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EFFECTS OF LEVEL OF KNOWLEDGE AND SOCIO-CULTURAL FACTORS ON CONTRACEPTIVE USE AMONG FEMALE ADOLESCENTS IN ENUGU EAST COUNCIL AREA OF ENUGU STATE, NIGERIA

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Abstract
This study examined how knowledge related to contraceptives and socio-cultural factors influence contraceptive use among female adolescents in Enugu East Council Area of Enugu State. Six research questions and two hypotheses were stated for the study which was based on a survey of 500 respondents, selected through the use of multi-stage sampling technique. Three instruments were triangulated and used for data collection. These comprised of structured questionnaire, in-depth interview guide, and the focus group discussions (FGD) guide. The statistical package for the social sciences (SPSS) was used to process field data. The findings, among other things, show that majority of female adolescents in Enugu East Local Government Area do not use contraceptives to prevent unwanted pregnancy although they perceived the right age to start engaging in sexual intercourse to be between ages 17-20. Knowledge of contraceptives was fairly reasonable, although friends and peers (other than parents or mothers) were major sources of such information. Adverse consequences of low contraceptive use in the area were unwanted pregnancy, contracting and spreading of sexually transmitted diseases. Finally, family life education, parents and media role in dissemination of the knowledge and benefits of contraceptives among adolescents, amongst others were recommended to stimulate a more positive sexual attitude and use of contraceptives among female adolescents in Enugu East Local Government Area.

Keywords: Contraceptives, Female adolescents, Socio-cultural factors**,** Level of knowledge**,** Reproductive health

Introduction

Adolescence for the purpose of this study encompass approximately ages 12-25, a period of transition between childhood and adulthood during which the individual assumes his/her position as an active member of society (Mburano, 2000). This period is divided into four overlapping stages: sexual awakening (12-15), first sexual intercourse (14-17), gender role definition (16-19) and social role definition (18-25). An adolescent is thus a person in a period between childhood and adulthood. This period starts with maturity of sexual organs and this continues until teens.

Often times, information about contraceptive use are not extended to adolescents in many cultures. However, knowledge and or use of contraceptives which are important components of reproductive healthcare services should be accessible, affordable and convenient to all users (ICPD, 1994).

Reproductive health implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation

of fertility which are not against the law, and the right of access to appropriate health care services (Oyekanmi, 1999).

Interestingly, despite limited access to contraceptive use information to adolescents across cultures, yet initiation of reproductive capability generally occurs in this period of 'adolescence' which is the period of transition from childhood to adulthood. Although the change is biological, the duration and nature of adolescence are primarily a social construct. It thus varies greatly from culture to culture. In a number of societies, menarche is taken as a sign of maturity and the readiness to marry or commence sexual activity (Riley, Samuelson and Huffman, 1993), although in a few, marriage precedes menarche.

Traditionally in African societies, marriage is the event used to mark the initiation of sexual activity and therefore the beginning of exposure to reproduction (United Nations, 1988b; 1989). Also women in most Nigerian societies are expected to marry or start a union at a younger age. Parental pressure on young girls to do so borders on coercion. Indeed, in some parts of Nigeria, daughters are even withdrawn from primary school for marriage (Oyekanmi, 1999), just to ensure chastity and virginity of the girl child at marriage (Usman, 1999) as well as to promote the desired long-lasting relationship between the two families (Adedokun, 1999).

Above cultural orientations justify or formalize sexual experiences of adolescents, first in the context of marriages. However, further sexual experiences of adolescents come as a result of deception, force, abuses and enticements, and apparently with an older man otherwise branded "sugar daddy". Among adolescents in school, Owuamanam (1994:61) found that "persuasion, celebration, love and proximity" accounted for 6.4%, 9.6%, 48.2% and 30.8% respectively of circumstances surrounding first sexual encounter. Furthermore, it has been shown that a large percentage of girls typically feel it is antisocial to refuse a boy friend sex. This predisposes many to early forms of prostitution (Obasi and Umoh, 2000).

Despite the certainty of adolescents' sexual exposure, a number of traditional myths, practices and taboos pertaining to human sexuality, fertility and reproduction are still adhered to in rural and urban areas, by both men and women, and even by some of the educated segments of the population. These may contribute to difficulties that adolescents encounter towards contraceptive use. Furthermore, since adolescents are usually outside the existing channels for sexual, contraceptive and health information, reproductive health are not designed to respond to their needs (Bongaarts and Bruce, 1995).

It is against this background that this study investigated knowledge and socio-cultural predicators of contraceptive use among female adolescents in Enugu East Council or Local Government Area of Enugu State.

Statement of the Problem

The socio-cultural setting in much of Africa and Nigeria in particular is such that sexual intercourse, pregnancy and childbirth are issues that adolescents (in marriage or yet to be married) actively participate in. This is not withstanding the fact that there is growing awareness that early childbearing poses health risk for the mother and the child, and may truncate a girl's educational career, threatening her economic prospects, and earning capacity and over-all well-being.

Child bearing during adolescence has emerged as an issue of increasing concern throughout the developing and the developed world. It is estimated that worldwide, about 15 million women aged 15-19 give birth each year and that about 11 percent of all babies are currently born to adolescents (United Nations, 1998). In terms of environmental influence on adolescents' sexual behaviour, studies have shown that pre-marital sexual activity is particularly high among urban than rural based youth (Gyeipi-Garbrah, 1985; Makinwa-Adebosuye, 1991), while sexual relations begin at an earlier age in rural areas (United Nation, 1998).

Regardless of where adolescents live in Nigeria, either in rural or urban area, their family's social status and economic resources available to them may determine whether the child hawks on the street, is given out in marriage in her teen, is in school or not and which school (Obasi and Umoh, 2000). Among the 467 itinerant female hawkers interviewed in Ibadan by Orunbaloye and Caldwell (1994), with an average age of 20 years, only 5% had never had sexual relations. 15 percent reportedly lost their virginity through rape, while a substantial number began sexual activity before age ten or slightly older. At the time of the survey, 38

percent of the sexually active hawkers reported only one sexual partner, 26 percent had two partners, 33 percent had three or more partners. Despite their young age, the authors noted that 29 percent had already had six or more sexual partners and 8 percent had ten or more. Generally, since the competition among them is tremendous, and the earnings almost devisory while they may receive very little support from their family, these hawkers are therefore dependent on selling goods and sex.

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Usman (1999): Bassett and Sherman (1994) observed that:

> Stereotyped sexual norms and peer pressure encourage young males to prove their manhood and enhance their social status by having sex. At the same time, young women are socialized to be submissive and not to discuss sex, which leaves them unable to refuse sex or insist on condom use.

Usman (1999) and Sai (1995) recorded that adolescent girls in many parts of Nigeria are married out legally before they are 16 years old, and are expected to get pregnant and give birth to children. According to Arkutu (1995), this reflects both structural and ideological forces, power and resource imbalances, which are played out in ways that impinge deeply on girl's and women's ability to determine their own sexual and reproductive life.

The dangers associated with adolescent child birth are graphically captured by McCauley and Salter (1995), who observed that young adolescents, especially those younger than 15, experience distressing or even tragic pregnancy outcomes more often than adult women. Younger adolescents, they noted, are more likely to experience premature labour, spontaneous abortion, and still births. Besides, they are up to four times as likely as women older than 20 to die from pregnancy related causes. Furthermore, Buvinic and Kurz (1997) observed that, pregnancy related illness such as hypertension and anaemia are more common among adolescents than among adult women. The pathetic cases of Vesico-Vaginal Fistula (VVF), which is rampant in Northern Nigeria attests to the preponderance of early child bearing (Shehu, 1992; Hellandu, 1992).

There is also the other dimension of adolescents' high risks sexual behaviour as regards their social and economic conditions. Early childbirth poses health risks for the mother and child, as well as leads to stoppage of education, which in turn generates a chain of socio-economic problems including unemployment, hunger, poverty, disease and powerlessness.

Despite increased knowledge of contraception and improved access to services in Africa, young people remain poor contraceptive users. In Nigeria and in some countries in other developing regions, substantial proportions of the population still do not know that any type of contraception exists. Data from the Nigerian Demographic and Health Survey (NDHS, 1990) shows that only 5.6% of married adolescents in the 15-19 age bracket were currently using contraceptives (Federal Office of Statistics, 1995). This trend has not significantly improved more than two decades later. Such low practice of contraception among adolescents in Nigeria may not be unconnected with the numerous obstacles they face when seeking a method.

Following their survey in Zimbabwe, Kim, Kols, Nyakuru et al (2001) observed that young people's access to reproductive health information, commodities and services is controlled by adults, including parents, service providers and political leaders. The situation is not different in Nigeria. Thus, problems of limited knowledge of and access to family planning are a reflection of the difficulties many governments have themselves experienced in extending services nationwide rather than the result of a deliberate policy to restrict access (United Nations, 1998).

Partly as a result of the unmet need for contraception in 1990, an estimated 25 million legal abortions were performed worldwide, or one legal abortion for every six births. The World Health Organization (WHO, 1994) also estimated that some 20 million unsafe abortions are performed each year. Global estimates of the number of young women that experience pregnancy and seek an abortion range from between 1 million and 4.4 million in developing countries (International Planned Parenthood Federation, 1994). The majority of the abortions is illegal and occurs in unsafe conditions. Many of these result in death, severe morbidity and infertility.

Until recently, the prevention and control of sexually transmitted diseases was a low priority for most countries and development agencies. The transmission of knowledge about sex and reproductive matters among Nigerian youths is unfortunately not accorded serious priority in our communities not even by parents (Umoh, 1998). Yet, most young people in developing countries, including Nigeria, still engage in unprotected sex. (Campbell and Mbizvo, 1994).

According to WHO (1995), about 13 million adolescents, the parents of next generation are infected at present by sexually transmitted diseases (STDs). Another interesting dimension is the fact that female adolescents as observed by Owuamanam (1994), are less inclined to disclose their infection to people because of the social stigma associated with STD, and the tendency to view a girls contracting of STD as evidence of moral laxity. On source of treatment, it was shown that, self-medication, and traditional healers were highly patronized. The untreated cases of STDs, as it were, can lead to infertility, which is yet another devastating blow to the lives of these individuals in a society where childbearing gives a measure of acceptance for the married (Obasi and Umoh, 2000).

The prevailing consequences of the sexual activities and adventures by adolescents include unintended pregnancy, increased number of deaths from unsafe abortions, and the increasing incidence of sexually transmitted diseases. In Nigerian communities, as in other communities around the world, gender roles and social norms, along with a host of economic and legal factors contribute to risky sexual behaviour of adolescents (Bassett, et. al, 1999).

Based on the annunciated scenario, the specific focus of this study stands out. The study interrogated knowledge and socio-cultural factors as predicators of contraceptive use among female adolescents in Enugu East Local Government Area of Enugu State.

Research Questions

The following research questions were put forward to guide the study;

1. What is the extent of contraceptive use amongst female adolescents in Enugu East Local Government Area?
2. What is the level of knowledge about contraceptives available to female adolescents in Enugu East Local Government Area?
3. In what ways do prevailing level of knowledge about contraceptives affect its use among female adolescents in Enugu East Local Government of Enugu state?
4. What are the socio-cultural factors influencing contraceptive use among female adolescents in Enugu East Local Government Area?
5. What are the consequences of the current level of contraceptive use among female adolescents in Enugu East Local Government Area of Enugu State?
6. In what ways could safe reproductive health and contraceptive use among female adolescents in Enugu East Local Government Area of Enugu State be enhanced?

Brief Literature Review on Knowledge and Use of Contraceptives among Adolescents

Family planning is an integral part of reproductive health. The health of women and children is expected to improve by reducing pregnancies occurring too early, too often, too late in life, or too closely (National Research Council Committee on Population, 1989). Because the widespread adoption of contraception allows a reduction of the absolute number of pregnancies and a shifting of the timing of pregnancy from high-risk to lower-risk ages and from shorter to longer birth intervals, the provision of family planning services has been highlighted as a key strategy for reducing maternal mortality and morbidity (Rosen field and Maine, 1985).

In response to these and other serious demographic and health issues, the Nigerian government put into effect a national population policy in 1989 that called for a reduction in the birthrate through voluntary fertility regulation methods compatible with the nation's economic and social goals (Federal Government of Nigeria, 1988). During 1992 – 1993, an information, education and communications campaign was launched to change attitude of Nigerians toward family planning, and to thereby increase their contraceptive use.

Following a survey conducted by Odimegwu in 1992/1993 in Nigeria, the majority of respondents reported knowing of a contraceptive (76%), only 28% were currently using one, and fewer than half (47%) reported ever having used one. While several reasons have been proffered for the low practice of contraception among Nigeria women, Federal Office of Statistics (FOS, 1995) notes the influence of desire for more children, religion, lack of knowledge, fatalism and side effects as being the most commonly given reasons by individuals. An interesting dimension in the practice of safe sex is the fact that many Nigerian men do not feel vulnerable to sexually transmitted diseases (STDs) and HIV. Obasi and Umoh (2000) noted that:

> The low practice of contraception among adolescents in Nigeria may not be unconnected with the numerous obstacles they face when seeking a method. Also, the view that sexual activity is wrong and immoral among the unmarried adolescents has prevented adolescents from obtaining these services or information. To prevent discovery of their sexual behavior or punishment risk from parents and scorn from society, adolescents commonly engage in unsafe sexual practices… They may also not have the money to procure contraceptives, nor the ability to travel freely in the face of pervasive poverty as well as poor and costly transportation system. Even if an adolescent girl manages to surmount all those obstacles in Nigeria, she faces yet, a more arduous task of persuading her partner to agree to contraceptive use.

In addition, survey findings conducted by Eggleston, Jackson and Hardae (1995) among 945 Jamaican students aged 11-14 indicated that while many adolescents are aware and familiar with many modern contraceptive methods, there is evidence that their knowledge is incomplete or inaccurate. Result from their findings shows that lack of knowledge, institutional barriers, cost of contraceptives and cultural values contribute to non-use of family planning among adolescents

Theoretical Thrust: Sexuality - Gender Framework

The theoretical framework for this study is sexuality- gender framework. In this framework, Dixon Mueller (1996:137) argued that, "attitudes and behaviours surrounding sexuality and gender carry profound meanings for women and men in every society and affect the quality of life in fundamental ways". She reviewed the four dimensions of sexuality, gender connotations and the ways they impact on reproductive health behaviours of men and women. These dimensions include: the formation of sexual partnership, sexual acts, social construction of sexuality and sexual drives and enjoyment. According to her, *sexual partnership* concerns the number of each person's sexual partners, current and past.

The next dimension is the *sexual act*, which goes beyond the mere focus on reproduction, which characterizes the conventional demographic conception of sex as a voluntary heterosexual intercourse with vaginal penetration and ejaculation. It extends to cover different acts of sexuality, such as rape or milder forms of coerced or forced sex, the use of pleasure enhancing devices, (some of which may be physically damaging, for example, the use of drying or tightening vaginal astringents) or other forms of sexual practices. The frequency and forms of sexual expression people engage in often come in as important elements of sexual and reproductive health behaviour.

The third dimension, *social construction of sexuality* refers to the process by which sexual thoughts, behaviours and conditions (for instance, sexual chastity and virginity) are interpreted and ascribed cultural meaning (Ortner and Whitehead, 1981; Vance, 1991). The social construction of sexuality is inevitably linked with cultural concepts of masculinity and femininity

The last dimension treated by Dixon-Mueller (1996), is *sexual drives and enjoyment.* This encompasses the physiological and socio-psychological aspects of sexuality, which interact to produce varying levels of arousability and orgasmic capacity that differ generally among individuals and change over the course of lifetime.

This framework posits summarily that sexual relationships often incorporate disparities in physical strength and in access to material and social resources. Girls and women often have limited powers and control over what happens to them sexually, in comparison to the male-folk. Yet, the framework notes that the extent to which a woman is able to negotiate the 'terms of trade' of a particular sexual relationship defines her capacity to protect herself against reproductive health hazards. More positively, according to Dixon-Mueller (1996:138) "It defines her ability to enjoy sex and to seek family planning advice and health care. From the

most intimate to the most public level, then, interpersonal power relations affect sexual and reproductive health outcomes".

Study Hypotheses

The following hypotheses were stated to guide the investigation of the issues identified for the present study:

1. There is a significant relationship between level of knowledge of adolescents about contraceptives and their use of such commodities to prevent pregnancies or STDs in Enugu East Local Government Area
2. There is a significant relationship between the level of educational attainment of adolescents and their use of contraceptives in Enugu East Local Government Area.

Materials and Methods

The area of study is Enugu East Council (Local Government) Area which is one of the seventeen (17) local government areas in Enugu State. It was created in October, 1996. The Local Government consists of twenty-three (23) communities, which are largely rural and culturally homogeneous.

The predominant occupation of the people is subsistent farming with crude implements, and labour is largely family based, as well as trading. Following the urbanization of some areas, some of the residents especially the urban residents are engaged in civil service and teaching. There are presently three health centers, about twenty (20) secondary schools, and two higher institutions of learning in the local government.

The study population is limited to female adolescents aged 12-25 years, which constitutes 18 percent of the entire population (NPC, 2006). Thus, the target population for the study is 50,236. However, a sample size of five hundred (500) respondents considered large enough applicable statistical computations was used. A breakdown of the sample size is as follows: four hundred and fifty respondents were administered with questionnaires; forty respondents were used in the Focus Group Discussion (FGD); while ten respondents were interviewed in depth

The multi-stage sampling technique was adopted for this study. First, Enugu East L.G.A was stratified into rural and urban communities. Then using the simple random sampling technique, two (2) rural communities namely (Amorji Nike and Ugwugo Nike) and two urban communities (Iji Nike and Emene) communities were selected. All the post primary schools in the selected communities were identified and numbered. Again, using the simple random sampling technique ten schools (eight in the urban and two in the rural communities) were selected. In each of the selected schools, a random sample of forty-five adolescents aged 12-25years were selected, thereby making a total of four hundred and fifty (450) respondents selected for the administration of the questionnaire.

The major instrument chosen for the purpose of collecting data in this study is the questionnaire because of the need for measurable data for easy quantification. In addition, qualitative data were gathered through the use of focus group discussions (FGDs) and in-depth interviews. These were considered necessary to give some contextual meaning to the quantitative findings in the study, as well as provide some vital information, which the questionnaire will be weak in eliciting.

For the qualitative data, a total of four FGDs sessions were conducted with ten participants in each session (two FGD sessions each for rural and urban dwellers respectively). The discussions were held with female adolescents, who were segregated into two homogeneous groups 12-17 and 18-25. Participants in the FGDs were selected from persons within the age group who were not administered with the questionnaire. On the other hand, ten respondents, of selected parents, teachers and health care service workers of these adolescents, were interviewed in-depth. These instruments were administered on the respondents during lesson breaks when the respondents were available and willing to attend to the researcher as well as fill the questionnaire schedule.

The questionnaire data was computer processed and analyzed using SPSS software programme. Simple statistics as well as graphic illustrations were used to describe the main characteristics of the study participants. The chi-square (x^2) was used to test the hypotheses while Pearson's product co-efficient was used to establish the relationship between the socio-cultural variables and the respondents' reproductive

health behaviour. The qualitative data from the FGD and in-depth interview were analyzed is using the descriptive method of qualitative data.

Data Presentation and Analysis

The researchers distributed 450 questionnaires and collected 433 (96.22%) of them. Consequently this analysis was based on 433 correctly filled and returned questionnaires. The analysis is done in sections A and B below as follows:

Section A: Personal Data of Respondents

Personal data of respondents are presented in Table 1

Table 1: Personal Data of Respondents

	Variables	**Frequency**	**Percent**
Distribution of respondents by place of Residence	Ugwugo Nike (rural)	41	9.5
	Iji Nike (urban)	179	41.3
	Emene (urban)	174	40.2
	Amorji Nike (rural)	39	9.0
	Total	**433**	**100.0**
Distribution of respondents by Age	12-15	67	15.5
	16-19	156	36.0
	20-23	170	39.3
	24 and above	40	9.2
	Total	**433**	**100.0**
Distribution of respondents by Level of Educational attainment	FSLC	201	46.4
	JSSC	164	37.9
	SSCE/TCII	48	11.1
	OND/Degree	20	4.6
	Total	**433**	**100.0**
Distribution of respondents by Marital Status	Singles	388	89.6
	Married	45	10.4
	Total	**433**	**100.0**
Distribution of respondents by person who pays your bills	Self	58	13.4
	Parents	309	71.4
	Boy Friend/Fiancé	42	9.7
	Guardians	13	3.0
	My husband	8	1.8
	Brother	3	.7
	Total	**433**	**100.0**

Table 1 shows that most of the respondents (81.5%) are from urban areas (Iji Nike and Emene), while the rest are from rural areas. Age distribution of respondents shows that 170 (39.3%) of the respondents were between the ages of 20-23 years, while just 40 (9.2%) of them are 24 years and above. The mean age of respondents is 16.46years. Enugu East Local Government Area is predominantly populated by Christians hence they constitute 94% of study participants

Section B: Analysis of Research Questions

Research Question 1: What is the extent of contraceptive use amongst female adolescents in Enugu East L.G.A of Enugu State? Findings are shown in tables 2 and3 below.

Table 2A: Distribution of Respondents by their Perception on Right age to indulge in sexual intercourse

Responses	**Frequency**	**Percent**
Anytime	24	5.5
Before 1 7 years	23	5.3
Between 17 and 20 years	206	47.6
21 and above	87	20.1
When married	87	20.1
No idea	6	1.4
Total	433	100.0

Table 2A shows that 206 (47.6%) of the respondents believe that the right age to indulge in sexual intercourse is between the ages of 17 and 20 years, while 6 (1.4%) of them had no idea on when it is right to have sex.

Table 2B: Distribution of respondents by whether they use of contraceptives?

Responses	**Frequency**	**Percent**
Yes	176	40.6
No	257	59.4
Total	**433**	**100.0**

Table 2B shows that 257 (59.4%) of the respondents do not make use of contraceptives while 176 (40.6%) of them agreed they do. Respondents who agreed to the personal use of contraceptives were further asked their choice of contraceptives. This is shown on table 3.

Table 3: Distribution of Respondents' by their preferred personal choice of contraceptive options

Responses	Frequency	Percent
Condom	136	31.4
Pills and Injectibles	29	6.7
Use of traditional herbs / charms	11	2.5
Others	-	-
Total	176	40.6
Not Applicable (Non Users of contraceptives)	257	59.4
Total	**433**	**100.0**

It could be seen from table 3 that 136 (31.4%) of the respondent prefer the usage of condom in Enugu East L.G.A, while only 11 (2.5%) of them would use traditional herbs and charms for contraceptives. Information gathered from the focus group discussions showed that the choice of condom is due to the fact that it is easily accessible and obtainable from shops around their neighbourhood. According to one of the FGD participants in the urban area, *"condoms are available in almost every patent medicine shop in my neighbourhood and they are very cheap"*. Consequently, it can be said that adolescents prefer the use of contraceptives that would not let adults know that they are sexually active.

Research Question 2: What is the level of knowledge about contraceptives among female adolescents in Enugu East L.G.A? The findings are shown in tables 4, 5, 6 and 7 below.

Table 4: Distribution of respondents by their assessment of their level of knowledgeable relevant to use of contraceptive options for preventing unwanted pregnancy?

Responses	Frequency	Percent
Exceptionally knowledgeable	-	-
Fairly knowledgeable	400	92
Fairly knowledgeable	-	-
Not knowledgeable	33	7.6
Total	**433**	**100.0**

Table 4 shows that 400 (92.4%) of the female adolescents agreed that they are fairly knowledgeable about use of contraceptives for preventing unwanted pregnancy while just 33 (7.6%) of them stated that they have no such knowledge. Respondents who maintained that they have knowledge of use of contraceptives for preventing unwanted pregnancy were further probed to state the method they were most familiar with. Their responses are shown in table 5 below.

Table 5: Distribution of Respondents according to ways of preventing unwanted pregnancy that they are most knowledgeable (most familiar) about

Responses	Frequency	Percent
Condom	159	36.8
Contraceptive pills, injectibles etc	105	24.2
Withdrawal	82	18.9
Abstinence	54	12.5
Use of traditional herbs and charms		
All of the above	33	7.6
Total	**433**	**100.0**

In Table 5, 159 (36.8%) of respondents who agreed to have knowledge of ways of preventing unwanted pregnancy with contraceptives said that condom is a sure means of preventing unwanted pregnancy, while 54 (12.5%) subscribed to abstinence. Respondents were further probed on dangers associated with casual or unprotected sex. Their responses are prevented in table 6.

Table 6: Respondents opinion about major dangers associated with casual or unprotected sex.

Responses	Frequency	Percent
Gonorrhoea	84	19.4
Staphylococcus	60	13.9
Candidiasis	62	14.3
HIV/AIDS	139	32.1
Unwanted pregnancy	52	12.0
Death resulting from abortion	21	4.8
Infertility arising from sexually transmitted diseases	15	3.5
Impotence	-	-
Total	**433**	**100**

Table 6 shows that 139 (32.1%) of the respondents identified HIV/AIDS as the major problem associated with casual or unprotected sex. while 21 (4.8%) were of the view that the danger of casual sex is death resulting from abortion. Respondents were further probed on their major source of information about contraceptives and their responses are presented in table 7 below.

Table 7: Distribution of respondents by their views about their major source of information or knowledge on contraceptives and its use

Responses	**Frequency**	**Percent**
Mothers	128	29.6
Peer group (age-mates/friends)	162	37.2
The media	118	27.2
Schools	25	5.8
Churches	-	-
Total	**433**	**100.0**

It could be seen from Table 7 that 162 (37.4%) of the respondents were of the view that friends or peer group are key sources of information/knowledge on contraceptive use among female adolescents in Enugu East area. Similarly, in the course of their discussion, about two-third of the FGD participants chorused *"No! What we know about sex and contraceptives are things our friends told us. We can't ask anybody, not even our parents"*. Consequently, it can be concluded that the level of awareness and knowledge of contraceptives is about average in Enugu East Local Govt. Area.

Research Question 3: In what ways do prevailing level of knowledge about contraceptives affect their use among female adolescents in Enugu East Local Government of Enugu state?

Table 8: Distribution of respondents by their opinion on ways in which level of knowledge about contraceptives affects their use among female adolescents in Enugu East

Responses	**Frequency**	**Percent**
Female adolescents have very poor knowledge of contraceptives which has significantly, in a negative way, affected their use of contraceptive devices	99	33.1
Female adolescents are fairly knowledgeable about contraceptives and make limited/moderate use of such contraceptive commodities	200	66.3
Female adolescents have widespread and exceptional knowledge about contraceptives; they make very extensive use of contraceptive commodities and devices	133	7.6
Don't know	-	-
Total	**433**	**100.0**

Table shows that majority of the respondents were of the opinion that there is moderate (fair) knowledge of contraceptives among female adolescents resulting in limited use of contraceptives in the area.

Research Question 4: "What are the socio-cultural factors influencing contraceptive use among female adolescents in Enugu East Local Government Area of Enugu State?" The findings are shown in tables 9 below.

Table 9: Distribution of respondents by their opinion about socio- cultural factors influencing contraceptive use among adolescents

Response	Frequency	Percent
Contraceptives are not necessary (poor knowledge of benefits)	60	13.9
It is expensive (affordability/poverty issues)	43	9.9
Male partner doesn't approve of it (role of patriarchy)	56	12.9
Don't know where to get them (accessibility issues)	35	8.1
No idea (low level of education, awareness, or enlightenment about contraceptives)	25	5.8
I don't engage in sexual act	38	8.8
Total	257	59.4
Not applicable	176	40.6
Total	**433**	**100.0**

It could be seen from table 9 that 60 (13.9%) of respondent who don't use contraceptives do so because they feel it is not necessary (poor knowledge of benefits), while only 25 (5.8%) of them have no idea (were uninformed) of what contraceptives are. However, it is noteworthy that adolescents' involvement in pre-marital sex was not denied by respondents, although reasons adduced for involvement differed. A respondent during in depth interview argued that *"Most adolescents from poor parental background engage in pre-marital sex because of hardship and financial difficulty"*. Majority of the participants during FGD expressed that *"We get some things like money, clothes, and opportunity for outing to fast food joints from our partners"*. It therefore follows that though some adolescents engage in pre-marital sex to express their love for their partners, majority of them do so because of the pecuniary gains they derive from it. Unfortunately, adolescents' access to information on contraceptives in the area was limited. According to the health care workers interviewed, *"we are hesitant in rendering any contraceptive information and services to adolescent especially those that are unmarried. Such knowledge makes them wild and beyond control"*.

Research Question 5: "What are the consequences of prevailing level of contraceptive use among female adolescents in Enugu East L.G.A of Enugu State?" The findings are shown in tables 10 and 11

Table 10: Have you ever been pregnant as a consequence of non use of contraceptives?

Responses	Frequency	Percent
Yes	55	12.7
No	378	87.3
Total	**433**	**100.0**

In table 10, 55 (12.7%) of the respondents agreed that they have ever been pregnant, while 378 (87.3%) of them said they have never been. Respondents who agreed to have ever been pregnant were further asked what they did with the pregnancy. Their responses revealed exposure to illegal abortions.

Healthcare workers interviewed stated that *"Abortion is not usually granted to adolescents except on health grounds because of its prohibition by the Nigerian law"*. Consequently, the researcher concluded that adolescents will always terminate pregnancy illegally and in an unsafe manner and place. More so, respondents were asked of ever contracted an STD. The responses are shown in table 11.

Table11: Have you ever contracted an STD?

Responses	Frequency	Percent
Yes	91	21.0
No	342	79.0
Total	**433**	**100.0**

Table 11 shows that 342 (79.0%) of respondents said they have never contracted an STD, while only 91 (21.0%) of them agreed they have.

The FGD revealed that, *adolescent girls do not usually tell people when they have infection"*. In this regard, one of the girls (discussants) cautioned, *"I don't want to have a bad name and reputation on account of sex related infection"*. The rest of the girls chorally agreed this.

Research Question 6: In what ways can reproductive health behavior and contraceptive use among female adolescents in Enugu East Local Government Area of Enugu State be enhanced? The findings are shown in Table 12 below.

Table 12: Responses on best approach to enhance reproductive health behaviour of female adolescents

Responses	Frequency	Percent
Give proper orientation on sex (sex and contraceptive use education)	194	44.8
Inculcating the moral values of the society in female adolescents (promoting culture of abstinence)	91	21.00
Provision of the basic needs of these female adolescents	56	12.9
Empowerment of parents to cater for their children	40	9.2
Free and compulsory education for female adolescent	52	12.0
Total	**433**	**100.0**

In table 12, 194 (44.8%) of the respondents said that sex education is a sure way of enhancing the reproductive health behaviour of female adolescents, while 40 (9.2%) of them were of the view that there is need to empower parents (financially and mentally) so that they can cater for their children. A key informants interviewed suggested, *"There is need for parents to teach their children especially the females sex education at the onset of menstruation"*. Consequently, the researchers concluded that knowledge is power and should not be bridged by anything including culture.

Test of Research Hypotheses

The two hypotheses postulated for this study were tested as follows:

Hypothesis 1: "There is a significant relationship between level of knowledge of adolescents about contraceptives and their use of such commodities to prevent pregnancies or STDs in Enugu East Local Government Area". Data in Table 13 formed the basis for testing hypothesis 1.

Table 13: Relationship between level of knowledge about contraceptives and their use for prevention of pregnancies or STDs by adolescents in Enugu East Local Government Area

Self assessed Level of Knowledge on Contraceptives	Have you ever used contraceptives to prevent pregnancies or STD			X2(3,N=433) = 62.723 P<.000
	Yes	No	Total	
Exceptionally knowledgeable	14	53	67	
Fairly knowledgeable	87	69	156	
Fairly knowledgeable	113	57	170	
Not knowledgeable	37	3	40	
Total	**251**	**182**	**433**	

The computed value of chi-square is 62.733 while the table value of chi-square at 0.05 level of significance with a degree of freedom (df) of 3 is 7.815. Since the computed chi square value is greater than the critical value, the researchers therefore accepted the alternative hypothesis. It follows therefore that there is a significant relationship between level of knowledge of adolescents about contraceptives and their use of such commodities to prevent pregnancies and STDs in Enugu East Local Government Area.

Hypothesis 2: "There is a significant relationship between level of educational attainment of adolescents and their use of contraceptives in Enugu East Local Government Area".

Table 14: Relationship between level of education of adolescents and use of contraceptives in Enugu East Local Government Area

Level of educational Attainment	Do you use contraceptives?			X2 (3, N=433) = 3.075 P<.380
	Yes	No	Total	
FSLC	165	36	201	
JSSC	128	36	164	
SSCE/TCII	41	7	48	
OND/Degree	14	6	20	
Total	**348**	**85**	**433**	

The computed value of chi-square is 3.075 while the table value of chi-square at 0.05 level of significance with a degree of freedom (df) of 3 is 7.815. Since the computed chi square value is less than the critical value, the researchers therefore rejected the alternative hypothesis. It implies that there is no significant relationship between level of education of adolescents and use of contraceptives in Enugu East Local Government Area.

Discussion of the Findings

This research work revealed a number of findings. First, it was found that majority of female adolescents (59.4%) of the area studied do not use contraceptives although they believe that the right age to have sex is between the ages of 17 and 20 years. However, 40.1% of the adolescents accepted that they use

contraceptives. It could be concluded that level of contraceptive use among adolescents in the area is moderate or limited. Furthermore, the study found that condom is the most frequently used method of contraceptive. Young female adolescents are usually hesitant to use family planning services because if parents and friends learned of their contraceptive use, they would deduce their sexual activities. It therefore follows that culture of silence regarding adolescent sexuality contribute to non-use of family planning. These findings are synonymous with the third component of Ajzen and Madden (1986) theory of planned behaviour in which they observed anticipated impediments and obstacles such as barring health care providers from providing reproductive health services to individuals younger than 16 years old, except for married women.

In reference to extent of knowledge about contraceptives possessed by adolescents, 92% of them claimed to be fairly knowledgeable while only 33% of them asserted that they are not knowledgeable about contraceptives. Furthermore, there was relatively high level of knowledge among the adolescents on the ways of preventing pregnancy and sexually transmitted diseases and or casual sex

However, contraceptive use among adolescents of the study area was at a moderate level (it is not widespread or involving most of the adolescents). About 66% of the respondents were strongly of the view that the level of contraceptive use among female adolescents of the area was very limited.

More so, the study revealed that there is a wide communication gap between adolescents and their parents on the subject of sex and contraceptive use. About 37.2% of the respondents, who actually constitute the majority, stated that their major source of information on the subject are friends and peer group. The low level of sex education in the family setting appears to result from the traditional norms and customs. Thus, adolescents are left to make decisions about their sexual activity and to cope with the emotional demands of sexual relationship. This finding agrees with Oyekanmi (2004) and Omoluabi (2004) who blamed socio-cultural and religious norms for seeing discussion of sex as a taboo. This approach has deepened suspicions, misunderstanding, confusion and uncertainty for adolescents and has invariably made them to lack the basic information on sexual and reproductive health matters.

Again, the study found that female adolescents' use of contraceptive and or sexual risk behaviours are influenced by both cultural and economic factors. In this regard, three major issues of poor knowledge of benefits, patriarchy and poverty, in that order, had tremendous influences on their contraceptive use. Poverty in particular, impacts negatively on affordability of contraceptive commodities. This finding buttresses the findings of Orunbaloye and Caldwell (1994) in which they observed that the earnings and support from ones family determines whether the child is exposed to early sexual and reproductive behaviour and how long he/she will continue in the act. Orunbaloye and Caldwell (1994) further argued that adolescent hawkers are dependent on selling goods and sex to survive because they receive very little support from their family.

Regarding consequences of the current limited level of contraceptive use among adolescents in the area, it was understood from the FGD session that teenage pregnancy is viewed as an aberration and most unwelcome in the area. Consequently, a teenager who is pregnant might seek for an abortion due to financial burdens of pregnancy (pre and post natal care), family disapproval, stigmatization from her peers and community, and potential abandonment by the baby's father. Despite these dangers, up to 55 (or 12.7%) of our respondents have been pregnant in the past due to none use of contraceptives and failure to abstain from sexual intercourse. Similarly, up to 91 respondents, constituting about 20.6% of those surveyed have contracted STD in the past. The FGD session also revealed that the occurrence of such STD is usually hidden and not talked about. The negative aspect of this is that it leads to further spread of the STD and damage of reproductive organs, which invariably can bring about infertility in a society where childbearing is accorded cultural meaning.

In the test of hypotheses, this study found significant relationship between level of knowledge of adolescents about contraceptives and their use of such contraceptives to prevent pregnancies in Enugu East Local Government Area. It implies that use of contraceptives by adolescents has to do with information or knowledge about the devices at their disposal. It follows that most adolescents use contraceptives on account of knowledge they sourced from friends and peers whom they asserted were their key sources of information on reproductive health issues and contraceptive options.

This study also found no significant relationship between level of educational attainment of adolescents and use of contraceptives in Enugu East Local Government Area. This shows that the non-use or use of contraceptives by adolescents has no bearing with their level of education. That is, anybody that has the intention and opportunity to use contraceptives can do so irrespective of his/her level of education.

Summary of the Findings

The findings of this study can be summarized as follows:

(i) Majority of female adolescents in Enugu East Local Government Area do not use contraceptives to prevent unwanted pregnancy but they perceived the right age to start engaging in sexual intercourse to be between ages 17-20 (age of maturity).

(ii) Amongst those that use contraceptives, the study found that condom was the most preferred or popular devise.

(iii) Knowledge of contraceptives among female adolescents in the area was fairly reasonable. About 92% of them claimed to be fairly knowledgeable while only 33% categorically asserted that they are not knowledgeable about contraceptives.

(iv) There was also relatively high level of knowledge among adolescents on ways of preventing pregnancy, STDs as well as dangers of casual sex.

(v) The major source of information and knowledge about contraceptives was found to be peers and friends. There is a wide communication gap between adolescents and their parents when it comes to sex and contraceptives due to traditional norms and customs of the area.

(vi) Due to fairly reasonable level of knowledge (rather than exceptional or widespread knowledge) contraceptive use among adolescent was limited or moderate. Not many of them use contraceptive devices even as facts from FGD reveal their early exposure to sexual activities.

(vii) The study also found that contraceptive use among female adolescents is influenced by both socio-cultural and economic factors. In this regard, three key issues of poor knowledge of benefits, patriarchal social system and poverty, in that order, were found to have tremendous influences on contraceptive use in the area.

(viii) Although many female adolescents have accurate knowledge on the subject of sex and contraceptives, such knowledge has not fully translated to safe sex and reproductive health practices. Consequently, this study also found unwanted pregnancy, contracting and spreading of STDs as the adverse consequences of unsafe sexual behaviour of the female adolescents.

(ix) The study found that significant relationship exist between level of knowledge of adolescents on contraceptives and their use of such contraceptives to prevent pregnancies in Enugu East Local Government Area. However, on the contrary, no significant relationship was found between level of educational attainment of adolescents and their use of contraceptives

Conclusion

This study has confirmed that use of contraceptives by female adolescents in Enugu East Local Government Area is stimulated, shaped or predicated upon level of knowledge possessed on the subject by the adolescents and socio-cultural norms of the area. Knowledge about contraceptives is not widespread in the area among adolescents. There is also poor knowledge of benefits, the patriarchal social system and poverty, all of which were found to have tremendous influences on contraceptive use in the area. Parents' denial of sex education to adolescents has done more harm to the adolescents and the society at large.

There is immense need for inculcation of sound morals, proper orientation of adolescents about sex, provision of counseling services and contraceptive education to them. This is with a view to ensure that reproductive health behaviour of the adolescents and their contraceptive use culture can be positively influenced.

Recommendations

The following recommendations are based on the findings of this study,

(i) Family life education should be introduced in families and religious groups for younger children. Such programs help adolescents develop the skills to make informed decisions about engaging in sexual intercourse and contraceptive use.

(ii) Parents should educate their daughters at home on safe sex and contraceptive use. Such education is to counter false information and fantasies created around sexual intercourse by friends and peers at school.

(iii) The media should regularly educate adolescents through programs and advertisements which promote knowledge and use of contraceptives.

(iv) Adolescents should be accorded basic reproductive health service irrespective of their age and marital status. Their tender age should place them on priority list for accessing health care and family planning information as a right.

(v) The government, non-governmental organizations (NGOs) and private sector should provide social support like bursary and unemployment stipend to adolescents in and out of school. This will reduce the harsh effects of poverty on them and the tendency to indulge in sex to make money.

(vi) The federal government should also enforce the policy on girl-child education to a certain level before marriage so as to empower them.

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