are willing to accept when they do (Abuosi & Anaba, 2019; Agbenu et al., 2024; Ehiawey et al., 2024). Contraceptive preference, in other words, is not just a clinical matter. It is a social one.

Ghana's policy environment reflects an understanding of this gap, at least in principle. The Ghana Adolescent Reproductive Health Policy (2000) committed to integrating reproductive health education into schools and establishing youth-friendly services (Agblevor et al., 2023). Under the FP2030 initiative, Ghana has targeted an mCPR of 44.4% by 2030 and a reduction in unmet need among sexually active adolescents from 57% to 30% (FP2030, 2023). A concrete step forward came in January 2022, when family planning services including long-acting reversible contraceptives (LARCs) were added to the National Health Insurance Scheme (NHIS) benefits package, removing a significant cost barrier for enrolled members. Yet contraceptive uptake has not risen at the rate these policies anticipated. The gap between what is available and what adolescents actually use points to something beyond cost or physical access.

Tema West Municipality, in Ghana's Greater Accra Region, offers a useful lens for examining these dynamics. It is a fast-growing peri-urban area where 18.9% of the population are adolescents, and where industrial growth and migration have created a distinct and complex social landscape (Tema

West Municipal Assembly, 2021). Its proximity to Accra can give the impression of relatively good health infrastructure, but service delivery in the municipality remains uneven and the challenges documented in the broader Tema Metropolis, including high rates of teenage pregnancy, unsafe abortions, and HIV infections among adolescents, suggest that Tema West faces similar structural pressures (Agbenu et al., 2024).

Existing literature on Tema West and peri-urban Ghana provides general evidence on adolescent reproductive health, but it lacks detailed analysis that combines awareness, perceived availability, contraceptive use, and preferences within a single local context. Most national and regional studies do not capture how adolescents in specific communities perceive access to contraceptives or how these perceptions influence their use and method choices (Ehiawey et al., 2024). In addition, limited attention is given to how individual and sociodemographic factors shape both contraceptive use and preferences among adolescents.

This study addresses these gaps by examining adolescents' awareness and perceptions of contraceptive availability in Tema West Municipality, assessing their level of contraceptive use and preferences, and identifying the factors that influence these preferences. It also evaluates the association between sociodemographic characteristics and contraceptive use. By integrating these components, the study provides context-specific evidence that reflects adolescents' experiences and behaviours, with the aim of informing targeted interventions to improve contraceptive access and utilisation in the municipality.

1.2 Statement of Problem

Ghana has implemented several policies aimed at improving adolescent reproductive health, including the inclusion of family planning services under the National Health Insurance Scheme, the integration of reproductive health education into school curricula, and national commitments under FP2030 to increase contraceptive uptake among young people (FP2030, 2023). Despite these efforts, progress remains limited. Adolescent and young adult childbearing persists, and modern contraceptive use among adolescents remains below national targets (Coughlin, 2016; Track20 Project, 2024). This suggests that policy availability alone does not translate into effective utilisation of contraceptive services.

Existing evidence shows that barriers such as stigma, fear of judgment, and concerns about confidentiality continue to limit adolescents' access to and use of contraceptives, even where services are available (Abuosi & Anaba, 2019; Agbenu et al., 2024). These factors influence both adolescents' perceptions of availability and their willingness to use services. As a result, understanding contraceptive use and preferences, alongside awareness and perceived availability, is necessary to explain current patterns of low utilisation.

Tema West Municipality reflects many of these challenges. The area is peri-urban, with a growing adolescent population and uneven health service delivery (Tema West Municipal Assembly, 2021). Available evidence from the broader Tema area indicates ongoing concerns such as teenage pregnancy and other adverse reproductive health outcomes among young people (Agbenu et al., 2024). However, there is limited local evidence that examines adolescents' awareness of contraceptive services, their perceptions of availability, their level of contraceptive use, and their preferences within this specific setting.

This study addresses this gap by assessing adolescents' awareness and perceptions of contraceptive availability, examining their contraceptive use and preferences, and identifying the factors that influence these outcomes in Tema West Municipality. By focusing on these objectives, the study provides context-specific evidence to inform interventions aimed at improving access to and utilisation of contraceptive services among adolescents.

1.3 Significance of Study

The practical case for this study is straightforward. Ghana cannot reach its FP2030 targets or meet SDG 3.7 on universal reproductive health access by relying on national-level data alone (FP2030, 2023). Adolescent contraceptive uptake in peri-urban municipalities like Tema West depends on whether the right methods are available in the right facilities, whether adolescents find those facilities safe enough to use, and whether the social environment around those facilities supports or discourages young people from seeking care. None of these questions can be answered from Accra with a national survey.

This study speaks directly to that problem. By assessing the availability of family planning services across health facilities in Tema West, it gives health managers and district planners an honest picture of what exists not what policies say should exist. By documenting adolescent contraceptive preferences and the factors that shape them, it gives service providers something more useful than compliance checklists: an account of what young people in this community want and what gets in the way. The two pieces together supply and demand, facility readiness and adolescent experience are what most existing research in this area has failed to combine (Ehiawey et al., 2024).

For Ghana's health system, the findings offer a basis for designing youth-friendly services that respond to real preferences rather than assumed ones. For policymakers, they provide municipal-level evidence to support resource allocation decisions that aggregate data cannot justify. And for communities across the peri-urban belt of Sub-Saharan Africa, where urban growth is running well ahead of health system adaptation, the study offers a replicable framework for understanding how adolescent reproductive health challenges play out at the local level and what it would take to address them.

It also contributes to the body of literature by first providing localized empirical evidence on the availability of family planning services and adolescent contraceptive preferences within a peri-urban Ghanaian municipality, addressing a critical gap in context-specific research. Also, it adopts a comprehensive approach by integrating supply-side factors, such as service availability, with demand-side determinants, including adolescents' preferences and socio-demographic influences. It also provides policy-relevant insights that support the development of adolescent-responsive and youth-friendly reproductive health interventions. Finally, the study offers a methodological and analytical framework that can be replicated in similar peri-urban settings across Ghana and Sub-Saharan Africa, which can improve regional and global studies on adolescent sexual and reproductive health.

1.4 Conceptual framework

The study adopts the Andersen Behavioral Model of Health Service Use as the guiding conceptual framework (Azfredrick, 2016; Xu et al., 2025). The model explains health-related behaviours through the interaction of three domains: predisposing characteristics, enabling factors, and need

factors. For this study, the framework was adapted to explain contraceptive method preferences among adolescents and young adults in Tema West Municipality, Ghana.

Predisposing characteristics comprise individual attributes that influence contraceptive decision-making. These include age, sex, educational level, religion, relationship status, and knowledge of contraceptive methods. These characteristics shape adolescents' attitudes, beliefs, and perceptions regarding contraception and contribute to the development of preferences for specific contraceptive methods.

Enabling factors represent the structural and environmental conditions that facilitate or hinder access to contraceptive services. These include perceived availability of contraceptives, affordability, proximity to service delivery points, youth-friendly services, and access to accurate reproductive health information. In this study, accessibility is operationalized primarily as adolescents' perceived availability of contraceptive services, directly addressing Objective 1. Need factors refer to participants perceived or actual reproductive health needs, including concerns about unintended pregnancy, sexual activity, relationship status, and perceived barriers to contraceptive use. These factors influence adolescents' motivation to seek contraceptive services and their preferences for contraceptive methods.

Within this adapted framework, contraceptive method preference is the primary outcome variable. It is assumed to result from the combined effects of predisposing characteristics, enabling factors, and need factors. Ever contraceptive use is considered an intermediate behavioural outcome that reflects previous engagement with contraceptive services and is influenced by the same set of individual and contextual factors. The framework therefore assumes that greater perceived accessibility, fewer barriers to contraceptive use, and favourable sociodemographic characteristics

are associated with both ever contraceptive use and the development of preferences for specific contraceptive methods. In relation to the study objectives, the framework assumes that perceived accessibility reflects the enabling environment for contraceptive services; perceived barriers represent need-related and contextual influences on contraceptive behaviour; selected sociodemographic characteristics are associated with ever contraceptive use; and the combined effects of predisposing, enabling, and need factors determine contraceptive method preferences among adolescents and young adults in Tema West Municipality.

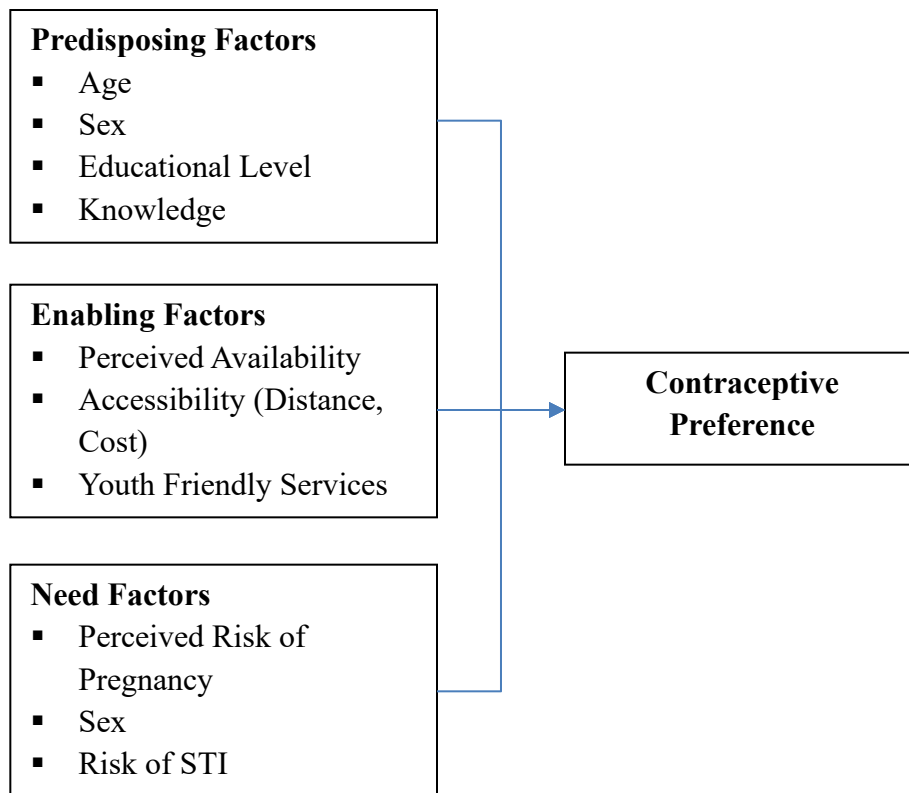


Figure 1.1 Conceptual Framework guiding Study (Adapted from the Andersen Behavioral Model of Health Service Use)

1.5 Research Questions

1. What is the level of accessibility to contraceptives among adolescents and young adults in Tema West Municipality?
2. What are the contraceptive method preferences among adolescents and young adults in Tema West Municipality?
3. What are the perceived barriers to contraceptive use among adolescents and young adults in Tema West Municipality?
4. Which sociodemographic factors are associated with ever contraceptive use among adolescents and young adults in Tema West Municipality?
5. Which factors are associated with contraceptive method preferences among adolescents and young adults in Tema West Municipality?

1.6 General Objective

To examine the accessibility and Contraceptive Preferences among Adolescents and young adults
In Tema West Municipality, Ghana

1.7 Specific Objectives

1. To assess the accessibility of contraceptives among adolescents and young adults within Tema West Municipality.
2. To explore contraceptive preferences among adolescents and young adults in Tema West Municipality.
3. To assess perceived barriers to contraceptive use among adolescents and young adults in Tema West Municipality.

4. To determine the sociodemographic factors associated with ever contraceptive use among adolescents and young adults in Tema West Municipality.
5. To identify factors that influence contraceptive method preferences among adolescents and young adults in Tema West Municipality.

1.8 Profile Of Study Area

The study was conducted in the Tema West Municipal Assembly (TWMA), located in the Greater Accra Region of Ghana. Established in 2018 under Legislative Instrument (LI) 2317, TWMA was carved out of the Tema Metropolitan Assembly. It spans a land area of approximately 66.8 square kilometers, representing about 2.1% of the total land area of the Greater Accra Region (Tema West Municipal Assembly, 2021). The municipality's capital, Baatsona, lies in the southwestern part near the coast. Geographically, it is situated at 5.6353° N and 0.0653° W and shares boundaries with Krowor Municipality to the west, Adentan Municipality to the northwest, Kpone Municipality to the north, Ashaiman Municipality to the northeast, and Tema Metropolitan Assembly to the east, with the Gulf of Guinea forming its southeastern boundary.

According to the 2021 Population and Housing Census, TWMA has a population of 196,224, with 49.4% males and 50.6% females. This population is projected to grow to 233,106 by 2025 (Ghana Statistical Service, 2021). The municipality comprises both urban and peri-urban settlements and hosts a diverse and rapidly expanding population. Its economy is driven largely by industry, commerce, and services, with a significant proportion of residents engaged in small-scale trading and various commercial activities. The blend of urbanization, economic growth, and demographic diversity makes TWMA an ideal setting for studying public health trends, economic development, and social dynamics in rapidly urbanizing environments.

The healthcare infrastructure in TWMA consists of multiple health facilities, including two (2) Quasi-government clinic, one Government complemented by over 20 private clinics, maternity homes, and hospitals that help meet the healthcare needs of the growing population (Tema West Assembly, 2023). Despite this relatively extensive network, disparities in healthcare access persist across the municipality. Urban communities such as Baatsona and Sakumono benefit from better access to healthcare services, while peri-urban areas continue to face shortages of trained health personnel, essential equipment, and logistical support.

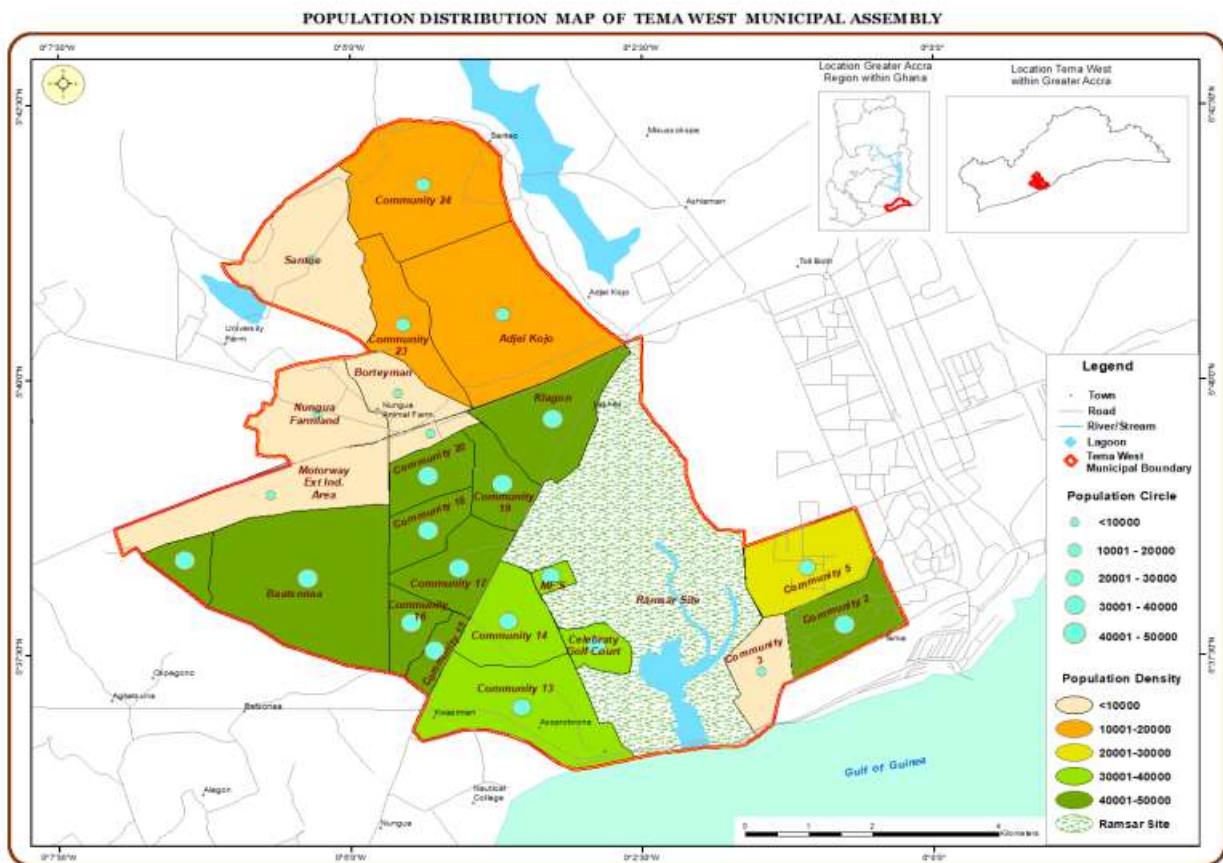


Figure 1.2 Population distribution map of Tema West Municipal Assembly
(Tema West Municipal Assembly, 2021)

1.9 Organization of Study

The study consists of 6 chapters including Chapter one which provides the introduction, background of the study, problem statement, research justification, conceptual framework, research questions, general and specific objectives, study area description, and the scope of the study. Chapter Two presents a comprehensive review of related literature, drawing on previous academic work, policy documents, and empirical studies relevant to adolescent reproductive health and family planning access. Chapter Three details the methodology of the study, including research design, target population, sampling techniques, data collection tools and procedures, operational definitions of variables, pre-testing, data handling, analysis methods, and ethical considerations. Chapter Four presents the results of the data analysis, including demographic characteristics, service availability indicators, accessibility metrics, and adolescents' awareness and perceptions. Chapter Five discusses the findings in relation to existing literature, highlights key patterns, and interprets the implications of the results within the context of the Andersen Behavioral Model. Chapter Six provides a summary of the study, key conclusions, and practical recommendations for health policymakers, service providers, and other stakeholders. It also suggests areas for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Family Planning

Family planning (FP) refers to the deliberate decision made by individuals or couples to determine the number of children they wish to have and the timing between births using contraceptive methods (FP2030, 2023; Nansseu et al., 2015). It plays a critical role in improving maternal and child health outcomes. Globally, effective family planning which had an effect in the uptake of contraceptives has been shown to prevent up to one-third of pregnancy-related deaths and approximately 44% of neonatal deaths (Ahmed et al., 2012). Ensuring a minimum birth interval of at least two years significantly reduces the risk of adverse pregnancy outcomes, including premature births and childhood malnutrition, which often lead to stunted growth (Yaya et al., 2020). These benefits of birth spacing are universally relevant and not limited to low-resource settings. Importantly, reproductive choices including whether to have children and how many remain a fundamental right of every individual.

A key component of Family planning is the use of contraceptives. Modern contraceptive methods have revolutionized family planning by providing individuals with safe, effective, and diverse options to manage their reproductive health (Deeksha et al., 2024; Festin, 2020). These methods are broadly categorized into hormonal methods, intrauterine contraceptive devices (IUCDs), barrier methods, post-coital contraception, and natural methods (Amarin, 2018; Colquitt & Martin, 2017; Tracy, 2017). Each category offers unique advantages and challenges, making it essential for users to understand the mechanisms, effectiveness, and suitability of each method based on their personal needs and circumstances.

2.2 Awareness and perception of Family Planning among Adolescents and young adults

Across diverse global contexts, research consistently shows that knowledge of family planning (FP) is generally high among adolescents and young adults, yet this does not always result in corresponding positive attitudes or high contraceptive use.

In Yemen, Masood & Alsonini (2017) reported that 95.6% of young adults had heard of reproductive health and FP services, with television (80.5%), relatives (33%), and radio (32.7%) being the primary sources of information. Despite the high awareness, the study emphasized that empowerment and informed decision-making were more prevalent among those with higher education levels and active club involvement.

Moving to Sub-Saharan Africa, similar patterns are evident. In Ethiopia, Katama & Hibstu (2016) found that 94.7% of female students had good knowledge of contraceptive methods especially injectables (83.9%), pills (72.7%), and condoms (48.6%). However, only 15.7% had ever used contraception, highlighting the disconnect between knowledge and practice. Another Ethiopian study by Bekele et al. (2020) further reinforced this gap, showing that only 43.4% had good knowledge and 52.3% had favorable attitudes toward FP. Key predictors of good knowledge included urban residence, higher education, and media exposure, while a desire for larger families and being a student were negatively associated with a positive attitude.

In Tanzania, Kara et al. (2019) found that 96% of students were aware of contraception, yet only 47.4% had ever used a method. Barriers included embarrassment (64.6%) and religious beliefs (32.3%), further demonstrating how sociocultural factors influence FP behavior despite high awareness.

In the Democratic Republic of Congo, Casey et al. (2020) reported that over 90% of adolescent and young women could name at least one modern contraceptive method. Nevertheless, unmet need remained high: 31.7% among 15–19-year-olds and 40.1% among 20–24-year-olds. Modern contraceptive use stood at 16.5%, with more than half of 15–19-year-olds using long-acting reversible contraceptives (LARCs), suggesting that when accessible, adolescents do adopt effective methods.

In Nigeria, Onasoga (2016) noted that while most respondents had high knowledge and a positive attitude toward emergency contraceptives, actual usage remained low, influenced by parental disapproval, accessibility issues, and peer pressure. Notably, there was no statistically significant relationship between knowledge levels and utilization.

In Ghana, studies similarly reveal a paradox: high knowledge levels yet poor service uptake. Boamah et al. (2014) found that 88.9% of adolescents knew at least one contraceptive method, with male condoms being the most widely known (84%) and used (82%). Yet, only 22.9% reported consistent contraceptive use. Lack of communication with partners and social stigma were major barriers. Z. Sulemana et al. (2024) further noted that although 99.7% of health-related tertiary students had FP knowledge mainly from school (51.8%) and clinics (41.4%) just 21.7% used family planning services. Perceived side effects like menstrual cramps (57.9%), infertility (33.1%), and weight gain (32.5%) discouraged use, compounded by community and family disapproval.

In a more recent Ghanaian study, I. Sulemana et al. (2025) found that 80.6% had high knowledge, and 54.3% had ever used a method, yet usage was significantly affected by factors like religion, education level, occupation, and provider friendliness. For instance, Christians and traditionalists

were significantly more likely to use FP, while fear of side effects and unfriendly providers reduced uptake.

Gbagbo (2020), studying contraceptive use among basic school pupils, revealed that 64.6% were aware of contraceptives, but misconceptions, sociocultural stigma, and lack of parental guidance led to high unmet needs. Pupils who had conversations with parents about FP were more likely to use contraceptives consistently.

A progressive comparison of studies from Yemen through several African countries—including Ethiopia, Tanzania, the Democratic Republic of the Congo (DRC), Nigeria, and Ghana reveals a consistent trend: although knowledge of family planning (FP) methods often exceeds 90% among adolescents, actual utilization remains significantly lower, typically falling below 50% and often ranging between 15% and 25%. This persistent gap between knowledge and practice is shaped by a combination of sociocultural, structural, and psychological barriers. Stigma and embarrassment about seeking FP services are common deterrents in countries like Tanzania and Ghana, while religious and cultural norms often discourage contraceptive use in Ethiopia and Nigeria.

In Ghana and Nigeria, adolescents frequently encounter limited access to youth-friendly services, and misinformation or fear of side effects such as infertility or weight gain further suppresses uptake, particularly in Ghana and the DRC. Additionally, a lack of open communication with parents or partners, as reported in studies from Ghana and Ethiopia, contributes to hesitancy in contraceptive use. These highlight the urgent need for adolescent-centered and context-specific interventions that move beyond basic awareness campaigns to address the deeper social, emotional, and systemic challenges adolescents face. Notably, peri-urban areas such as Tema West

Municipality are often overlooked in such research, despite facing unique service delivery challenges due to their transitional position between urban and rural health systems.

2.3 Accessibility and availability of Family planning services in health facilities

A study by Rai et al. (2023) in Nepal found that nearly all health facilities (97.8%) provided family planning services, but readiness indices only improved marginally from 68.0% in 2015 to 70.9% in 2021. The study showed that regular management meetings and quality assurance activities were key predictors of improved readiness. However, only about half of facilities provided delivery services, and gaps in emergency obstetric care and antenatal readiness persisted.

In Nigeria, Obong & Oyibo (2023) observed that while 65.6% of primary health care (PHC) facilities offered at least five modern contraceptive methods, stock-outs were widespread emergency contraceptives were unavailable in 96.9% of facilities. Furthermore, only 34.4% of PHCs had IEC materials, and just 25% had updated guidelines or commodity checklists, indicating systemic weaknesses in service support and quality assurance.

Similarly, a study by Ssanyu et al. (2025) across 152 facilities found high availability of short-acting contraceptives (99.0%) but limited access to long-acting methods (34.2%) and permanent options (8.9%). Average readiness was low at 46.7%, and provider-imposed restrictions based on age, marital status, or spousal consent affected 97.7% of health workers. Inadequate refresher training and low provider confidence, especially in PFP and PNFP facilities, further reduced service quality.

Mpunga et al. (2017), in their multi-country assessment across 10 African nations, reported that Niger (96%) and Sierra Leone (94%) had the highest percentage of facilities offering FP services,

while the DRC (33%) and Djibouti (57%) had the lowest. Availability of three or more contraceptive methods was uncommon, with the most frequent options being male condoms, COCs, and injectables. Tanzania had the highest proportion of facilities (72%) meeting all six readiness tracer indicators (e.g., guidelines, trained staff, contraceptive availability), while Benin and Mauritania had the lowest (17%). Stock-outs, lack of trained personnel, and absence of guidelines were common across all countries. Adolescents, particularly unmarried ones, were disproportionately affected by access restrictions.

Zooming into Ghana, Amenah et al. (2025) highlighted differences in adolescent sexual and reproductive health (ASRH) service availability and readiness. In Shai Osudoku, 65% of facilities provided a full range of ASRH services (including FP), compared to just 16% in Ningo Prampram. Service provision varied across facility types: CHPS compounds (57%), health centres (59%), and clinics (44%). Surprisingly, rural facilities slightly outperformed urban ones in readiness: 46% of rural facilities had trained staff versus 23% in urban areas, and 29% had service guidelines compared to 21% in urban counterparts.

Across all contexts, several patterns emerge: short-acting contraceptives are generally more available than long-acting options; urban-rural discrepancies remain inconsistent; and readiness is undermined by stock-outs, lack of guidelines, limited provider training, and sociocultural barriers such as age and marital restrictions. Ghana's case, especially in peri-urban areas like Tema West Municipality, reflects this broader trend where availability may be high but true readiness, particularly for adolescent-centered delivery, remains suboptimal. This shows the urgent need for comprehensive, context-specific interventions that enhance both structural readiness and equitable access.

2.4 Contraceptive Use and Preferences among Adolescents and young adults

Empirical evidence shows that contraceptive use among young adults is shaped by a combination of knowledge, accessibility, sociocultural norms, and socio demographic characteristics. Across settings, young adults often demonstrate awareness of modern contraceptives, yet this awareness does not consistently translate into regular or effective use. The following sections review evidence from developed countries, developing countries, and Ghana to highlight prevailing patterns, preferences, and gaps that inform the present study.

2.4.1 Contraceptive Use and Preferences among Adolescents and young adults in Developed Countries

In developed countries, widespread availability of contraceptive services shifts attention from access constraints to issues of method preference, consistency, and behavioural adherence. Jahanfar and Zendehdel (2024), in a study among university students in Michigan, United States, reported high contraceptive knowledge levels, with a mean score of 16.53 ± 2.38 out of 18. Despite this high awareness, students showed clear method preferences, with 49.2% relying primarily on condoms and 36.3% using oral contraceptive pills. These preferences suggest a tendency toward user-controlled methods that align with non-marital and short-term relationship contexts.

Similarly, Otobo et al. (2022), studying reproductive aged participants attending Ghent University Summer School in Belgium, found 100% contraceptive awareness, with 73.3% identifying formal health education as their main source of information. High knowledge levels translated into dual protection strategies, as 93.3% reported using contraception for both pregnancy and sexually transmitted infection prevention. Method availability remained consistent, with 60% reporting

condom access and 40% oral contraceptive pill access. However, despite optimal access and knowledge, 26.7% of participants reported having experienced unintended pregnancies. This finding demonstrates that even in resource rich settings, knowledge and availability alone are insufficient to ensure consistent contraceptive effectiveness.

2.4.2 Contraceptive Use and Preferences among Adolescents and young adults in Developing Countries

In developing country contexts, contraceptive use among young adults is more strongly influenced by cultural norms, peer dynamics, and health system limitations. Coetzee and Ngunyulu (2015), examining female undergraduates in South Africa, reported that 74% of participants were sexually active, yet only 79% of sexually active students used any form of contraception. Male condoms (25%) and oral contraceptive pills (38%) were the most used methods, although overall utilization levels were notably lower than those reported in developed countries.

Peer influence plays a central role in contraceptive decision making. Iyoke et al. (2014), studying Nigerian university students, found that over 98% of male students and 85% students relied on peer information when selecting contraceptive methods. This reliance resulted in suboptimal outcomes, as 49.2% of female students preferred traditional methods, while adherence to modern contraceptives was limited to 35%. These findings indicate that information source strongly shapes contraceptive behaviour.

In Uganda, Mehra et al. (2012) reported that 18.6% of sexually active university students did not use contraception during their most recent sexual encounter. Non-use was significantly higher among students not in stable relationships. Regression analysis showed that relationship status,

age, and age at sexual debut were significant predictors of contraceptive non-use. These studies collectively demonstrate that in developing country settings, contraceptive use among young adults is constrained by social and structural factors beyond individual knowledge.

2.4.3 Contraceptive Use and Preferences among Adolescents and Young Adults in Ghana

In Ghana, contraceptive behaviour among young adults reflects a combination of relatively high awareness and persistent barriers to consistent use. Kugbey et al. (2018), analysing data from 1,648 school aged adolescents using the Ghana Global School based Student Health Survey, found that among sexually active respondents, only 26.2% used condoms during their last sexual encounter, while 32.5% reported having multiple sexual partners. These early risk patterns provide important context for understanding behaviours that may persist into young adulthood.

University focused studies further highlight knowledge practice gaps. Nimo Appiah Agyekum and Kayi (2013), using qualitative methods among University of Ghana students, found that knowledge was largely limited to male and female condoms, with minimal awareness of hormonal or long-acting reversible contraceptives. Negative attitudes toward unmarried contraceptive users further discouraged uptake.

Gbagbo and Nkrumah (2019) reported that although undergraduate students demonstrated positive attitudes toward family planning with a mean score of 4.0, actual practice showed that emergency contraceptive pills accounted for 31% of contraceptive use among females aged 21 to 24 years. This reliance on emergency contraception suggests reactive rather than preventive behaviour. Botchwey et al. (2022) similarly found that while 89.8% of female university students had heard of modern contraceptives, only 58.1% were current users. Pills (96.9%), female condoms (72.2%),

and injectables (52.6%) were the most reported methods. Social media emerged as the dominant information source, followed by peers and mass media.

2.5 Socio-demographic Factors and Contraceptive Use among Adolescents and young adults

2.5.1 Age and Contraceptive Behaviour Patterns

Evidence from diverse settings indicates that age plays an important role in shaping modern contraceptive use among young adults, although the direction and strength of this relationship differ across contexts. Studies from Ethiopia suggest a decline in protective sexual behaviour with increasing age. Shiferaw et al. (2014) reported that condom use during the most recent sexual encounter decreased from 62 percent among students aged 19 years or younger to 39 percent among those aged 20–24 years and 23.8 percent among students aged 25 years or older. Further analysis showed that sexually active male students aged 20–24 years (COR = 2.3, $p = 0.006$) and those aged 25 years and above (COR = 1.8, $p = 0.006$) were significantly more likely to use condoms inconsistently compared with younger students.

In contrast, evidence from Ghana points to a different age-related pattern. Amoah et al. (2023) found a positive association between age and modern contraceptive use, with older participants being nearly three times more likely to use modern contraceptive methods (AOR = 2.93, $p = 0.023$) compared with younger individuals. This contrast highlights that the influence of age on contraceptive behaviour is context dependent and may reflect differences in cultural expectations, cumulative sexual experience, relationship stability, and access to reproductive health services.

2.5.2 Gender Differences in Contraceptive Decision-Making

Gender also plays a significant role in shaping modern contraceptive use and sexual risk behaviours among young adults, with evidence showing notable differences in both decision making and consistency of use between males and females. Findings from Ethiopia illustrate these disparities. Shiferaw et al. (2014) reported that over a six-month period, 55 percent of male participants demonstrated inconsistent condom use, compared with a substantially higher proportion of females (89.2 percent). These differences suggest that gender specific social expectations and relationship dynamics influence contraceptive practices. Further analysis from the same study highlights the interaction between gender and substance use in shaping contraceptive behaviour. Among female participants, the combined use of alcohol and hard drugs was significantly associated with occasional condom use (COR = 2.2, $p = 0.00$), indicating increased vulnerability to inconsistent protection. This association was not observed among male participants, underscoring the gendered nature of risk exposure and behavioural responses. These findings suggest that gender differences in contraceptive behaviour are not only related to biological sex but are also shaped by social norms, substance use patterns, and power dynamics within sexual relationships.

2.5.3 Educational and Socioeconomic Determinants

Educational attainment and socioeconomic status demonstrate consistent positive associations with contraceptive use across multiple contexts, though the modes vary. Grindlay et al. (2018) found in Accra that modern contraceptive use was significantly associated with higher education levels, with secondary education (AOR 2.1, $p = 0.01$), tertiary education (AOR 4.3, $p = 0.01$), and vocational/technical schooling (AOR 2.8, $p = 0.03$) all showing positive

associations compared to primary education.

Iyoke et al. (2014) went further to demonstrate that health science-related courses of study significantly increased the likelihood of adherence to modern contraceptive methods (OR 3.5, 95% CI 1.3–9.6), highlighting how that specialized knowledge gained through educational programs directly influences contraceptive behaviour adoption. Similarly, receiving information from health personnel, media, or workshops increased adherence likelihood (OR 9.54, 95% CI 3.5–26.3), indicating that information quality and source credibility significantly impact contraceptive decisions in the same study.

The socio-economic influence is further highlighted in the study by Khalajabadi Farahani et al. (2018), who found that studying in private universities served as a significant predictor of having multiple sexual relations among Iranian male students, suggesting that socioeconomic status influences sexual risk behaviours that subsequently affect contraceptive needs and utilization patterns.

2.5.4 Information Sources and their influence on contraceptive decisions

Information sources also significantly influence contraceptive knowledge acquisition and subsequent behaviour adoption among university students. Iyoke et al. (2014) revealed that over 98% of Nigerian male students and 85% of female students made contraceptive choices based on peer information rather than professional guidance, leading to suboptimal method selection with only 35% adherence to modern contraceptives among female students.

Similarly, Botchwey et al. (2022) found that among Ghanaian young adults, social media served as the primary information source about contraceptives, followed by peers, radio/TV,

and health workers. This reliance on informal information sources may contribute to knowledge gaps and misconceptions that affect contraceptive behaviour.

However, professional information sources demonstrate superior outcomes. Interestingly, Grindlay et al. (2018) found that students who had ever talked with someone about contraception were significantly more likely to use modern contraception (AOR 4.7, $p \leq 0.001$), indicating that interpersonal communication about contraceptive topics, regardless of the specific source, positively influences behaviour adoption.

2.6 Barriers affecting adolescents' and young adults access to family planning services

Despite widespread knowledge of contraceptive methods across multiple countries, adolescents continue to experience substantial barriers in accessing and using family planning (FP) services. A consistent theme across studies is the disconnect between high levels of knowledge and low contraceptive use. For instance, while Masood & Alsonini (2017) found that 95.6% of young adults in Yemen were aware of FP methods, and Z. Sulemana et al. (2024) found near-universal knowledge (99.7%) among Ghanaian tertiary students, actual usage rates remained significantly lower. I. Sulemana et al. (2025) reported that only 21.7% of students utilized FP services despite their high knowledge levels, underscoring the persistent knowledge-practice gap.

Cultural and religious beliefs represent prominent barriers. In Ethiopia and Nigeria, contraceptive uptake was hindered by concerns over side effects, religious objections, and societal expectations (Bekele et al., 2020; Onasoga, 2016). For instance, Onasoga (2016) identified parental attitudes, peer influence, and religious norms as significant deterrents to emergency contraceptive use among

Nigerian adolescents. Similarly, Kara et al. (2019) noted that Tanzanian students faced embarrassment and religious constraints when seeking contraceptives.

Stigma and fear of judgment from health providers also contribute to underutilization. In Ghana, studies by Boamah et al. (2014) and I. Sulemana et al. (2025) revealed that concerns over confidentiality, fear of being judged, and lack of adolescent-friendly services limited adolescents' willingness to access FP services. These findings were echoed in the Democratic Republic of the Congo Casey et al. (2020), where adolescents cited fear, misinformation, and provider biases as deterrents.

Another common barrier is the lack of trained providers and facility readiness. Ssanyu et al. (2025) observed that 97.7% of health workers, imposed access restrictions based on marital status, age, or spousal consent. Similarly, Amenah et al. (2025) identified disparities in staff training and availability of service guidelines in Ghanaian districts. Poor provider attitudes and inadequate infrastructure disproportionately impact adolescents in peri-urban areas like Tema West, where rapid urbanization masks underlying inequities.

Structural challenges such as stock-outs and incomplete service offerings further compound the problem. Obong & Oyibo (2023) found frequent stock-outs of essential contraceptives in Delta State, Nigeria. Mpunga et al. (2017) noted that only 33% of facilities in the DRC met availability standards, with urban-rural and public-private disparities exacerbating inequities. The lack of long-acting contraceptives and poor service readiness remain key challenges across many settings.

2.7 Enabling Factors affecting adolescents' and young adults access to family planning services

While the barriers are well-documented, several studies also highlight enabling factors that can enhance adolescents' access to FP services. Education consistently emerges as a strong predictor of both knowledge and favorable attitudes. Masood and Alsonini (2017) found that higher education levels were associated with greater reproductive health awareness among Yemeni youth. Bekele et al. (2020) similarly noted that older age, urban residence, and higher education levels predicted better knowledge and attitudes toward FP.

Mass media and school-based education play significant roles in disseminating FP information. Television, radio, and school curricula were major sources of information in Yemen, Ghana, and other African countries (Masood & Alsonini, 2017; Z.S. Sulemana et al., 2024). Boamah et al. (2014) showed that adolescents who discussed FP with partners before sexual initiation were more likely to use contraceptives consistently, indicating that interpersonal communication and peer support serve as key facilitators.

Facility-level factors also matter. Regular administrative meetings, external supervision, and the presence of trained staff were positively associated with facility readiness (Rai et al., 2023; Ssanyu et al., 2025). In Ghana, Amenah et al. (2025) found that rural facilities outperformed urban ones in some readiness indicators, such as staff training and service guideline availability, suggesting that targeted interventions can improve outcomes even in less-resourced settings.

Access to a range of contraceptive options is another enabler. Facilities that offered multiple FP methods, including long-acting reversible contraceptives, were more likely to meet service quality standards (Mpunga et al., 2017; Obong & Oyibo, 2023). In the DRC, Casey et al. (2020) found

that a significant proportion of adolescents who used FP services opted for long-acting methods when available.

Finally, supportive community and family environments play an essential role. Gbagbo (2020) noted that basic school pupils in Ghana who received contraceptive education from parents or guardians were more likely to use modern methods consistently. Sulemana et al. (2025) emphasized that addressing community and partner acceptance is crucial for improving FP uptake among youth.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

This study adopted an analytical cross-sectional design with a quantitative approach. An analytical cross-sectional design involves collecting data on exposures, outcomes, and relevant characteristics from a defined population at one point in time and statistically examining relationships among variables. Unlike a purely descriptive design, which is limited to summarising characteristics or patterns, the analytical cross-sectional design was appropriate because this study did not only describe contraceptive accessibility, use, and preferences, but also tested associations between sociodemographic factors and ever contraceptive use and identified predictors of contraceptive method preference. No variables were manipulated, and participants were not followed over time; therefore, the design was suitable for estimating patterns and associations rather than establishing causality.

The choice of an analytical cross-sectional design was justified by the nature of the study objectives. The assessment of contraceptive accessibility required measurement of participants' awareness, perceived availability, affordability, confidentiality, distance, and service convenience at the time of data collection. The exploration of contraceptive preferences required a quantitative description of preferred methods and reasons for preference among adolescents and young adults within the same period. In addition, the objectives that examined sociodemographic factors associated with ever contraceptive use and factors influencing contraceptive method preference required inferential statistical analysis, including chi-square tests and multinomial logistic regression. The analytical cross-sectional design therefore provided a coherent methodological

basis for both describing the study population and examining statistically significant relationships among the variables.

This design is consistent with approaches commonly used in adolescent reproductive health and contraceptive-use studies where researchers seek to measure prevalence and examine associations within a defined population. Similar analytical cross-sectional approaches have been applied in studies of contraceptive accessibility, utilisation, and preferences among young people in Ghana and other sub-Saharan African settings (Gbagbo & Nkrumah, 2019; Hallidu & Sumaila, 2022; Salawu & Akinwaare, 2024). Using this design also allowed the findings from Tema West Municipality to be compared with related empirical studies while acknowledging that the observed associations should not be interpreted as causal relationships.

3.2 Research Paradigm and Philosophical Approach

The philosophical position that guided this study was post-positivism. This paradigm assumes that an objective reality exists independently of the researcher but can only be estimated imperfectly due to limitations in measurement and observation (Creswell & Creswell, 2018). In this study, the researcher aimed to approximate this reality through systematic data collection, standardised measurement, and statistical analysis, while recognising that findings are probabilistic rather than absolute.

This position aligned with the quantitative design of the study, which relied on a structured questionnaire and Likert-scale measures to generate measurable and comparable data. Statistical techniques, including descriptive statistics, chi-square tests, and multinomial logistic regression,

were used to examine patterns and associations related to contraceptive accessibility, use, and preferences among adolescents.

The post-positivist approach was appropriate for this study because it supported objective measurement of variables and the identification of relationships between sociodemographic factors and contraceptive outcomes within the study population.

3.3 Study Population

3.3.1 Target Population

The target population comprised adolescents and young adults aged 10 to 25 years residing in Tema West Municipality in the Greater Accra Region of Ghana. This range covered early (10–13 years), middle (14–17 years), and late adolescence/young adulthood (18–25 years), allowing the study to capture variations in contraceptive awareness, access, and preferences across developmental stages. While the World Health Organization defines adolescence as 10–19 years (WHO, 2018), the inclusion of individuals up to 25 years extended the scope to young adults who often share similar reproductive health experiences and decision-making contexts with older adolescents.

3.3.2 Profile of Tema West Municipality

Tema West Municipality is one of the eleven districts in the Greater Accra Region. It is located on the eastern side of the region, bordering the Tema Metropolitan Assembly to the east and Ashaiman to the north. The municipality has an urban and peri-urban structure influenced by its proximity to the Tema Harbour and the surrounding industrial area. This setting attracts a diverse and mobile

population. Data from the Ghana Statistical Service (2021) indicated a heterogeneous population, including Ga-Dangme, Akan, Ewe, and northern Ghanaian groups.

Health infrastructure in the municipality included government hospitals, Community-based Health Planning and Services (CHPS) compounds, health centres, private clinics, and facilities operated by non-governmental organisations. Many of these facilities provided reproductive health and family planning services, although variations existed in their level of adolescent- and youth-friendly service provision.

3.3.3 Study Population

The study population consisted of individuals aged 10 to 25 years who were accessible within Tema West Municipality. Participants were recruited from senior secondary schools, health facilities, community centres, and youth organisations. This approach included both in-school and out-of-school participants, allowing the study to capture differences in contraceptive access, use, and preferences across educational and social contexts.

3.3.4 Inclusion Criteria

Participants were included if they met the following criteria: they were aged 10–25 years; had resided in Tema West Municipality for at least six months prior to data collection; were able to read and respond to a questionnaire in English or were willing to receive assistance from a trained research assistant; and provided informed assent or consent to participate. For participants under 18 years, written parental or guardian consent was obtained.

3.3.5 Exclusion Criteria

Participants were excluded if they had cognitive or communication limitations that prevented meaningful participation; had resided in the municipality for less than six months; or declined to provide assent or consent. Participation remained voluntary throughout the study.

3.4 Sample Size and Sampling Technique

3.4.1 Sample Size Calculation

Sample size determination is process of deciding the number of participants to include in a study, ensuring the sample is large enough to represent the population accurately while being manageable within available resources (Creswell & Creswell, 2023).

The sample size for the survey was determined using Cochran's formula for estimating a population proportion in cross-sectional studies. Cochran formula is a widely used statistical method for sample size determination, when conducting research involving large populations based on level of confidence and precision (Cochrane, 1977).

$$n1 = \frac{Z^2 P (1 - p)}{e^2}$$

Where:

- N1 = initial sample size
- Z= Z-score corresponding to a 95% confidence level (1.96)
- P = estimated national prevalence of contraceptive use (24.4%) from the Track20 Project (2024)

- e = desired margin of error (5% or 0.05)

$$n1 = \frac{(1.96)^2 0.24 (1-0.24)}{(0.05)^2} \approx 283$$

Although Cochran's formula yielded a minimum required sample size of 283 participants, the final sample size for this study was 264. This reduction was primarily due to incomplete questionnaires and non-response during data collection. Questionnaires with substantial missing data were excluded during data cleaning to maintain data quality and ensure the validity of the analysis. Despite this reduction, the achieved sample size remained adequate for the statistical analyses conducted.

3.4.2 Sampling Technique

A multi-stage sampling approach incorporating cluster and convenience (intercept) sampling techniques was used to recruit participants for the study. In the first stage, schools, health facilities, community centres, and youth organisations within Tema West Municipality were purposively identified as recruitment sites because they provided access to adolescents and young people within the target population. In the second stage, eligible participants aged 10–25 years who were present at these sites during the data collection period were approached consecutively and invited to participate until the required sample size was achieved. All individuals who met the inclusion criteria and provided informed consent (or assent with parental/guardian consent where applicable) were enrolled.

This approach was appropriate because no comprehensive sampling frame or centralized registry of all adolescents and young people in Tema West Municipality was available, making true probability-based simple random sampling impractical. Recruiting participants from multiple

community settings helped capture individuals from diverse backgrounds and increased the diversity of the study sample.

However, because participants were recruited from selected sites rather than through probability sampling of the entire target population, the study is subject to potential selection bias. Adolescents and young people who did not attend the selected schools, health facilities, community centres, or youth organisations, or who were unavailable during the data collection period, may have been underrepresented. Consequently, the findings should be interpreted with caution, and the generalizability of the results to all adolescents and young people in Tema West Municipality may be limited.

3.5 Data Collection Procedure and Tools

3.5.1 Data Collection Instrument

The primary data collection instrument was a structured self-administered questionnaire adapted from the 54-item instrument developed and validated by Salawu and Akinwaare (2024). The original instrument assessed contraceptive accessibility and utilisation among undergraduate students in Nigeria. For this study, the instrument was modified to reflect the characteristics of respondents aged 10 to 25 years in Tema West Municipality, Ghana. The modifications addressed three areas: the study population (from university students to adolescents and young people, including out-of-school individuals), the study setting (from a university environment to a municipal and community-based context), and the study focus (with greater emphasis on contraceptive preferences in line with the study objectives).

The adapted questionnaire consisted of five sections. Section A collected socio-demographic data, including age, gender, religion, ethnicity, relationship status, education level, school enrolment,

living arrangement, employment status, and household income. Section B assessed the availability and accessibility of family planning services using Yes/No items and a four-point Likert scale. Section C examined contraceptive preferences, including an item that asked participants to indicate their preferred contraceptive method under conditions of free and confidential access. Section D measured factors influencing contraceptive preferences using a four-point Likert scale, incorporating both adapted items and newly developed items relevant to adolescents and young people, such as concerns about parental discovery, confidentiality, peer influence, stigma, fertility concerns, and social media exposure. Section E included three open-ended questions that allowed participants to describe their experiences and provide recommendations. The questionnaire was written in simple English appropriate for both junior and senior high school respondents. The estimated completion time ranged from 15 to 20 minutes.

3.5.2 Validity

Content validity was assessed by presenting the adapted questionnaire to the study supervisor and two reproductive health specialists with experience in Ghanaian community health settings. They reviewed the instrument for relevance, clarity, and alignment with the study objectives. Face validity, particularly the suitability of language for younger respondents, was assessed through review by a secondary school teacher and a youth health worker within Tema West Municipality.

3.5.3 Reliability

A pretest involving 43 adolescents and young adults was conducted to assess the internal consistency of the questionnaire before the main data collection. Reliability analysis using Cronbach's alpha was performed on the 25-item scale covering accessibility to family planning

services and perceived barriers to contraceptive use. The overall Cronbach's alpha coefficient was 0.896, indicating excellent internal consistency of the instrument.

Item-total statistics showed corrected item-total correlation coefficients ranging from 0.111 to 0.712. Although a few items demonstrated relatively low item-total correlations, the Cronbach's alpha values obtained if individual items were deleted ranged from 0.886 to 0.900, indicating that the removal of any single item would not result in a meaningful improvement in the overall reliability of the scale. Consequently, all 25 items were retained for the main study because they were considered conceptually important for measuring the constructs of interest.

Based on the pretest findings, the questionnaire was considered reliable and suitable for administration in the main study among adolescents and young adults in Tema West Municipality. Internal consistency was assessed using Cronbach's alpha coefficient based on data from a pilot study.

3.5.4 Administration

The questionnaire was administered in group settings of approximately 20 to 30 participants in classrooms, health facility waiting areas, or community centres. A trained research assistant was present to provide clarification without influencing responses. Questionnaires were distributed and collected within the same session to ensure completeness and limit external interference. For younger participants or those with difficulty reading English, an interviewer-assisted option was provided, where the research assistant read each question aloud and recorded responses as stated by the participant without interpretation.

3.6 Study Variables

The variables in this study were organised into dependent variables, independent variables, and covariates, consistent with the final analytical approach, which included descriptive analysis, chi-square tests, and multinomial logistic regression conducted in R.

3.6.1 Dependent Variables

The primary dependent variable was contraceptive use preference, constructed from responses to item 28 of the questionnaire, which asked respondents to indicate the method they would prefer if family planning services were freely available and confidential. This variable was treated as a nominal categorical outcome and recoded into six analytic groups: barrier methods, hormonal methods, long-acting reversible contraceptives (LARCs), fertility awareness-based methods (FABM), behavioral methods, and no preference, which served as the reference category in the multinomial regression model. A secondary dependent variable captured ever use of contraception, based on item 25 and coded as a binary variable (yes vs. no/prefer not to say). This variable was analysed using chi-square tests to assess associations with key predictors. Current contraceptive use, measured from item 26, was also coded as a binary variable and reported descriptively to provide additional context on present contraceptive behavior.

3.6.2 Independent Variables

Sociodemographic Variables (Section A: Items 1–10)

Sociodemographic characteristics were included as categorical predictors in both bivariate and multivariable analyses. These included age (item 1: 10–13, 14–16, 17–19, ≥ 20 years), gender (item 2), religion (item 3), ethnicity (item 4), relationship status (item 5), education level (item 6), school enrolment status (item 7), living arrangement (item 8), employment status (item 9), and household

income (item 10). These variables were entered into the multinomial regression model to estimate adjusted odds ratios (aOR), although some categories showed sparse data, resulting in wide confidence intervals.

Accessibility Variables (Section B: Items 11–22)

Accessibility was assessed using both binary and Likert-scale indicators using awareness of the contraceptives and facilities as proxies coupled with the perception of how accessible these services and products are. Binary variables included awareness of contraceptives (item 11), knowledge of a facility providing services (item 12), availability of youth-friendly services (item 13), access through pharmacies (item 14), and ease of obtaining contraceptive information (item 15).

Perceived accessibility was further assessed using Likert-scale items (items 16–22), covering service hours, availability of preferred methods, affordability, provider respect, confidentiality, ability to access services when needed, and distance to facilities. These items were treated as ordinal variables and were also combined into a composite availability score and dichotomised availability category (high vs. low availability) for summary analysis.

Influencing Factors (Section D: Items 31–48)

Influencing factors were measured using 18 Likert-scale items (1 = strongly disagree to 4 = strongly agree). Based on conceptual grouping and empirical patterns observed in the analysis, these variables were recategorised into seven domains:

- Personal factors (Items 31, 36, 45): fear of side effects, lack of knowledge, and concerns about future fertility

- Partner and peer influence (Items 32, 41, 48): partner influence, peer influence, and preference for discreet contraceptive use
- Economic and physical barriers (Items 33, 34, 44): cost, distance, and facility opening hours
- Sociocultural influences (Items 35, 39, 43, 46): religion, parental discovery concerns, family communication, and marital norms
- Health system factors (Items 38, 40, 42): provider attitudes, confidentiality, and perceived stigma
- Perceived benefits (Item 37): trust in contraceptive effectiveness

Mean scores were computed for descriptive analysis, while individual items were retained in inferential interpretation due to variability across responses.

Covariates and Model Considerations

All sociodemographic variables were included in the multinomial logistic regression model to estimate adjusted effects on contraceptive preference. Variables such as education, relationship status, and household income were treated as potential confounders. The final model identified statistically significant predictors across selected contraceptive categories; however, several estimates showed extremely wide or undefined confidence intervals due to sparse data in some categories. These estimates were interpreted cautiously.

Table 3.1 Variables of Study

Variable	Type	Measurement Scale	Role
Contraceptive preference (item 28 recategorised)	Categorical (multinomial)	Nominal	Dependent (primary)
Ever use of contraception (item 25)	Binary	Nominal	Dependent
Current contraceptive use (item 26)	Binary	Nominal	Dependent
Age (item 1)	Categorical	Ordinal	Independent
Gender (item 2)	Binary	Nominal	Independent
Religion (item 3)	Categorical	Nominal	Independent
Ethnicity (item 4)	Categorical	Nominal	Independent
Relationship status (item 5)	Categorical	Nominal	Independent
Education level (item 6)	Categorical	Ordinal	Independent
School enrolment (item 7)	Binary	Nominal	Independent
Living arrangement (item 8)	Categorical	Nominal	Independent
Employment status (item 9)	Categorical	Nominal	Independent
Household income (item 10)	Categorical	Ordinal	Independent / Confounder
Awareness of FP services (item 11)	Binary	Nominal	Independent
Knowledge of FP facility (item 12)	Binary	Nominal	Independent
Youth-friendly service availability (item 13)	Binary	Nominal	Independent
Pharmacy access (item 14)	Binary	Nominal	Independent

Variable	Type	Measurement Scale	Role
Ease of information access (item 15)	Binary	Nominal	Independent
Perceived accessibility items (items 16–22)	Likert scale	Ordinal	Independent
Availability score/category	Composite / Binary	Ordinal/Nominal	Independent
Influencing factor domains (items 31–48)	Composite (Likert mean)	Approx. interval	Independent

3.7 Data Handling

After each data collection session, research assistants conducted an immediate completeness check on all returned questionnaires. Any questionnaire with more than 20% of closed-response items missing was flagged for exclusion from the analysis. Where feasible, respondents present at the time of collection were asked to complete any skipped items before finalisation.

Data entry was performed using IBM SPSS Statistics version 25. A double-entry procedure was applied to minimise transcription errors. Each questionnaire was entered independently by two data entry personnel, and the resulting datasets were compared electronically. Any discrepancies identified were verified against the original paper questionnaire and corrected accordingly.

Following data entry, systematic data cleaning procedures were implemented. Range checks ensured that all variables fell within valid limits (e.g., age categories corresponded to predefined groups; Likert-scale items ranged from 1 to 4). Consistency checks identified incompatible responses, such as reporting no contraceptive use while indicating a current method. These cases were reviewed against the original questionnaires and corrected or coded as missing where

necessary. Outliers were examined for continuous variables, including composite scores such as the availability index. Missing data were handled using listwise deletion for regression analyses, including multinomial logistic regression conducted in R, to ensure consistency of estimates. For composite Likert-scale measures, mean substitution was applied only when fewer than 20% of component items were missing. All physical questionnaires were stored in a locked cabinet accessible only to the principal researcher. Electronic datasets were stored on a password-protected computer, with encrypted backups maintained on a separate external device. During data entry, all personal identifiers were removed and replaced with unique alphanumeric codes. No linkage between identifiers and participants was retained after data collection.

3.8 Data Analysis

Data analysis was conducted using IBM SPSS Statistics version 25 for descriptive and bivariate analyses, while multinomial logistic regression was performed in R to examine factors associated with contraceptive method preference. All statistical tests were evaluated at a significance level of $p < 0.05$.

3.8.1 Descriptive Statistics

Descriptive statistics were generated for all study variables. Categorical variables were summarised using frequencies and percentages. Continuous variables, including composite scores derived from Likert-scale items, were summarised using means, standard deviations, and observed ranges. Sociodemographic characteristics, contraceptive use patterns, and method preferences were presented in tabular form with concise narrative summaries focusing on dominant patterns.

Composite measures were computed for perceived accessibility (items 16–22) and influencing factors (items 31–48). The accessibility score was further categorised into high and low availability based on distribution patterns. Influencing factors were analysed both at the item level and by grouped thematic domains.

3.8.2 Objective 1: Accessibility of contraceptives among adolescents and young adults in Tema West Municipality.

Accessibility of contraceptives among participants in Tema West Municipality was assessed using responses from Section B of the questionnaire. Binary indicators (items 11–15) were summarised as proportions to describe adolescents' access to contraceptive services, including knowledge of service delivery points, availability of youth-friendly services, access through pharmacies, and ease of obtaining contraceptive information. Likert-scale items (items 16–22) were analysed using frequency distributions and mean scores to examine perceived accessibility, including facility opening hours, affordability, provider attitude, confidentiality, and distance to service points. A composite accessibility score was computed by summing responses across items assessing the availability and ease of access to contraceptive services, with total scores ranging from 1 to 28. The score was dichotomized into “low” and “high” accessibility using a Midpoint-based dichotomization cut-off value of 14. Scores less than 14 were classified as low perception of accessibility, while scores greater than or equal to 14 were classified as high perception of accessibility.

3.8.3 Objective 2: To explore contraceptive preferences among adolescents and young adults in Tema West Municipality

To explore contraceptive preferences among adolescents in Tema West Municipality, both descriptive and inferential statistical methods were applied. Contraceptive use (item 25: ever use; item 26: current use) was summarised using frequencies and percentages to describe utilisation patterns within the study population. Preferences for contraceptive methods (item 28) were also summarised and recategorised into method groups (barrier, hormonal, LARC, FABM, behavioral, and no preference). Associations between contraceptive use and sociodemographic variables were examined using the Pearson chi-square test, while Fisher's exact test was applied where more than 20% of expected cell counts were less than five. Significant associations were observed for age, religion, relationship status, education level, schooling status, living arrangement, employment status, and household income.

3.8.4 Objective 3: Perceived Barriers to Contraceptive Use

Responses to the Likert-scale items assessing perceived barriers to contraceptive use (Items 31–48) were analysed using descriptive statistics. Frequencies, percentages, means, and standard deviations were computed for each item. For interpretation, the items were grouped into thematic domains comprising personal factors, partner and peer influence, economic and physical barriers, sociocultural influences, health system factors, perceived benefits, and media and information influences. Mean scores and response distributions were used to describe the level of agreement with each perceived barrier.

3.8.5 Objective 4: Sociodemographic Factors Associated with Ever Contraceptive Use

The association between sociodemographic characteristics and ever contraceptive use was examined using the Pearson chi-square test of independence. Variables analysed included age, gender, religion, ethnicity, relationship status, educational level, current schooling status, living arrangement, employment status, and household income. A p-value of less than 0.05 was considered statistically significant.

3.8.6 Objective 5: Factors Associated with Contraceptive Method Preferences

Multinomial logistic regression analysis was performed to identify factors associated with contraceptive method preferences, using no contraceptive preference as the reference category. Sociodemographic variables that were considered relevant to contraceptive behaviour were entered into the model to estimate adjusted odds ratios (aORs) with corresponding 95% confidence intervals. To improve model stability, contraceptive methods were regrouped into barrier methods, modern methods (combining hormonal and long-acting reversible contraceptives), and fertility awareness-based/behavioural methods. Statistical significance was determined at a p-value of less than 0.05.

3.9 Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of Ensign Global University. Administrative approval was also secured from relevant authorities within the Tema West Municipality prior to data collection.

Participation in the study was entirely voluntary. Eligible adolescents were approached in their respective schools and communities after permission had been obtained from school authorities and, where applicable, parents or guardians. Each participant was provided with an information

sheet explaining the purpose of the study, procedures involved, potential risks, and expected benefits. Written informed consent was obtained from participants aged 18 years and above, while assent was obtained from minors alongside prior parental or guardian consent.

The study posed minimal risk to participants. However, given the sensitive nature of questions related to sexual relationships and contraceptive use (Section C of the questionnaire), some respondents could have experienced discomfort. To address this, participants were informed that they could skip any question or withdraw from the study at any time without consequence. Data collection was conducted in a private setting to ensure comfort and reduce social pressure.

Confidentiality and anonymity were strictly maintained throughout the study. No names or personal identifiers were collected. Each questionnaire was assigned a unique code during data entry, and responses were stored securely. Data were reported in aggregate form, ensuring that no individual participant could be identified.

3.10 Limitations of the Study

This study had several limitations. First, the cross-sectional design limited the ability to establish causal relationships between accessibility, influencing factors, and contraceptive preferences. Second, data were collected using self-reported questionnaires, which may be subject to recall bias and social desirability bias, particularly given the sensitivity of sexual and reproductive health topics. Third, some categories in the multinomial logistic regression analysis had small sample sizes, resulting in wide or unstable confidence intervals. This limits the precision of some estimates. Another limitation of this study relates to the administration of questionnaires among participants recruited from schools. Although measures were implemented to protect confidentiality, including independent completion of questionnaires, instructions not to discuss responses, and assurances of

anonymity, data collection was conducted in classroom settings with groups of participants. Given the sensitive nature of questions on sexual relationships and contraceptive use, particularly among adolescents aged 10–17 years, the presence of peers may have reduced perceived privacy and introduced social desirability bias. Consequently, some participants may have underreported or modified their responses to conform to perceived social expectations. As a result, the findings should be interpreted with caution, particularly for the younger age group. Finally, the study was conducted within Tema West Municipality, which may limit the generalisability of findings to adolescents in other regions of Ghana.

3.11 Assumptions

The study was based on several assumptions. It was assumed that respondents understood the questionnaire items and provided honest responses reflecting their experiences and perceptions. It was also assumed that participants were able to accurately recall their contraceptive use and related behaviours. In addition, the study assumed that the Likert-scale items used to measure accessibility and influencing factors appropriately captured the constructs of interest. The grouping of influencing factors into thematic domains was assumed to reflect meaningful underlying patterns in the data. These assumptions supported the interpretation of both descriptive and regression analyses.

CHAPTER FOUR

RESULTS OF STUDY

4.1 Sociodemographic Characteristics of Participants

A total of 264 participated in the study. More than half of respondents (56.4%) were aged 20 years and above, indicating that young adults constituted most of the sample. Gender distribution was nearly equal, with males (50.8%) slightly exceeding females (49.2%). Christianity was the predominant religion (65.5%), and the largest ethnic groups represented were Ga-Adangbe (33.0%) and Akan (31.8%). Nearly half of participants were single (48.5%), although a substantial proportion reported being in dating relationships (36.0%). Educational attainment was relatively high, with most respondents having tertiary education (59.5%), and over half (58.3%) were currently in school. Living arrangements varied, though the largest group resided with both parents (28.0%), followed by those living independently or with friends (21.2%). Regarding economic engagement, part-time employment (36.7%) and unemployment (36.7%) were equally common, while a smaller proportion worked full-time (26.5%). In terms of household income, over half of respondents (52.3%) reported monthly earnings of at least GHS 2000, suggesting relatively higher economic standing among participants.

Table 4.1 Sociodemographic Characteristics of Participants (N = 264)

Variable	Frequency (n)	Percentage (%)
Age (years)		
10–13	29	11.0
14–16	37	14.0
17–19	49	18.6

Variable	Frequency (n)	Percentage (%)
≥20	149	56.4
Gender		
Male	134	50.8
Female	130	49.2
Religion		
Christian	173	65.5
Islam	55	20.8
Traditionalist	24	9.1
Others	12	4.5
Ethnicity		
Akan	84	31.8
Ewe	46	17.4
Northern	43	16.3
Ga-Adangbe	87	33.0
Other	4	1.5
Relationship Status		
Single	128	48.5
Dating	95	36.0
Married/Cohabiting	39	14.8
Other	2	0.8
Highest Level of Education		
No Formal Education	2	0.8
Primary	17	6.4
JHS	35	13.3

Variable	Frequency (n)	Percentage (%)
SHS	53	20.1
Tertiary	157	59.5
Currently in School		
Yes	154	58.3
No	110	41.7
Living Arrangement		
Both Parents	74	28.0
Friends/Alone	56	21.2
Guardian/Relative	46	17.4
One Parent	42	15.9
Partner/Spouse	41	15.5
Other	5	1.9
Employment Status		
Yes, Full Time	70	26.5
Yes, Part Time	97	36.7
No, Not Working	97	36.7
Household Monthly Income		
< GHS 500	15	5.7
GHS 500–999	25	9.5
GHS 1000–1999	46	17.4
≥ GHS 2000	138	52.3
I Don't Know	40	15.2

Source: Field Data, 2026

4.2 Objective 1: To assess the accessibility of contraceptives among adolescents and young adults within Tema West Municipality.

4.2.1 Awareness of Family Planning Services Among Adolescents and young adults in Tema West Municipality

Awareness of family planning services was high, with most participants (92.8%) reporting knowledge of their availability within community health facilities. However, this broad awareness did not fully translate into specific access knowledge, as only 64.0% indicated that they knew at least one facility where young people could obtain such services. Perceived accessibility was moderate; about six in ten respondents reported the presence of youth-friendly health centers (61.0%) and access to contraceptives through nearby pharmacies (61.0%). Similarly, 66.3% indicated that it was easy to obtain contraceptive information within their community.

Table 4.2 Awareness of Family Planning Services Among Adolescents and young adults in Tema West Municipality (N = 264)

Variable	Frequency (n)	Percentage (%)
Awareness of family planning services in community health facilities		
Yes	245	92.8
No	19	7.2
Knowledge of at least one facility providing youth family planning services		
Yes	169	64.0
No	95	36.0
Availability of youth/adolescent-friendly health centres nearby		
Yes	161	61.0
No	103	39.0
Access to contraceptives from nearby pharmacies		
Yes	161	61.0
No	103	39.0

Variable	Frequency (n)	Percentage (%)
Ease of finding contraceptive information in the community		
Yes	175	66.3
No	89	33.7

Source: Field Data, 2026

4.2.2 Perceived Availability of Contraceptives Among Adolescents and young adults in Tema West Municipality

Across the indicators, agreement responses predominated, particularly for access to services when needed (78.0% agree/strongly agree), manageable distance to facilities (76.2%), and affordability of services (73.1%). Provider-related factors were also positively rated, with 69.4% reporting respectful treatment and 75.0% expressing trust in confidentiality. In contrast, perceptions of facility opening hours were less favorable, with a substantial proportion of respondents (41.6%) reporting disagreement, reflected in the lowest mean score ($M = 2.37$, $SD = 1.00$). Mean scores ranged from 2.37 to 2.90, indicating moderate perceived accessibility across domains, with structural factors such as service hours presenting the most notable constraint. The overall mean score was 19.14 ± 3.42 out of a possible 28 indicating a relatively high perception when it comes the availability of contraceptives.

Table 4.3 Perceived Accessibility of Family Planning Services Among Adolescents and young adults in Tema West Municipality (N = 264)

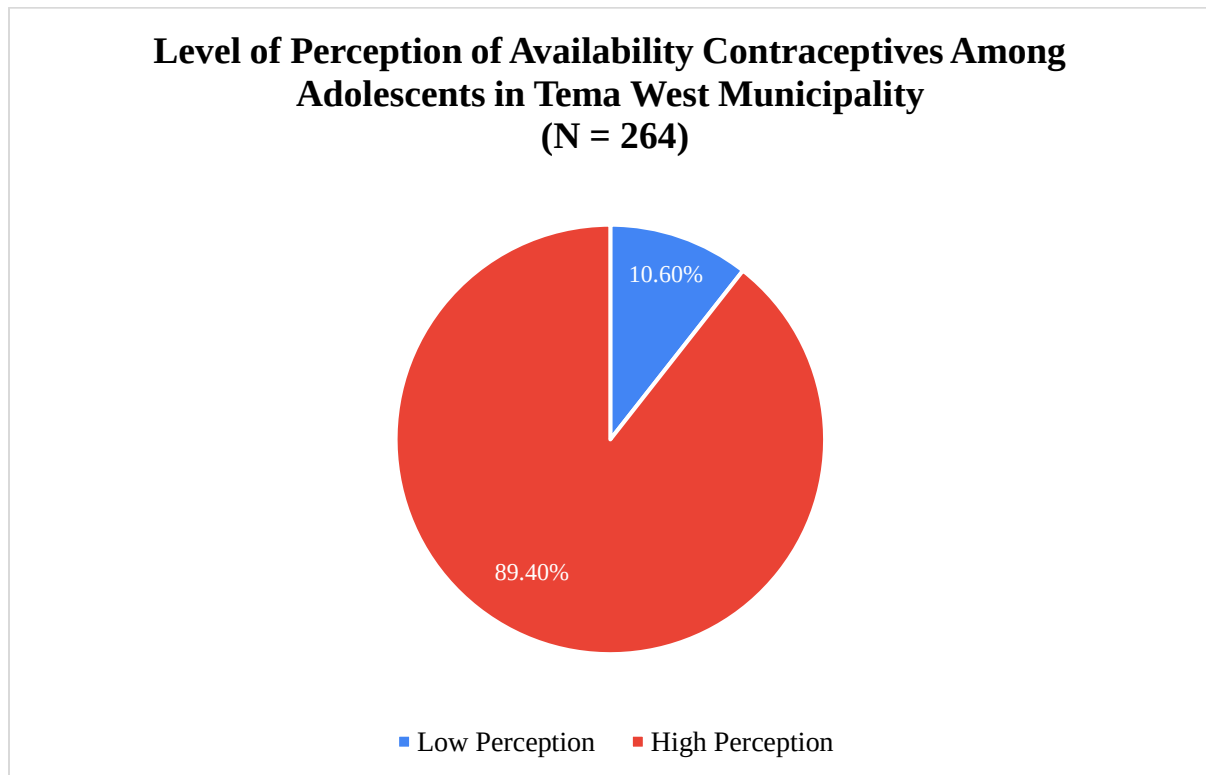
Variable	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean $\pm$ SD	Range (1–4)
Convenient facility opening hours	78 (29.5)	32 (12.1)	131 (49.6)	23 (8.7)	2.37 $\pm$ 1.00	1–4

Preferred contraceptive method available	21 (8.0)	76 (28.8)	142 (53.8)	25 (9.5)	2.65 ± 0.76	1–4
Cost of services is affordable	18 (6.8)	53 (20.1)	167 (63.3)	26 (9.8)	2.76 ± 0.72	1–4
Providers treat adolescents with respect	11 (4.2)	70 (26.5)	153 (58.0)	30 (11.4)	2.77 ± 0.70	1–4
Trust in confidentiality/privacy	19 (7.2)	47 (17.8)	158 (59.8)	40 (15.2)	2.83 ± 0.77	1–4
Access to services when needed	10 (3.8)	48 (18.2)	165 (62.5)	41 (15.5)	2.90 ± 0.69	1–4
Distance to facility is manageable	12 (4.5)	51 (19.3)	162 (61.4)	39 (14.8)	2.86 ± 0.71	1–4
Overall					19.14 ± 3.42	1-28

Source: Field Data, 2026

4.2.3 Level of Perception of Availability Contraceptives Among Adolescents and young adults in Tema West Municipality

Most participants (89.4%) reported a high perceived availability of family planning services, while only 10.6% reported low perceived availability.



Source: Field Data, 2026, Range = 1-28, cut-off = 14

Figure 4.1 Level of Perception of Availability Contraceptives Among Adolescents and young adults in Tema West Municipality (N = 264)

4.3 Objective 2: To explore contraceptive preferences among adolescents and young adults in Tema West Municipality.

4.3.1 Contraceptive Use Among Adolescents and young adults in Tema West Municipality

Slightly more than half of the participants (51.9%) reported no history of sexual relationships, while 45.1% indicated prior sexual experience. Contraceptive use was limited, with 61.0% reporting that they had never used any method. Current use was lower, as three-quarters of respondents (75.0%) indicated that they were not using any contraceptive method at the time of the study.

Table 4.4 Contraceptive Use Among Adolescents and young adults in Tema West Municipality (N = 264)

Variable	Frequency (n)	Percentage (%)
Ever been in a sexual relationship		
Yes	119	45.1
No	137	51.9
Prefer not to say	8	3.0
Ever used contraception		
Yes	101	38.3
No	161	61.0
Prefer not to say	2	0.8
Currently using contraception		
Yes	65	24.6
No	198	75.0
Prefer not to say	1	0.4

Source: Field Data, 2026

4.3.2 Level of Usage of Contraceptive Methods Among Participants

Most participants (61.0%) reported that they had never used any contraceptive method. Among those who had used contraception, the male condom was the most reported method (24.6%), followed by emergency contraception (14.8%) and the withdrawal method (13.6%). Abstinence was reported by 10.2% of respondents. Use of long-acting methods such as implants (6.8%) and IUDs (3.0%) remained low. Other methods, including oral pills, injectables, and fertility-awareness-based methods, were reported by relatively small proportions.

Table 4.5 Use of Contraceptive Methods Among Adolescents and young adults in Tema West Municipality (N = 264)

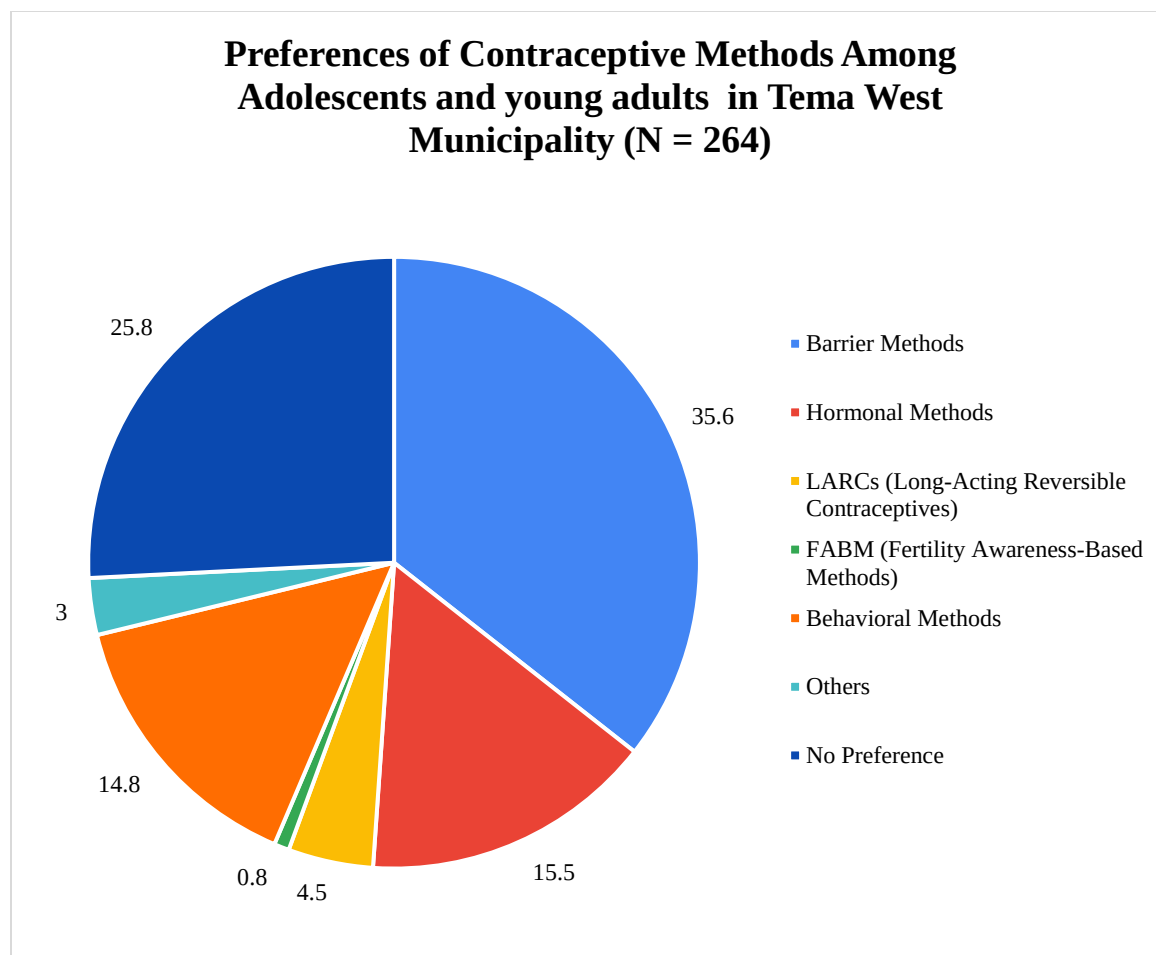
Contraceptive Method	Frequency (n)	Percentage (%)
Male condom	65	24.6
Female condom	9	3.4
Oral contraceptive pills (daily pill)	15	5.7
Emergency contraception (Postinor)	39	14.8
Injectable contraceptive	11	4.2
Implant (Implanon or Jadelle)	18	6.8
IUD / Copper T	8	3.0
Withdrawal method (pull-out)	36	13.6
Calendar / Rhythm method	11	4.2
Standard Days Method	5	1.9
Lactational Amenorrhoea Method (LAM)	2	0.8
Abstinence	27	10.2

Contraceptive Method	Frequency (n)	Percentage (%)
I have never used any contraceptive method	161	61.0
Other	2	0.8

Source: Field Data, 2026

4.3.3 Preferences of Contraceptive Methods Among Participants

Barrier methods were the most preferred category of contraceptives (35.6%), with respondents commonly indicating options such as the male and female condoms. This was followed by a notable proportion of respondents who reported no preference (25.8%), suggesting uncertainty or potential gaps in knowledge and access to family planning services. Hormonal methods accounted for 15.5% of preferences and included choices such as oral contraceptive pills, injectable contraceptives, implants, and emergency contraception. Behavioral methods were selected by 14.8% of respondents, encompassing practices such as abstinence and the withdrawal method. Preference for long-acting reversible contraceptives (LARCs), particularly implants and intrauterine devices (IUDs), was relatively low (4.5%), while fertility awareness-based methods, such as the calendar or rhythm method, were rarely selected (0.8%). The remaining 3% represented participants who preferred other methods.



Source: Field Data, 2026

Figure 4.2 Preferences of Contraceptive Methods Among Adolescents and young adults in Tema West Municipality (N = 264)

4.3.4 Reasons for Preferred Contraceptive Methods Among Adolescents and young adults in Tema West Municipality

The most reported reason for contraceptive preference fell under “other reasons” (29.2%), indicating a wide range of unspecified influences that may reflect personal, contextual, or experiential factors not captured in the predefined options. Among the defined categories, convenience and ease of use (25.4%) emerged as the most frequently cited factor, with respondents highlighting reasons such as the method being easy to use and lasting a long time without repeated

action. This was followed by method effectiveness and reliability (20.9%), including considerations such as the method being highly effective at preventing pregnancy and having worked well during previous use. Method characteristics and clinical attributes accounted for 9.1% of responses, encompassing preferences related to hormonal composition and procedures involving injections or insertions. In contrast, privacy considerations (4.9%), such as the ability to use a method discreetly without a partner or family member knowing, were less commonly reported. Similarly, cultural and religious acceptability (3.8%), including alignment with religious or cultural beliefs, and partner influence (3.4%), such as partner comfort with the method, played relatively minor roles. Economic considerations were also low (3.4%), with affordability cited by a small proportion of respondents.

Table 4.6 Reasons for Preferred Contraceptive Methods Among Adolescents and young adults in Tema West Municipality (N = 264)

Variable	Frequency (n)	Percentage (%)
Method effectiveness and reliability	55	20.9
Convenience and ease of use	67	25.4
Method characteristics and clinical attributes	24	9.1
Privacy and autonomy	13	4.9
Social and partner influence	9	3.4
Cultural and religious acceptability	10	3.8
Economic considerations	9	3.4
Other reasons	77	29.2

Source: Field Data, 2026

4.3.5 Source of Current Contraceptive Supply Among Adolescents and young adults in Tema West Municipality

The majority of adolescents (75.0%) reported that they were not currently using any contraceptive method. Among those who reported a source, pharmacies or chemical shops were the most commonly used (12.1%), followed by friends or partners (4.5%) and community health centres (3.4%). Formal healthcare facilities such as private clinics (2.3%) and government hospitals (1.9%) were less frequently reported, while very few respondents obtained contraceptives from community health workers (0.4%).

Table 4.7 Source of Current Contraceptive Supply Among Adolescents in Tema West Municipality (N = 264)

Variable	Frequency (n)	Percentage (%)
I am not currently using any contraceptive	198	75.0
Pharmacy or chemical shop	32	12.1
A friend or partner	12	4.5
Community health centre (CHPS)	9	3.4
Private hospital or clinic	6	2.3
Government hospital	5	1.9
Community health worker	1	0.4
Other	1	0.4

Source: Field Data, 2026

4.4 Objective 3: To assess perceived barriers to contraceptive use among adolescents and young adults in Tema West Municipality.

Within personal factors, infertility concerns showed higher agreement (54.9%; 2.61 ± 0.86) and lack of knowledge (55.7%; 2.56 ± 0.88), while fear of side effects recorded the lowest agreement (32.2%; 2.10 ± 0.90). Partner and peer influence demonstrated moderate agreement, particularly for partner influence (56.0%; 2.55 ± 0.77) and preference for discreet methods (55.7%; 2.62 ± 0.90). Economic and physical barriers were less prominent, with most respondents disagreeing that cost was a barrier (63.2%; 2.31 ± 0.81), although distance showed moderate agreement (53.4%; 2.53 ± 0.80). Sociocultural factors revealed mixed patterns, with limited discussion at home showing relatively high agreement (60.2%; 2.78 ± 0.87), while religious influence had lower agreement (38.3%; 2.39 ± 0.85). Health system factors also reflected moderate agreement, including fear of judgment by staff (52.6%; 2.58 ± 0.87). Trust in contraceptive effectiveness was high (61.4%; 2.79 ± 0.80), and media influence recorded the highest agreement overall (69.4%; 2.81 ± 0.72).

Table 4.8 Perceived Barriers to Contraceptive use among Adolescents and young adults in Tema West Municipality (N = 264)

Domain	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean $\pm$ SD	Range (1–4)
Personal Factors						
Fear of side effects	77 (29.2)	102 (38.6)	67 (25.4)	18 (6.8)	2.10 ± 0.90	1–4
Lack of knowledge	34 (12.9)	83 (31.4)	113 (42.8)	34 (12.9)	2.56 ± 0.88	1–4

Domain	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean $\pm$ SD	Range (1–4)
Infertility concerns	24 (9.1)	95 (36.0)	104 (39.4)	41 (15.5)	2.61 $\pm$ 0.86	1–4
Partner and Peer Influence						
Partner influence	24 (9.1)	92 (34.8)	126 (47.7)	22 (8.3)	2.55 $\pm$ 0.77	1–4
Peer influence	26 (9.8)	110 (41.7)	96 (36.4)	32 (12.1)	2.51 $\pm$ 0.83	1–4
Preference for secrecy	30 (11.4)	87 (33.0)	101 (38.3)	46 (17.4)	2.62 $\pm$ 0.90	1–4
Economic and Physical Barriers						
Cost as a barrier	36 (13.6)	131 (49.6)	76 (28.8)	21 (8.0)	2.31 $\pm$ 0.81	1–4
Distance as a barrier	26 (9.8)	97 (36.7)	115 (43.6)	26 (9.8)	2.53 $\pm$ 0.80	1–4
Inconvenient facility hours	25 (9.5)	120 (45.5)	87 (33.0)	32 (12.1)	2.48 $\pm$ 0.83	1–4
Sociocultural Influences						
Religious/cultural influence	31 (11.7)	132 (50.0)	68 (25.8)	33 (12.5)	2.39 $\pm$ 0.85	1–4
Fear of parental discovery	32 (12.1)	121 (45.8)	81 (30.7)	30 (11.4)	2.41 $\pm$ 0.85	1–4
Limited discussion at home	15 (5.7)	90 (34.1)	98 (37.1)	61 (23.1)	2.78 $\pm$ 0.87	1–4
Belief contraceptives are for married people	36 (13.6)	111 (42.0)	81 (30.7)	36 (13.6)	2.44 $\pm$ 0.89	1–4

Domain	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean $\pm$ SD	Range (1–4)
Health System Factors						
Negative provider attitude	24 (9.1)	111 (42.0)	100 (37.9)	29 (11.0)	2.51 $\pm$ 0.81	1–4
Lack of trust in confidentiality	29 (11.0)	115 (43.6)	76 (28.8)	44 (16.7)	2.51 $\pm$ 0.90	1–4
Fear of judgment by staff	26 (9.8)	99 (37.5)	98 (37.1)	41 (15.5)	2.58 $\pm$ 0.87	1–4
Perceived Benefits						
Trust in effectiveness	8 (3.0)	94 (35.6)	108 (40.9)	54 (20.5)	2.79 $\pm$ 0.80	1–4
Media and Information						
Media/social media influence	8 (3.0)	73 (27.7)	143 (54.2)	40 (15.2)	2.81 $\pm$ 0.72	1–4

Source: Field Data, 2026

4.5 Objective 4: To determine the sociodemographic factors associated with ever contraceptive use among adolescents and young adults in Tema West Municipality.

Significant associations with ever use of contraceptives were observed for age ($\chi^2 = 27.563$, $p < 0.001$), religion ($\chi^2 = 9.969$, $p = 0.019$), relationship status ($\chi^2 = 54.372$, $p < 0.001$), education level ($\chi^2 = 23.075$, $p < 0.001$), current schooling status ($\chi^2 = 16.715$, $p < 0.001$), living arrangement ($\chi^2 = 40.171$, $p < 0.001$), employment status ($\chi^2 = 22.752$, $p < 0.001$), and household income ($\chi^2 = 20.975$, $p < 0.001$). The proportion of respondents who had ever used contraceptives increased with age, from 3.4% among those aged 10–13 years to 48.3% among those aged 20 years and above. Ever contraceptive use was also more common among respondents who were married or cohabiting (76.9%) or dating (48.4%) than among those who were single (18.0%). Similarly, respondents with tertiary education (46.5%), those not currently in school (52.7%), those living with a partner or spouse (68.3%), those employed full-time (60.0%), and those from households with a monthly income of at least GHS 2,000 (50.7%) reported higher levels of contraceptive use. In contrast, gender ($p = 0.280$) and ethnicity ($p = 0.663$) were not significantly associated with ever contraceptive use.

Table 4.9 Association Between Sociodemographic Characteristics and Ever Use of Contraceptives Among participants in Tema West Municipality (N = 264)

Variable	Yes n (%)	No/Prefer not to say n (%)	χ^2 (p-value)
Age			27.563 (<0.001)
10–13	1 (3.4)	28 (96.6)	
14–16	7 (18.9)	30 (81.1)	
17–19	21 (42.9)	28 (57.1)	
≥20	72 (48.3)	77 (51.7)	
Gender			1.167 (0.280)
Male	47 (35.1)	87 (64.9)	
Female	54 (41.5)	76 (58.5)	

Variable	Yes n (%)	No/Prefer not to say n (%)	χ^2 (p-value)
Religion			9.969 (0.019)
Christian	72 (41.6)	101 (58.4)	
Islam	16 (29.1)	39 (70.9)	
Traditionalist	5 (20.8)	19 (79.2)	
Others	8 (66.7)	4 (33.3)	
Ethnicity			2.397 (0.663)
Akan	33 (39.3)	51 (60.7)	
Ewe	20 (43.5)	26 (56.5)	
Northern	18 (41.9)	25 (58.1)	
Ga-Adangbe	28 (32.2)	59 (67.8)	
Other	2 (50.0)	2 (50.0)	
Relationship status			54.372 (<0.001)
Single	23 (18.0)	105 (82.0)	
Dating	46 (48.4)	49 (51.6)	
Married/Cohabiting	30 (76.9)	9 (23.1)	
Other	2 (100.0)	0 (0.0)	
Education level			23.075 (<0.001)
No formal education	1 (50.0)	1 (50.0)	
Primary	1 (5.9)	16 (94.1)	
JHS	4 (11.4)	31 (88.6)	
SHS	22 (41.5)	31 (58.5)	
Tertiary	73 (46.5)	84 (53.5)	
Currently in school			16.715 (<0.001)
Yes	43 (27.9)	111 (72.1)	
No	58 (52.7)	52 (47.3)	
Living arrangement			40.171 (<0.001)
Both parents	14 (18.9)	60 (81.1)	
Friends/Alone	27 (48.2)	29 (51.8)	
Guardian/Relative	13 (28.3)	33 (71.7)	
One parent	14 (33.3)	28 (66.7)	
Other	5 (100.0)	0 (0.0)	
Partner/Spouse	28 (68.3)	13 (31.7)	
Employment status			22.752 (<0.001)
Yes, full-time	42 (60.0)	28 (40.0)	
Yes, part-time	36 (37.1)	61 (62.9)	
Not working	23 (23.7)	74 (76.3)	
Household income			20.975 (<0.001)
< GHS500	2 (13.3)	13 (86.7)	
GHS500–999	7 (28.0)	18 (72.0)	
GHS1000–1999	14 (30.4)	32 (69.6)	

Variable	Yes n (%)	No/Prefer not to say n (%)	χ^2 (p-value)
≥ GHS2000	70 (50.7)	68 (49.3)	
I don't know	8 (20.0)	32 (80.0)	

Source: Field Data, 2026

4.6 Objective 5: To identify factors that influence contraceptive method preferences among adolescents and young adults in Tema West Municipality.

4.6.1 Multinomial Logistic Regression of Factors Associated with Contraceptive Method Preference

The multinomial logistic regression analysis showed that gender, relationship status, and schooling were significantly associated with contraceptive preference. Males had higher odds of preferring barrier methods compared to females (aOR = 4.13, 95% CI: 1.73–9.89, $p = 0.001$), but lower odds of preferring modern methods (aOR = 0.15, 95% CI: 0.05–0.44, $p < 0.001$). Adolescents who were in a relationship were more likely to prefer barrier (aOR = 6.48, 95% CI: 2.23–18.87, $p < 0.001$), modern (aOR = 5.84, 95% CI: 1.83–18.61, $p = 0.003$), and FABM/behavioral methods (aOR = 5.23, 95% CI: 1.66–16.45, $p = 0.005$) compared to those who were single, with a similar pattern observed among those who were married or cohabiting for modern methods (aOR = 6.42, 95% CI: 1.22–33.71, $p = 0.028$). Respondents who were not in school had higher odds of preferring barrier (aOR = 7.95, 95% CI: 2.55–24.80, $p < 0.001$), modern (aOR = 7.24, 95% CI: 2.16–24.22, $p = 0.001$), and FABM/behavioral methods (aOR = 4.60, 95% CI: 1.36–15.61, $p = 0.014$). Religion was associated with barrier method preference, where respondents of other religions had lower odds compared to Christians (aOR = 0.29, 95% CI: 0.12–0.74, $p = 0.009$). Lower household income was associated with increased odds of barrier method preference, particularly among those earning less than 500 (aOR = 33.37, 95% CI: 3.08–361.38, $p = 0.004$). To address sparse data and

unstable estimates observed in earlier models, contraceptive methods were regrouped such that hormonal and long-acting reversible contraceptives (LARC) were combined into a “modern” category, while fertility awareness-based and behavioral methods were combined into a single category. This regrouping improved model stability; however, some estimates retained wide confidence intervals, indicating residual imprecision that should be interpreted cautiously.

Table 4.10 Multinomial Logistic Regression of Factors Associated with Contraceptive Preference

Method	Variable	Category	aOR	95% CI	p-value
Barrier	Age	10–13	0.09	0.00–5.36	0.250
		14–16	1.43	0.29–6.94	0.658
		≥20	1.74	0.44–6.94	0.432
	Gender	Male	4.13	1.73–9.89	0.001*
	Religion	Other	0.29	0.12–0.74	0.009*
	Relationship status	In relationship	6.48	2.23–18.87	<0.001*
		Married/Cohabiting	4.87	0.87–27.40	0.072*
	Education	Basic	1.37	0.02–85.40	0.880
		High school	0.50	0.15–1.64	0.251
	Schooling status	No	7.95	2.55–24.80	<0.001*
	Living arrangement	Independent	0.49	0.13–1.78	0.277
		Other	0.17	0.04–0.64	0.009*
	Household income	<500	33.37	3.08–	0.004*
				361.38	
Modern	Age	500–999	8.02	1.53–41.97	0.014*
		10–13	0.76	0.07–8.90	0.826
		14–16	1.74	0.36–8.39	0.488
	Gender	≥20	0.49	0.12–2.06	0.332
		Male	0.15	0.05–0.44	<0.001*
		Other	0.81	0.33–2.00	0.650
	Relationship status	In relationship	5.84	1.83–18.61	0.003*
		Married/Cohabiting	6.42	1.22–33.71	0.028*
	Education	Basic	0.20	0.01–5.50	0.343
		High school	0.72	0.19–2.63	0.614
	Schooling status	No	7.24	2.16–24.22	0.001*

Method	Variable	Category	aOR	95% CI	p-value
FABM / Behavioral	Living arrangement	Independent	1.50	0.38–5.90	0.561
		Other	1.84	0.56–6.04	0.316
	Household income	<500	3.40	0.18–65.20	0.417
		500–999	0.96	0.11–8.26	0.969
	Age	10–13	2.25	0.35–14.43	0.393
		14–16	1.94	0.40–9.37	0.412
		≥20	3.28	0.66–16.20	0.146
	Gender	Male	1.23	0.51–2.95	0.650
	Religion	Other	0.45	0.18–1.12	0.085
	Relationship status	In relationship	5.23	1.66–16.45	0.005*
		Married/Cohabiting	3.71	0.60–23.10	0.160
	Education	Basic	1.30	0.14–11.90	0.819
		High School	1.45	0.38–5.46	0.586
	Schooling status	No	4.60	1.36–15.61	0.014*
	Living arrangement	Independent	0.46	0.11–1.91	0.285
		Other	0.27	0.07–0.97	0.044
	Household income	<500	—	—	<0.001*

Source: Field Data, 2026. Note: Reference category: Others/No Preference. Reference groups: Female, Christian, Single, Tertiary education, In school, Living with parents, and income ≥ 2000 . aOR = Adjusted Odds Ratio; CI = Confidence Interval. Hormonal and long-acting reversible contraceptive (LARC) methods were combined into a single “Modern” category, while fertility awareness-based methods (FABM) and behavioral methods were combined into “FABM/Behavioral.” Educational level was collapsed into three categories: Basic (no formal education and primary), High School (JHS and SHS), and Tertiary (reference category) to improve cell sizes and ensure stable estimates. “—” indicates estimates that were not stable due to sparse data. * Statistical significance was set at $p < 0.05$.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

This chapter discusses findings from a descriptive cross-sectional study examining accessibility and contraceptive preferences among 264 adolescents and young in Tema West Municipality, Greater Accra Region, Ghana. The discussion follows the study's four specific objectives: assessing family planning (FP) service availability, exploring contraceptive preferences, examining sociodemographic associations with contraceptive use, and identifying factors shaping those preferences. Findings are compared against published literature from comparable settings across Sub-Saharan Africa and beyond.

5.2 Objective 1: To assess the accessibility of contraceptives among adolescents and young adults within Tema West Municipality.

The findings on accessibility reveal a clear distinction between nominal awareness and functional access. Although most adolescents and young adults in Tema West Municipality were aware that family planning services existed, fewer could identify a specific service delivery point, and the lowest ratings were recorded for convenience of facility opening hours. This pattern suggests that access in this setting is not primarily limited by absence of information or cost, but by the practical conditions under which services are delivered. The finding therefore complicates the assumption that high awareness naturally leads to service utilisation. Instead, it shows that adolescents may know that services exist while still perceiving them as difficult to use in real-life circumstances.

This finding both aligns with and extends previous evidence. Amenah et al. (2025) reported uneven adolescent sexual and reproductive health service readiness across Ghanaian districts, while Rai et al. (2023) showed that facility provision does not necessarily indicate readiness. In comparison, the Tema West findings show that even when adolescents report relatively positive perceptions of affordability, distance, respect, and confidentiality, a single structural weakness such as inconvenient opening hours can weaken overall access. Thus, the study links facility readiness literature with adolescent experience by showing that service availability must be interpreted from the user's point of view, not only from the facility's perspective.

A further contrast emerges when the Tema West results are compared with studies from settings where stock-outs and commodity availability dominate access constraints. Obong and Oyibo (2023) and Mpunga et al. (2017) emphasized shortages of methods, guidelines, and trained personnel as major barriers. In Tema West, however, adolescents reported moderate access to pharmacies and some confidence in provider respect and confidentiality, suggesting that the challenge is less about absolute absence of services and more about how services are organized, communicated, and made convenient for young people. This distinction is important because interventions focused only on increasing commodities may not resolve adolescent access barriers if service hours, confidentiality, and youth-friendly pathways remain weak.

The reliance on pharmacies and chemical shops further reinforces this linkage between convenience and behaviour. Pharmacies were used more often than formal public or private facilities, suggesting that adolescents may choose access points that reduce waiting time, social visibility, and interaction with formal providers. This preference mirrors wider evidence that adolescents often prioritize discretion and ease of access over comprehensive counselling. However, it also creates a gap: pharmacies may provide short-acting methods more easily but are

less likely to offer counselling, method comparison, or long-acting reversible contraceptives. The study therefore identifies an important service-delivery gap between where adolescents actually seek contraceptives and where comprehensive contraceptive counselling is most likely to occur.

Taken together, these results suggest that accessibility in Tema West is best understood as a layered construct. Awareness forms the first layer, but it is insufficient without practical knowledge of service points, convenient hours, confidentiality, and acceptable provider interaction. This linkage supports the enabling factors component of the Andersen Behavioral Model: services must be not only available but also usable within the adolescent's social and daily context. The key gap identified by this study is therefore not simply low awareness, but the mismatch between service availability and adolescent-friendly access conditions.

The likely explanation is that adolescents integrate their service experiences holistically rather than averaging scores from a questionnaire. A facility that is affordable, nearby, and respectful but closed when you can get there is functionally inaccessible. The weakest dimension (opening hours) may act as a gating variable: if you cannot get through the door at the right time, the other indicators become irrelevant. This finding suggests that service accessibility assessments should weight convenience and timing more heavily, rather than treating all dimensions as equally important in composite scoring.

5.3 Objective 2: To explore contraceptive preferences among adolescents and young adults in Tema West Municipality.

The findings on contraceptive use and preference show another important gap between knowledge, access, and behaviour. Although awareness of family planning was high, 61.0% of respondents had never used contraception and 75.0% were not current users. This pattern is consistent with

studies in Ghana, Tanzania, and the Democratic Republic of Congo, where high awareness has repeatedly failed to translate into consistent use (Boamah et al., 2014; Kara et al., 2019; Casey et al., 2020). However, the Tema West findings add a local dimension by showing that low use persists even in a peri-urban municipality where adolescents perceive some level of service availability. This suggests that the problem is not simply informational, but behavioural, social, and service-related.

Barrier methods were the most preferred contraceptive category, which links Tema West to patterns observed in developed and developing country contexts. Jahanfar and Zendehdel (2024) found condom preference among university students in the United States, while Coetzee and Ngunyulu (2015) reported condom use among South African undergraduates. In Tema West, the preference for barrier methods may similarly reflect user control, perceived safety, ease of access, and avoidance of clinical procedures. Yet the context differs: in developed settings, barrier-method preference often occurs alongside stronger formal service access, whereas in Tema West it appears alongside low current use, reliance on pharmacies, and uncertainty about method choice. This contrast suggests that preference for condoms may represent both autonomy and limited exposure to broader contraceptive counselling.

The relatively high proportion reporting no contraceptive preference is particularly important. It indicates that a sizeable group of adolescents may not have enough information, confidence, or counselling exposure to make an informed method choice. This finding links directly with the study's access results: when formal health facilities are not the dominant source of contraceptives, opportunities for structured counselling are reduced. It also contrasts with contexts such as the DRC, where Casey et al. (2020) found greater use of long-acting methods when these were

accessible. In Tema West, low preference for long-acting reversible contraceptives suggests a gap in both availability and acceptability of methods requiring provider interaction.

The preference for convenience and ease of use also links method choice to accessibility. Adolescents did not appear to select methods only on the basis of clinical effectiveness; rather, they prioritised methods that were easy to obtain, simple to use, and compatible with privacy concerns. This explains the preference for condoms and the continued use of emergency contraception and withdrawal. Compared with studies emphasizing effectiveness or method mix, the Tema West findings show that adolescent contraceptive preference is shaped by the practical fit between method characteristics and the adolescent's social environment. The gap for service providers is therefore to bridge convenience with effectiveness by making counselling and a wider range of methods accessible in ways that preserve privacy and autonomy.

5.4 Objective 3: To assess perceived barriers to contraceptive use among adolescents and young adults in Tema West Municipality.

The perceived barriers identified in Tema West show that contraceptive decision-making is shaped more by social and informational constraints than by cost alone. Infertility concerns, lack of knowledge, limited family communication, fear of provider judgment, and media influence were more prominent than cost. This partly aligns with Z. Sulemana et al. (2024), who identified infertility myths and side-effect concerns among Ghanaian tertiary students, and with Bekele et al. (2020), who reported similar misconceptions in Ethiopia. However, Tema West differs in that fear of side effects was less prominent than infertility concerns, suggesting that adolescents may distinguish between temporary side effects and perceived long-term fertility risks. This distinction is important because it reveals a more specific misconception that family planning education must address.

Partner and peer influence provide another linkage between the study's preference findings and its barrier findings. The preference for discreet methods and moderate influence of partners suggest that method choice is not made in isolation. This supports findings by Onasoga (2016), Boamah et al. (2014), and Gbagbo (2020), which showed that peers, partners, and social approval affect contraceptive behaviour. In Tema West, these influences may help explain both the preference for barrier methods and the low uptake of LARCs, since condoms are easier to obtain discreetly and require less formal health system engagement. The gap is therefore not only clinical but relational: adolescent contraceptive programmes must address negotiation, partner communication, and stigma alongside method information.

Economic barriers were less prominent in this study than in some previous research. This contrasts with studies such as Obong and Oyibo (2023) and Mpunga et al. (2017), where weak service readiness, stock-outs, and limited resources were major constraints. In Tema West, cost was not strongly perceived as a barrier, possibly because pharmacies and public services provide relatively affordable short-acting methods. Yet distance and service hours remained relevant, showing that financial affordability does not equal practical accessibility. This contrast highlights an important linkage: when cost barriers decline, other barriers such as convenience, confidentiality, and provider interaction become more visible.

The sociocultural findings also refine the literature. While studies from Tanzania and Nigeria have emphasized religion as a major barrier (Kara et al., 2019; Onasoga, 2016), the Tema West results suggest that limited family communication may be more influential than formal religious beliefs. This does not mean religion is irrelevant, but it suggests that within this peri-urban Ghanaian context, everyday household silence around contraception may be more consequential than explicit doctrinal opposition. This is an important gap in existing studies, many of which treat sociocultural

barriers broadly without distinguishing family communication, parental concern, partner influence, and religion as separate mechanisms.

Health system barriers remain important despite relatively positive ratings for respect and confidentiality in the accessibility section. Fear of judgment, negative provider attitudes, and confidentiality concerns persisted as moderate barriers, echoing findings by Boamah et al. (2014), I. Sulemana et al. (2025), Casey et al. (2020), and Ssanyu et al. (2025). The apparent contradiction between moderate trust in confidentiality and continued fear of judgment suggests that adolescents may distinguish between formal confidentiality and the interpersonal discomfort of being seen, questioned, or judged. This linkage reinforces the need for youth-friendly services that address both privacy procedures and provider communication style.

Finally, media and social media recorded the highest agreement among all measured factors, while trust in contraceptive effectiveness was also relatively high. These findings complement evidence presented in the literature review showing that mass media and digital platforms are increasingly important sources of family planning information for young people (Masood & Alsonini, 2017; Z. Sulemana et al., 2024; Botchwey et al., 2022). The strong influence of media suggests that although adolescents generally trust the effectiveness of contraceptives, the quality of information they receive through digital platforms is likely to shape their perceptions and decisions. This highlights the need for evidence-based reproductive health messaging through social media and other youth-oriented communication channels to address persistent misconceptions while reinforcing accurate information about contraceptive safety and effectiveness.

5.5 Objective 4: Relationship Between Sociodemographic Factors and Contraceptive Use

The association between age and contraceptive use was highly significant (chi-square = 27.563, $p < 0.001$), with 71.3% of adolescents aged 20 and above reporting ever-use compared to substantially lower rates in younger age groups. This aligns with Amoah et al. (2023) in Ghana, where older participants were nearly three times more likely to use modern contraceptives (AOR = 2.93, $p = 0.023$).

This pattern contrasts with Ethiopian data from Shiferaw et al. (2014), where condom use declined with age from 62% among those aged 19 or younger down to 23.8% among those aged 25 and above and from Wasie et al. (2012), who found that younger students in Northwest Ethiopia were 11 times more likely to use condoms than older peers. The divergence likely reflects contextual differences: in Ghana, older adolescents may have accumulated more health service exposure, more stable relationship structures, and greater autonomy over their reproductive decisions. In Ethiopia, peer norms and risk awareness among younger cohorts may play a larger role in driving early protective behavior. Age, in short, does not have a fixed relationship with contraceptive behavior context determines the direction.

Education was strongly and consistently associated with contraceptive use (chi-square = 23.075, $p < 0.001$). Among adolescents with tertiary education, 72.3% reported ever using contraception. Grindlay et al. (2018) in Accra found that tertiary education was associated with an AOR of 4.3 ($p = 0.01$) for modern contraceptive use, compared to primary education. Iyoke et al. (2014) in Nigeria found that health science students had 3.5 times higher odds of adhering to modern methods (OR = 3.5; CI 1.3–9.6), and that receiving information from health personnel or workshops increased adherence likelihood substantially (OR = 9.54; CI 3.5–26.3).

Education probably works through multiple channels simultaneously: health literacy, delayed entry into marriage, financial independence, and access to information through formal curricula. The concentration of contraceptive use among tertiary-educated adolescents in this study also reflects the sample's composition 59.5% had tertiary education which may limit generalizability to less-educated subgroups in Tema West.

The most significant association in the data was relationship status (chi-square = 54.372, $p < 0.001$). Among those in dating relationships, 45.5% reported ever using contraception; among married or cohabiting adolescents, 29.7%; and among those who were single, just 22.8%. Adolescents in active relationships have a more concrete, immediate reason to think about contraception it becomes relevant in a way it may not for those who are not currently sexually active.

Mehra et al. (2012) in Uganda found that non-stable relationships predicted contraceptive non-use, suggesting the relationship between partnership stability and contraceptive behavior is not linear. What appears to matter most is perceived need: adolescents in casual or socially unacknowledged sexual relationships may underestimate their risk or feel unable to negotiate contraceptive use without inadvertently disclosing the relationship.

Religion showed a statistically significant association with contraceptive use (chi-square = 9.969, $p = 0.019$). Christians, who comprised 65.5% of the sample, showed the highest contraceptive use rates. This aligns with findings from Sulemana et al. (2025), who also found that Christians in Ghana were significantly more likely to use FP services than other religious groups.

The finding contrasts with evidence from Ethiopia, where religious beliefs were cited as significant deterrents (Bekele et al., 2020), and from Tanzania, where 32.3% of students identified religious beliefs as a barrier to contraceptive access (Kara et al., 2019). In Nigeria, Onasoga (2016)

identified religious norms as significant deterrents to emergency contraceptive use. The direction of the relationship between religion and contraceptive behavior is not fixed across settings — it varies by denomination, national policy environment, and local community norms, and should not be assumed to be uniformly restrictive.

Gender was not significantly associated with contraceptive use in this study ($p = 0.280$). This deserves explanation rather than dismissal. In Ethiopia, Shiferaw et al. (2014) found pronounced gender differences, with 89.2% of female students reporting inconsistent condom use compared to 55% of male students. The same study linked female alcohol and drug use to occasional condom use ($COR = 2.2$, $p = 0.00$), a pattern absent among male participants.

In Tema West, gender non-significance probably reflects the near-equal gender distribution in the sample (50.8% male, 49.2% female) combined with relatively high education levels, which may attenuate gendered disparities in health decision-making. A peri-urban, largely tertiary-educated sample is likely more gender-equitable in reproductive health behavior than a rural or secondary-school sample. This does not mean gender is irrelevant to contraceptive use in Tema West, it suggests that education and socioeconomic status may mediate gender effects in this context.

5.6 Objective 5: Multinomial Regression Analysis to identify factors that influence preferences

The multinomial logistic regression analysis identified gender, relationship status, schooling status, religion, and income as key predictors of contraceptive preference. Contraceptive methods were grouped into broader categories to address sparse data and improve estimate stability, with hormonal and long-acting reversible contraceptive (LARC) methods classified as “modern,” and fertility awareness-based and behavioral methods combined into a single category. Within this

framework, gender differences were evident. Male adolescents had higher odds of preferring barrier methods (aOR = 4.13; $p = 0.001$) but lower odds of preferring modern methods (aOR = 0.15; $p < 0.001$), indicating that female adolescents were more likely to prefer modern contraceptive options. This aligns with Coetzee and Ngunyulu (2015), who reported that male condoms accounted for over 70% of contraceptive use among male adolescents, reflecting male control over barrier methods. Similarly, Jahanfar and Zendehdel (2024) found that female students were significantly more likely to use hormonal contraceptives (OR = 2.84; 95% CI: 1.90–4.25), supporting the observed preference for modern methods among females. Casey et al. (2020) also reported that approximately 60% of adolescent girls preferred methods they could control independently, reinforcing the role of autonomy in contraceptive choice.

Relationship status showed a strong and consistent association across all contraceptive categories. Adolescents in a relationship had higher odds of preferring barrier (aOR = 6.48; $p < 0.001$), modern (aOR = 5.84; $p = 0.003$), and FABM/behavioral methods (aOR = 5.23; $p = 0.005$), with those who were married or cohabiting also showing increased odds of preferring modern methods (aOR = 6.42; $p = 0.028$). This is consistent with Kara et al. (2019), who reported that adolescents in relationships were nearly three times more likely to use any contraceptive method compared to those not in relationships (OR = 2.97; 95% CI: 1.85–4.76). Casey et al. (2020) further observed that about 48% of unmarried adolescents reported inconsistent contraceptive use, often switching between methods, which supports the finding that adolescents in relationships engage with multiple method types, including both modern and FABM/behavioral options.

Education was not significantly associated with contraceptive preference in this analysis. Educational level was collapsed into low, secondary, and tertiary categories to improve cell sizes,

which may have reduced sensitivity to detect differences. This contrasts with Boamah et al. (2014), who found that adolescents with secondary education were more than twice as likely to use modern contraceptives compared to those with no formal education (OR = 2.31; $p < 0.01$). Similarly, Apanga and Adam (2015) reported that adolescents with at least secondary education had significantly higher contraceptive use (AOR = 1.94; 95% CI: 1.10–3.43). The absence of a significant association in this study likely reflects the aggregation of categories rather than a true lack of effect.

Schooling status showed a strong association, with adolescents not currently in school having higher odds of preferring barrier (aOR = 7.95; $p < 0.001$), modern (aOR = 7.24; $p = 0.001$), and FABM/behavioral methods (aOR = 4.60; $p = 0.014$). This differs from Apanga and Adam (2015), who reported that in-school adolescents were more likely to use contraceptives (AOR = 2.10; 95% CI: 1.20–3.67), attributed to improved access to information. However, Ssanyu et al. (2025) observed that out-of-school adolescents had higher levels of sexual activity and unmet contraceptive need, which may explain the higher likelihood of contraceptive preference observed in this study.

Religious affiliation was associated with barrier method preference, with adolescents from non-Christian backgrounds having lower odds of preferring barrier methods (aOR = 0.29; $p = 0.009$). This contrasts with Casey et al. (2020), who found that adolescents from more religious backgrounds were 1.8 times more likely to rely on natural or abstinence-based methods compared to modern methods. The present finding suggests that religious influence on contraceptive choice may vary across contexts and may not uniformly translate into preference for traditional methods.

Income was associated with contraceptive preference, particularly for barrier methods. Adolescents with lower income (<500) had substantially higher odds of preferring barrier methods (aOR = 33.37; $p = 0.004$), although the wide confidence interval (95% CI: 3.08–361.38) indicates limited precision. This is consistent with Ssanyu et al. (2025), who reported that adolescents from low-income households were significantly more likely to rely on condoms (AOR = 2.67; 95% CI: 1.45–4.91), while those from higher-income groups were more likely to use long-acting or hormonal methods due to better access and affordability.

The grouping of contraceptive methods and selected predictors was necessary to address sparse data and improve the stability of the regression estimates. While this approach enhanced interpretability, some estimates retained wide confidence intervals, indicating residual imprecision. Overall, the findings indicate that contraceptive preference among adolescents is influenced by gender dynamics, relationship context, schooling exposure, and socioeconomic access, with patterns that are broadly consistent with existing literature while also reflecting context-specific variations.

5.7 Theoretical Implications

This study was guided by the Andersen Behavioral Model of Health Service Use, which explains health behavior through predisposing, enabling, and need factors. The findings support the model in several ways. Predisposing factors such as age, education, and relationship status significantly influenced contraceptive use and preference. Enabling factors, particularly accessibility dimensions such as service hours, provider attitudes, and confidentiality, shaped adolescents'

ability to utilise services. Despite high awareness, perceived need and actual utilisation remained low, indicating that awareness alone is insufficient to drive behaviour.

The study extends the model by highlighting the role of social and informational influences, particularly media exposure and family communication, as key determinants of contraceptive behavior among adolescents. These findings suggest that in adolescent populations, enabling factors must include not only physical access but also social acceptability and information environments. Overall, the study demonstrates that contraceptive behaviour among adolescents is shaped by the interaction of structural access, social context, and individual characteristics.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the conclusions drawn from the study and outlines recommendations based on the findings. It also discusses theoretical implications and suggests areas for further research.

6.2 Conclusions

The study shows that contraceptive accessibility among adolescents in Tema West Municipality remains limited, with low perceived availability driven by structural barriers such as inconvenient service hours, provider attitudes, and inadequate youth-friendly services. Contraceptive preferences are dominated by barrier methods, particularly condoms, alongside some reliance on emergency contraception, while long-acting methods remain poorly utilised due to limited visibility and access. Preferences are influenced by convenience and perceived effectiveness, but also strongly shaped by social and informational factors. Key determinants include age, education, relationship status, religion, income, and employment, while gender shows no significant influence. Media exposure, limited family communication, concerns about infertility, and fear of provider judgment emerge as the main factors influencing contraceptive preferences, whereas cost is less significant. These findings indicate that improving adolescent contraceptive uptake in Tema West Municipality requires interventions focused on service accessibility, adolescent-responsive care, and targeted communication strategies.

6.3 Recommendations

1. **Improve Service Accessibility:** Given that a large proportion of adolescents reported low perceived availability (89.4%) and identified inconvenient service hours as a key barrier, health facilities in Tema West Municipality should extend operating hours beyond standard working times to include evenings and weekends. The Municipal Health Directorate should also implement flexible service delivery models, including designated adolescent service days and mobile outreach through CHPS compounds.
2. **Strengthen Youth-Friendly Services:** In response to findings showing fear of provider judgment (mean = 2.58 ± 0.87) and concerns about confidentiality, the Ghana Health Service should implement targeted training programmes for healthcare providers to improve adolescent-sensitive service delivery, with emphasis on confidentiality, non-judgmental communication, and respectful care.
3. **Enhance Contraceptive Counselling:** Considering that 25.8% of adolescents reported no clear contraceptive preference and preference for long-acting methods was low, the Ghana Health Service, together with hospitals and clinics in Tema West Municipality, should strengthen contraceptive counselling by providing structured and practical information on all available methods, including hormonal and long-acting reversible contraceptives.
4. **Align Services with Adolescent Preferences:** As barrier methods (35.6%) and short-term methods dominate preferences, largely driven by convenience (25.4%), health facilities should ensure consistent availability of these methods while simultaneously promoting informed choice through demonstrations and counselling on underutilised options such as long-acting contraceptives.

5. **Promote Parent–Adolescent Communication:** Given the high level of limited family discussion on contraception (mean = 2.78 ± 0.87), community-based programmes led by the Municipal Health Directorate, local NGOs, and community leaders should encourage open discussions on sexual and reproductive health within households.

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APPENDIX I: TIMELINE

ACTIVITY	TIME					
	November 2025	December 2025	January 2026	Ferbruar 2026	March 2026	April 2026
Proposal Development						
Submission of proposal to ethical review committee						
Data collection						
Data entry and analysis						
Report writing						
Submission of final project						

APPENDIX II: BUDGET

ITEM	QUANTITY	UNIT COST (GHC)	TOTAL COST (GHC)
Proposal Printing	1	30	30.00
Binding Cost		20	20.00
Questionnaire and Informed consent Printing	223	5	1,115
5% contingency			58.25
Grand Total			1223.25

APPENDIX III: PARTICIPANT INFORMATION SHEET

Title of Study: Access and Utilization of Family Planning Services Among Adolescents in Tema West Municipality, Ghana

Principal Investigator: Dr. Marfoaah Tettey-Amlalo. MPH Candidate, Ensign College of Public Health

Introduction and Purpose of the Study

You are invited to participate in a research study being conducted as part of a Master of Public Health thesis at Ensign College of Public Health. The purpose of this study is to examine how adolescents in Tema West Municipality access and use family planning services, their level of awareness, and the factors that influence their use of these services. Your views and experiences will contribute to improving adolescent-friendly health services in your community.

Why You Have Been Selected

You have been selected because you are an adolescent aged 10–25 years residing in Tema West Municipality. Your participation will help provide important information on how reproductive health services can be improved for young people.

What Participation Involves

If you agree to participate, you will be asked to complete a structured questionnaire. The questions will focus on your knowledge and perceptions of family planning, your use of contraceptive methods, and factors that may influence your choices. The questionnaire will take approximately 30 to 45 minutes to complete.

Voluntary Participation

Your participation is entirely voluntary. You may choose not to answer any question you are not comfortable with, and you may withdraw from the study at any time without any consequences.

Confidentiality and Privacy

All information you provide will be kept confidential. Your name will not be recorded on the questionnaire. Instead, a unique identification code will be assigned to your responses. Data collected will be securely stored and accessed only by the research team.

Risks and Discomforts

There are no major risks associated with this study. However, some questions may be personal in nature. If you feel uncomfortable at any time, you may skip any question or stop participating.

Benefits

There are no direct financial or material benefits to you. However, your participation will help improve understanding of adolescent access to family planning services and may contribute to better health policies and services for young people in Ghana.

Ethical Approval

This study has been approved by the Ensign Global University Institutional Review Board. Permission has also been obtained from the Tema West Municipal Health Directorate. For participants under 18 years, parental or guardian consent will be obtained in addition to your assent.

Contact for Questions

If you have any questions about this study, please contact:

Name of Researcher: Dr. Marfoaah Tettey-Amlalo

Contact: +233 55 848 6127

APPENDIX IV: INFORMED CONSENT FORM

Consent to Participate in the Study

I confirm that:

- I have read and understood the information provided about the study.
- I have had the opportunity to ask questions and received satisfactory answers.
- I understand that my participation is voluntary and that I can withdraw at any time without any consequences.
- I agree to participate in this study.

Participant Decision

Do you agree to participate in this study?

☐ YES

☐ NO

Participant Details

Participant's Signature / Thumbprint: _____

Date: _____

Interviewer Details

Name of Interviewer: _____

Date of Interview: _____

For Participants Under 18 Years

Parental/Guardian Consent Given: ☐ YES ☐ NO

Assent Given by Adolescent: ☐ YES ☐ NO

APPENDIX V: DATA COLLECTION INSTRUMENT

QUESTIONNAIRE: ACCESSIBILITY AND CONTRACEPTIVE PREFERENCES AMONG ADOLESCENTS AND YOUNG ADULTS IN TEMA WEST MUNICIPALITY, GHANA

PREAMBLE AND INFORMED CONSENT

My name is Dr Marfoaah Tettey-Amlalo, and I am a postgraduate student conducting research on how young people in Tema West access family planning services and what contraceptive options they prefer. This study is part of a master's dissertation submitted to Ensign College of Public Health, Kpong, Eastern Region, Ghana.

Your participation is entirely voluntary. You may stop at any time without giving a reason and without any consequences. No names will be collected. Your answers will be kept strictly confidential and used only for academic research. Individual responses will not be shared with your school, parents, community leaders, or health facility staff. If you are under 18 years old, your parent or guardian has already given written permission for you to participate. You still have the right to decide whether you want to take part.

If any question makes you uncomfortable, you may skip it and move to the next one. Please answer as honestly as you can. There are no right or wrong answers only your experience matters.

Estimated time to complete: 15–20 minutes

By continuing to fill in this questionnaire, you confirm that you understand the above information and agree to participate.

SECTION A: BACKGROUND INFORMATION

This section asks about your personal background. The information helps us understand the different groups of young people in Tema West. Please tick (✓) or write in the space provided.

1. How old are you?

- ☐ 10–13 years
- ☐ 14–16 years
- ☐ 17–19 years
- ☐ 20 years or older

2. What is your gender?

- ☐ Male
- ☐ Female

3. What is your religion?

- ☐ Christianity
- ☐ Islam
- ☐ Traditional/African religion
- ☐ Other (please specify): _____

4. What is your ethnic background?

- ☐ Ga-Dangme
- ☐ Akan
- ☐ Ewe
- ☐ Northern groups (Dagomba, Frafra, Gonja, etc.)
- ☐ Other (please specify): _____

5. What is your current relationship status?

- ☐ Single (not in a relationship)
- ☐ In a relationship but not married
- ☐ Married or cohabiting
- ☐ Other: _____

6. What is the highest level of school you have completed or are currently attending?

- ☐ Primary School
- ☐ Junior High School (JHS)
- ☐ Senior High School (SHS)
- ☐ Tertiary (polytechnic, university, nursing training, etc.)
- ☐ No Formal Education

7. Are you currently enrolled in school?

- ☐ Yes
- ☐ No

8. Who do you currently live with?

- ☐ Both parents
- ☐ One parent
- ☐ Guardian or relative
- ☐ Partner or spouse
- ☐ Friends or on my own
- ☐ Other: _____

9. Are you currently doing any paid work?

- ☐ Yes, full time
- ☐ Yes, part time or casually
- ☐ No, I am not working

10. Which of the following best describes your household's monthly income? (This helps us understand financial access to services.)

- ☐ Less than GHS 500
- ☐ GHS 500 – GHS 999
- ☐ GHS 1,000 – GHS 1,999
- ☐ GHS 2,000 or more
- ☐ I do not know

SECTION B: AVAILABILITY OF FAMILY PLANNING SERVICES IN YOUR COMMUNITY

This section asks about family planning services in Tema West — whether they exist, whether you know about them, and whether you can reach them. Please answer each question honestly.

Instructions: For questions 11–15, circle **YES** or **NO**.

11. I am aware that family planning services exist in health facilities in my community. **YES / NO**

12. I know of at least one health facility in Tema West where a young person can get family planning services. **YES / NO**

13. There is a youth-friendly or adolescent-friendly health centre in my community or nearby. **YES / NO**

14. I have received or could receive contraceptives from a pharmacy near me. **YES / NO**

15. It is easy for me to find information about contraceptives in my community. **YES / NO**

Instructions: For questions 16–22, indicate how much you agree or disagree with each statement. Tick (✓) ONE box per row.

#	Statement	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
16	The opening hours of health facilities in my community are convenient for young people (e.g., after school hours or on weekends).				
17	The contraceptive method I would prefer is available at health facilities near me.				
18	The cost of family planning services in my community is affordable for young people.				

19	Healthcare providers at facilities near me treat young people with respect when they ask about family planning.				
20	I trust that a healthcare provider at a facility near me would keep my visit private.				
21	I can access family planning services in my community at any time I need them.				
22	The distance from my home to the nearest family planning facility is manageable for me.				

23. If you have ever obtained a contraceptive, where did you get it from? (Tick ALL that apply)

- ☐ Government hospital
- ☐ Private hospital or clinic
- ☐ Community health centre or CHPS compound
- ☐ Pharmacy or chemical shop
- ☐ Community health worker (CHW)
- ☐ A friend or peer
- ☐ I have never obtained a contraceptive
- ☐ Other: _____

SECTION C: CONTRACEPTIVE PREFERENCES

This section asks about your personal experiences with and preferences for contraception. Some questions may feel personal; please remember that your answers are completely anonymous. Skip any question you are not comfortable answering.

24. Have you ever been in a sexual relationship? (Tick ONE)

- ☐ Yes

- ☐ No
- ☐ Prefer not to say

25. Have you ever used any method of contraception (to prevent pregnancy or STIs)?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

26. Are you currently using any contraceptive method?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

27. Which of the following contraceptive methods have you ever used? (Tick ALL that apply)

- ☐ Male condom
- ☐ Female condom
- ☐ Oral contraceptive pills (daily pill)
- ☐ Emergency contraception (Postinor/morning-after pill)
- ☐ Injectable contraceptive (Depo-Provera / Noristerat)
- ☐ Implant (Implanon or Jadelle — rod inserted under the skin)
- ☐ IUD / Copper T (device inserted in the womb)
- ☐ Withdrawal method (pull-out)
- ☐ Calendar / rhythm method
- ☐ Standard Days Method
- ☐ Lactational Amenorrhoea Method (LAM)
- ☐ Abstinence (deliberately avoiding sex)

- ☐ I have never used any contraceptive
- ☐ Other: _____

28. If family planning services were freely and confidentially available to you, which ONE method would you MOST prefer to use? (Tick ONE only)

- ☐ Male condom
- ☐ Female condom
- ☐ Oral contraceptive pills (daily pill)
- ☐ Emergency contraception (Postinor)
- ☐ Injectable contraceptive
- ☐ Implant
- ☐ IUD / Copper T
- ☐ Withdrawal method
- ☐ Calendar / rhythm method
- ☐ Abstinence
- ☐ No preference / not sure
- ☐ Other: _____

29. What is the MAIN reason you chose the method in question 28? (Tick ONE only)

- ☐ It is highly effective at preventing pregnancy
- ☐ It is easy to use
- ☐ It is private — a partner or family member would not know I am using it
- ☐ It involves no injections or insertions
- ☐ It contains no hormones
- ☐ My partner is comfortable with it
- ☐ It is accepted by my religion or culture

- ☐ It is affordable
- ☐ It lasts a long time without repeated action
- ☐ I have used it before, and it worked well
- ☐ Other: _____

30. Where do you currently obtain your contraceptive supply? (Tick ONE)

- ☐ Government hospital
- ☐ Private hospital or clinic
- ☐ Pharmacy or chemical shop
- ☐ Community health centre or CHPS compound
- ☐ Community health worker
- ☐ A friend or partner
- ☐ I am not currently using any contraceptive
- ☐ Other: _____

SECTION D: FACTORS THAT INFLUENCE YOUR CONTRACEPTIVE PREFERENCES

The statements below explore what makes it easier or harder for young people in your community to use contraceptives. Read each statement carefully and indicate how much you agree or disagree. There are no right or wrong answers.

Instructions: Tick (✓) ONE box per row.

#	Statement	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
31	I avoid or would avoid using contraceptives because I am worried about side effects.				

32	My partner's opinion about contraceptives influences which method I use or would use.				
33	The cost of contraceptives is a barrier that stops me from using them.				
34	The distance to the nearest family planning facility stops me from going there.				
35	My religious or cultural beliefs affect which contraceptive method I choose.				
36	I do not have enough knowledge about the different contraceptive methods available to me.				
37	I trust that the contraceptive method I prefer is effective enough to prevent pregnancy.				
38	The attitude of healthcare providers at facilities near me puts me off seeking contraceptives.				
39	I am worried that my parents or guardian would find out if I went to get contraceptives.				
40	I do not trust health facilities to keep my visit for family planning services private.				
41	My friends or peers influence which contraceptive method I choose or would choose.				
42	I have felt or would feel judged or disrespected by healthcare staff because of my age when seeking contraceptives.				

43	Contraception is not something discussed openly at home in my family.				
44	Health facility opening hours conflict with my school or work schedule, making it difficult to attend.				
45	I am worried that using contraceptives now might affect my ability to have children in the future.				
46	I believe contraceptives are meant for married people, not unmarried young people.				
47	Information I have seen on social media or TV has shaped what I know about contraceptives.				
48	I prefer or would prefer a contraceptive method that my partner does not need to know about.				

THANK YOU FOR YOUR PARTICIPATION.

Your time and honesty are greatly appreciated. The information you have shared will contribute directly to research aimed at improving family planning services for young people in Tema West. Your responses are completely confidential, and your identity will not be disclosed under any circumstances.