

**INTENTION AND DECISION MAKING REGARDING CONTRACEPTION
ACCEPTANCE AMONG TERTIARY SCHOOL ADOLESCENTS IN
BLANTYRE DISTRICT, MALAWI**

Master of Science degree (Reproductive Health : Adolescent RH)

By

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Submitted to Faculty of Nursing, Kamuzu College of Nursing, University of Malawi

in Partial Fulfilment of the Requirements for the Award of Master of Science
Degree in Reproductive Health (Adolescent RH)

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August 2012

DECLARATION

I, Esnath Mwayiwawo Kapito, hereby declare that this thesis is my own original work which has not been submitted to any other institution for similar purposes.

Where other people's work has been used acknowledgements have been made.

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CERTIFICATE OF APPROVAL

The undersigned certify that this thesis represents the student's own work and effort and has been submitted with our approval.



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DEDICATION

To my dear mother, Grace Cecily Kalepa (nee Masoadyera) for her inspiration for advancement in my studies and endless support in form of encouragement and prayers. She is always proud with any achievement I make in life and stands by me which has helped me reach this far. May God bless her with a long and healthy life.

ACKNOWLEDGEMENTS

My first and foremost thanks should go to the Almighty God who has blessed me with the intelligence and wisdom for me to come up with this thesis. He is worthy of praises and honour.

I also appreciate Dr. A. Kazembe, my supervisor for her patience, commitment, inspiration and constructive criticisms throughout the study period which has enabled me to come up with this whole dissertation. I also acknowledge Prof. Kaye Bultmeiere for her encouragement and advice on the study especially during the proposal stage. Let me also express my gratitude to Dr. A. Maluwa for whose guidance and assistance in shaping this thesis cannot be ignored. His time and support has enabled the completion of this thesis.

I would also like to thank the NAC-Global Fund through the Ministry of Health for the scholarship that has helped me to study for this program at Kamuzu College of Nursing. In addition, Kamuzu College of Nursing and all library staff for their support, the availability of the internet for easy search and access to information for the thesis.

I would also like to thank the management of the tertiary schools in Blantyre for accepting me to conduct the study at their institutions. I would also like to thank all the respondents for the openness and trust to share their experiences as regards to contraceptive use among them. In addition, let me thank my data collection assistant, Kennedy Mjojo for his understanding and endurance during the data collection period.

To my husband, Lackson, daughter, Janet and son, Andrew, for their endless support in form of encouragement, endurance and prayers. They had to withstand periods of absence from family matters and their understanding helped me to reach this far.

Lastly, but not least, let me also thank all my colleagues for their moral and academic support throughout the study period. May God bless you all.

ABSTRACT

There is low contraceptive use reported in most of sub-Saharan Africa including Malawi despite adolescents indulging themselves in risky sexual and reproductive health behaviours such as unprotected sexual activities. This study explored intentions and decision making regarding contraceptive acceptance among tertiary school sexually active adolescents in Blantyre district in the southern region of Malawi.

A qualitative basic interpretive design was used for the study involving 18-19 year old male and female adolescents. A purposive sampling was used and a total of 23 (13 female and 10 male) adolescents participated in the study. Data was collected through in-depth interviews using a semi-structured interview guide. Descriptive statistics were computed for demographic data while the qualitative data was analysed by manifest content analysis using verbatim transcription from which categories and themes were created.

Five themes emerged from the data, which included contraceptives information; contraceptive knowledge; attitude towards contraceptive use; consistency in contraceptive use and motivating factors for contraceptive use. Some respondents had positive attitudes towards contraceptive use which were developed from knowledge on the benefits of contraceptives hence avert the negative consequences of sex.

Adolescents reported that they had self efficacy to use condoms. They also admitted to have perceived behaviour control in terms of time, opportunity and resources to use condoms.

While most adolescents in this study were using less effective contraceptive methods, other respondents were not using any contraceptive at all. Use of condoms, withdrawal and calendar methods were well-accepted as compared to the other methods such as the pill, norplant and injectable contraceptives. Contraceptives that require a health facility consultation were unpopular to the adolescents. Lack of adequate and accurate information was found to be a major hindrance to contraceptive use among the respondents. Information gaps were identified in other contraceptive methods except the condom which was found to be the most widely discussed and used among the adolescents.

Religious, cultural and societal beliefs of the respondents held negative attitudes on premarital sex and consequently the use of contraceptives among adolescents. Despite adolescents adopting this negative attitude towards sex, they still indulged in sexual relationships. Rampant misinformation jeopardised the knowledge respondents had consequently hindered contraceptive use as respondents developed negative attitudes towards contraceptives. Respondents lacked details on contraceptives as well as how they are properly used.

There is need for the health educators, teachers, parents and others to reach out to the adolescents with accurate information about sex and contraceptives. Civic education should emphasise the positive aspects of contraceptives to the public in general and particularly adolescents in order to increase their awareness, which can affect the intention to use, and the actual use of contraceptives. Adolescents need to be assisted to have goals in life which can help them focus on their future hence delay pregnancy beyond adolescence.

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ABBREVIATIONS AND ACRONYMS

AIDS :	Acquired Immunodeficiency Syndrome
HIV :	Human Immunodeficiency virus
ICPD :	International Conference on Population and Development
MDG :	Millennium Development Goal
MDHS:	Malawi Demographic and Health Survey
MICS :	Multiple Indicator Cluster Survey
MOH :	Ministry of Health
NSO :	National Statistical Office
SRHR :	Sexual and Reproductive Health and Rights
STI :	Sexually Transmitted Infections
TPB :	Theory of Planned Behaviour
TRA :	Theory of Reasoned Action
UK :	United Kingdom
UN :	United Nations
UNFPA:	United Nations Population Funds
UNESCO:	United Nations Educational Scientific and Cultural Organisation
UNICEF:	United Nations Children’s Fund
USA/US:	United States of America
VCT :	Voluntary Counselling and Testing
WHO :	World Health Organization
YFHS :	Youth Friendly Health Services

GLOSSARY OF TERMS

Adolescents: are young people, female or male, aged 10-19 years.

Adolescence is defined as the stage of life during which individuals reach sexual maturity; it is the period of transition from puberty to maturity.

Youths: youths are all young people female or male from age 14-25 years

Young Adolescents: are adolescents aged 10-14years (WHO, 2003)

Old Adolescents: are adolescents aged 15-19years WHO, 2003)

Reproductive health: reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.

Youth Friendly services: these are services with high quality services that are attractive, affordable, appropriate and acceptable to youths.

Self-efficacy: Self-efficacy is defined as confidence in one's ability to exhibit the motivation and capability to achieve a given goal (Bandura, 1986).

Sexually active: an individual is considered sexually active or experienced if she or he has ever had heterosexual intercourse at least once in their lifetime.

Condom use self-efficacy: Condom use self-efficacy is defined as the belief that one is both capable of and likely to use condoms in sexual situations

Note: Although adolescent are defined as young people age 10-19years, in order to avoid monotony, different terms such as adolescents, youths and young people are used in this study. All meant to refer to people aged 10-19 years.

CHAPTER ONE

Introduction and background information

Introduction

Maternal morbidity and mortality remain one of the most devastating reproductive health problems in resource-limited settings. About 15% of total maternal deaths worldwide and 26% in Africa occur among adolescents (WHO, 2009). In low and middle-income countries, complications from pregnancy, childbirth and unsafe abortions are the leading causes of death among young women aged 15-19 and their maternal deaths are twice as high as for older women (Gribble, 2010).

Adolescent births in Malawi are higher than statistics for Africa. There are 193 births in Malawi as compared to 188 per 1,000 births in Africa among adolescents aged 15-19 years (Khunga, 2011). Early childbirth contributes to population momentum when there is a high concentration of people in their childbearing years. According to WHO (2009), other consequences of unintended pregnancies and early childbirth include school interruption, unsafe abortion accounting to 2.5 million adolescents aged 15-19 every year and complications of pregnancy and childbirth accounting for 23% of the overall disease burden. These complications include pre-eclampsia, severe anaemia, obstructed and prolonged labour, vesicovaginal fistula, infections, malaria, preterm labour and delivery, low birth weight, asphyxia, perinatal and infant mortality, and maternal death. Therefore, adolescent pregnancy contributes to the cycle of maternal deaths (WHO, 2009).

Family planning, however, is one of the initiatives that have proved to reduce maternal morbidity and mortality both directly and indirectly. High level of contraceptive use reduces the total fertility rate and high risk births especially high risk parity among young adolescents hence reducing the maternal mortality ratio. Additionally, contraceptive services can help reduce the volume of unplanned births and improve pre-conceptual health (Tsui, McDonald-Mosley & Burke, 2010). Reduction in the total fertility rate in developing countries from 1990 to 2005 led to a 15% decrease in maternal mortality rate in these countries (Stover & Ross, 2010).

The International Conference Population and Development (ICPD, 1994) which engrossed governments from around the world endorsed the need to promote and protect the rights of adolescents to reproductive health information and care. One of the actions was the need to place quality and voluntary family planning in the context of a much broader approach for women of all age groups. The ICPD called on governments to make information and services accessible to young people on sexuality so that they protect themselves from unwanted pregnancies. Hence adolescent reproductive health and rights call for the need for them to have a satisfying and safe sex life and the freedom to have children only, when they decide (United Nations, 1994).

In the same vein, the International Community has prioritised reducing maternal mortality through their commitment to the Millennium Development Goals (MDGs). With global attention focused on the Millennium Development Goals, countries that recognise the importance of healthy young adults have also a better chance of reaching their targets. That is, programs which are aimed at helping the youth achieve their potential will also help nations achieve Goal number 3 (promoting gender equality and empowering women), Goal number 4 (reducing child mortality), Goal number 5

(improving maternal health) and Goal number 6 (combating HIV/AIDS, malaria, and other diseases (Gribble, 2010).

In Malawi existing policies, guidelines and programs favour the provision of health promotion information and services to the youth. These include the National Population Policy, National Sexual and Reproductive Health and Rights (SRHR) Policy, National Reproductive Health Strategy and National Family Planning Policy and Contraceptive Guidelines and the Youth Friendly Health Services (YFHS) initiative. All these efforts promote the participation of adolescents in making decisions about healthcare. That is, the youth have the right to make appropriate decisions about their health care hence develop healthy behaviours.

The YFHS assessment in several districts of Malawi found that a wide-range of sexual and reproductive health services are offered to adolescents including information and distribution of contraceptives (Ministry of Health (MOH), 1999). However, a study done in Malawi, Burkina Faso, Ghana and Uganda several years later still revealed low contraceptive use by adolescents who are sexually active (Biddlecom, Munthali, Singh, & Woog, 2007). In addition to that, Wittenberg et al. (2007) reported that among the 63% of young women who had given birth before 20 years, 18% did not want to have a child that time and 15% did not want to have a child at all. This denotes that these adolescents had unwanted pregnancies.

The decision to use contraception or not among adolescents is complex. This is largely because sexual activity often precedes the ability to make responsible sexual decisions (Holcomb, Williams & Skipper, 2009; Godeau, Gabhainn, Vignes, Ross, Boyce & Todd, 2008). Malawian adolescents start sexual intercourse by 12 years with most of the girls by 19 years of age (Munthali, Moore, Konyani & Zakeyo, 2006). Despite pre-marital sex among the adolescents, the use of contraceptives including

condoms is low (Munthali, Chimbiri & Zulu, 2004). In cases where adolescents use contraceptives, consistent and correct use of any contraception remains a challenge for most adolescents (Cleland, Bernstein, Ezeh, Faundes, Glasier & Innis, 2006; Munthali et al, 2006). As such, female adolescents have the greater risk for unintended pregnancies than their older counterparts (Holcomb et al, 2009).

There was need to understand how adolescents make sexual and reproductive decisions that may, or may not, prevent them from experiencing unplanned pregnancies and early childbearing. This is because adolescence is marked by period of developing greater autonomy and adolescents encounter more choices that they have to make independently (Brockman & Russel, 2009). The choices that adolescents make are manifested by remarkable changes in behaviour. Not much was known in Malawi on adolescents' decision making as regards to the reproductive health behaviours especially on use of contraceptives. Hence this study tries to gain a deeper understanding on the factors that influence adolescents' decision making to use or not to use contraceptives.

Background to the study

Currently there are 1.2 billion youths in the world which translates to one in every five adults. 85% of these youth live in the developing world. Globally, adolescents currently reach sexual maturity and are often sexually active at an earlier age than in the past (Pera & van Tonder, 2005). The result is the increased number of unintended pregnancies and births. In fact, more than 70% of unmarried adolescents aged 15-19 experience unwanted pregnancies and an estimated 14 million young women aged 15-19 years gave birth each year between 1995 and 2000, with 12.8 million births occurring in developing countries (WHO, 2007). Nearly 70% of young women in sub-

Saharan Africa, Southeast Asia and South central Asia have unmet need for contraception (Barroso, 2010).

However, adolescence can be stressful and difficult since it is characterised by rapid physical growth, reproductive maturity and psychosocial advancement. During this vulnerable transition period, adolescents are expected to make responsible reproductive and sexual health decisions (Neinstein, Gordon, Katzman, Rosen Woods, 2008). These decisions include whether or not to engage themselves in sexual relationships and/ or to use contraceptives. During this period, adolescents are potentially at risk of unintended pregnancy as they indulge in sexual experimentation which is usually unprotected (Wittenberg et al, 2007). Hence, adolescents who are sexually active may not use contraceptives. Yet, most sexually active male and female adolescents do not want to have children because they are in school, too young or not married, and therefore are prone to the risk of unintended pregnancy, unless they are using an effective method of contraception (Bankole, Ahmed, Neema, Ouedraogo, & Konyani, 2007).

The risks and negative consequences of adolescent sexual intercourse are of national concern. Adolescents face the risk of unintended pregnancies which lead to premarital births or unsafe abortions. A range of factors influence aspects of adolescents' sexual behaviour such as the initiation of sex, type and number of partners and the use of any form of contraception. Early sexual activity, particularly when associated with inconsistent use or non-use of contraception, has serious short and long-term health-compromising consequences because it happens before young people are developmentally equipped to handle the consequences (Godeau et al, 2008).

Adolescent fertility regulation through family planning is a major intervention which is designed to reduce unwanted pregnancy (Center for Reproductive Rights,

2010). Health benefits of family planning to the individual woman include reducing exposure to unwanted pregnancy, pregnancy complications, unsafe abortions, childbirth complications, and some cancers (Antarsh, 2004). Family planning is also critical to reduce poverty, maternal and child mortality as well as to empower women to choose when and with whom to have children (Cleland et al, 2006). As a result of contraception use, young women have the opportunity to pursue educational and professional goals hence they attain high education and have better job prospects that enhance their economic well-being. Therefore the quality of life of adolescents is improved by use of contraceptives.

Adolescent sexual decision-making is a complex issue that has received much attention in the literature (Commendador, 2010). It has been documented that decision making requires positive self-esteem, problem-solving, and reasoning skills which serve as probable protective factors for a variety of adolescent risk behaviours, including sexual activity (Goodson, Buhi, & Dunsmore, 2006). Felton and Bartoces (2002) also found that lower levels of problem-solving skills, health-promoting behaviours, and education were all possible predictors of early intercourse.

However, it is difficult to understand how adolescents make decisions about sexual activity and the use of contraception. Several views suggest that adolescents make decisions differently than adults. Steinberg (2005) proposes that adolescents evaluate possible consequences from their actions differently than adults do, resulting in more risky decisions with adverse outcomes.

Adolescents, for instance, differ from adults in their perception of and attitude toward risk. Adolescents and young adults take more risks with health than do older adults by engaging in unprotected sex (Scott, Reppucci & Wooland, 1995) which may result in unintended pregnancies and contraction of sexually transmitted infections

including HIV. In addition, Kibombo, Neema and Ahmed (2007) found a positive association between perceived risk and sexual behaviour among male adolescents. Thus despite perceiving themselves to be at moderate risk for HIV, they still engaged in such high risk behaviours as having unprotected sex.

Gage (1998) states that the physiological changes occurring in adolescence contribute to increased sexual motivation. Weinberger et al, (2005) propose that immature frontal lobes of the brains of adolescents contribute to poor decision making, in relation to estimating frequencies and probabilities. Adolescents may calculate differently the probability or magnitude of a given risk. For instance, adolescents may be less willing to risk disfiguring side effects of a medical treatment regime due to concerns about body image and peer approval.

In fact, as adolescents go through adolescence, they are susceptible to peer pressure. Often, adolescents consider what peers are doing and thinking as well as what is accepted to be strong motivators related to engaging in sexual activity. Peer pressure seems to outweigh adolescents' perceptions about the opinions of parents and of other family members.

In resource-rich countries, such as the United States of America, contraception use by adolescents was found to be the cause of decline in rates of teenage pregnancy, teenage childbirths and abortions from the early 1990s. However, after 2003, there was a reversal in contraceptive use especially condoms which led to an upsurge of these rates from 2006 (Santielli, 2009). In her analysis of the same trends, Tanne (2010) attributed the increase in teenage pregnancy to the U.S government policy of abstinence only sex education. Hence contraception use by adolescents helps young people plan their lives and avoid accidental pregnancies.

Malawi has poor indicators for reproductive health. According to MDHS (2010), the total fertility rate is at 5.7 while the contraceptive prevalence rate is 35% and the maternal mortality ratio is 675 per 100,000 live births (NSO, 2011). The unmet need for contraception is 28% and there is a high prevalence of unintended pregnancy which is at 35%. For Malawian adolescents aged 15-19 years, the fertility rate in 1999-2000 was 160 per 1,000 adolescents (UN, 2002 cited by WHO, 2007). In addition, the contraceptive prevalence rate for girls aged 15-19 is 29% (NSO, 2011).

Adolescent fertility and sexual activity is a major public health issue in Malawi where adolescents constitute more than one-fifth of the population. Sexual activity begins early, with 14 % of girls and 26% of boys aged 15-19 years having had sexual intercourse before 15 years (NSO, 2011) and 65% being sexually active before 18 years (Munthali et al, 2006). Additionally, 67.9% of adolescents begin childbearing by 19 years (MICS, 2006). The gap between the first sexual intercourse and first marriage is widening due to declining age at menarche and the currently rising educational needs (Lema, Mpanga & Makanani, 2002).

Nevertheless, this study revealed more factors that affect Malawian adolescents' decision making to use contraceptives or not. The study considered the contextual determinants to the choices adolescents make. Therefore, this study discovered how the adolescents reach a decision to use or not to use contraceptives.

Problem statement

More than 70% of adolescents in Malawi do not use any contraception at first sexual intercourse (Munthali et al 2006). This is in spite of the youth having high knowledge on the availability of contraceptives and their role in protecting against unwanted pregnancy.

In fact, evidence shows that nearly 90% of 15-19 year old adolescents approve of family planning, but most of those who are sexually active do not use contraceptives (Lema et al, 2002, Munthali et al, 2004). And, according to The Allan Guttmacher Institute (2005), only 15% of female adolescents and 31% of male adolescents are currently using any modern method of contraception. This translates into a remarkably high unmet need for contraceptives for Malawian adolescents.

Little is known on the factors that influence adolescents' decision to use or not to use contraceptives in Malawi. Munthali et al, (2006) reported that adolescents did not mention lack of access to contraceptives as a primary reason for not using them; rather, the respondents had vague information such as regretting not using contraception at their sexual debut experience. Hence there was need to understand and address the reasons for not accessing or using contraceptives by adolescents. This study aimed at exploring factors that influence adolescents' decision making regarding their contraceptive practices in their sexual life.

Brief introduction to the Conceptual framework for the study

The study was guided by the Theory of Planned Behaviour (TPB) which was developed by Icek Ajzen in 1985. This theory has several components but the ones that have been used in the study were attitudes towards behaviour, normative beliefs and subjective norms, perceived susceptibility, perceived behavioural control, behavioural intention and behaviour.

Attitudes toward behaviour.

These are the adolescents' impression of contraceptive use as well as what they value in life.

Normative beliefs and subjective norms.

These are the adolescents' perceptions of beliefs on contraception use of important people in their lives as well as the presence of societal, cultural and religious influence in their behaviours (use or non-use of contraceptives).

Perceived susceptibility.

This is the perception of risk and susceptibility of the adolescents to consequences of unprotected sexual intercourse. The study will explore adolescents' perception of risk to unwanted pregnancy.

Perceived behaviour control.

This is the adolescents' perceived ease or difficulty of using contraceptives.

Behaviour intention.

The study seeks to unveil the adolescent willingness to use contraceptives or not. This usually results from the attitudes, normative beliefs, subjective norms, perceived susceptibility and perceived behaviour control.

Behaviour.

This is the actual utilisation of contraceptives or not and may be based on the behaviour control or behaviour intention.

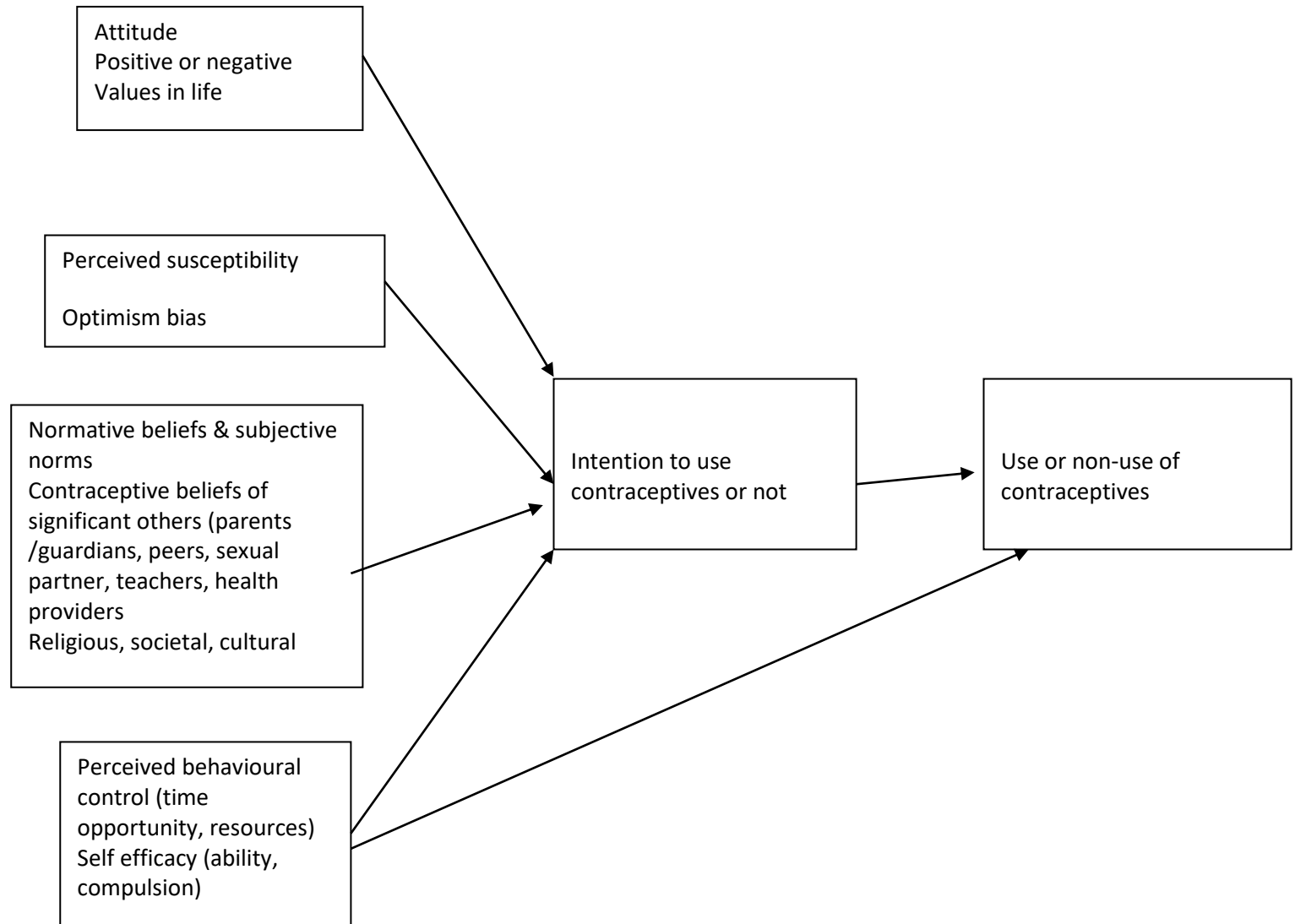


Figure 1: A diagrammatic modification of the theory of planned behaviour to the study

Aim of study

To explore adolescents' intention and decision making regarding contraceptives acceptance among tertiary school sexually active adolescents.

The specific objectives

The specific objectives were to;

- Identify the adolescents' attitudes toward contraceptive use.
- Establish adolescents' normative beliefs and subjective norms regarding contraceptive use.
- Determine adolescents' perception of risk to unwanted pregnancy.
- Describe adolescents' perceived ability to use contraceptives.

Significance of study

Family planning, which includes contraceptive use, is the long-term strategy for reducing maternal disease burden and mortality. Currently, contraception use is repositioned as the key strategy for achievement of targets for both Millennium Development Goals (MDGs) and Malawi Growth and Development Strategy (MGDS) (Government of Malawi, 2007). Hence this study unveiled the factors that influence adolescent decision making to use or not to use contraceptives. This will guide policy and development, or improvement, of strategies which aimed at finding solutions to factors that do not favour, and strengthening those that promote, contraception use. In other words, this study will result in improved interventions that will promote contraception use among adolescents hence reduce the prevalence of teenage pregnancy and its effects. Consequently, this will enhance the reproductive health of adolescents and help accomplish MDG 5b which aims at achieving universal access to reproductive health.

Conclusion

This chapter has put the study into perspective by describing the background to the study, the study problem, the aim of the study and its objectives, and the significance of the study. The use of contraceptives among adolescents is low and more than 70% of adolescents in Malawi do not use any contraception at first intercourse. There is need to unveil adolescents' intention and decision making regarding contraceptive acceptance among the adolescents. This information will assist in the development and improvement of strategies that promote contraceptive use among adolescents.

CHAPTER TWO

Literature Review

Introduction

This chapter presents a review of literature related to factors that influence adolescent decision making to use or not to use contraceptives. Specifically the review covers adolescent sexuality and the use of contraceptives, socio-cultural issues around contraceptive use and the attitudes of adolescents' use of contraceptives. The Theory of Planned Behaviour (TPB) which guided the study will be described in terms of its application in the decision making process towards the acceptance of contraceptives among adolescents.

An integrative literature search was conducted to find quality studies and articles relevant to intention and decision making regarding contraceptive use among adolescents. An integrative approach to literature review serves many purposes including the check of evidence existing in the topic of interest. Whitemore and Knaff (2005) acknowledge that integrative literature review allows for simultaneous inclusion of experimental, non-experimental research as well as theoretical and empirical literature.

Several databases were used to search for primary research articles to ensure comprehensive literature search such as in the Cumulative Index of Nursing and Allied Health literature (CINAHL), PubMed and World Health Organisation websites. Additionally, publications from various National Health Surveys and other reports were manually searched from Kamuzu College of Nursing and College of Medicine libraries. Keywords of integration for search were adolescent decision making; adolescent contraceptive use; adolescent contraceptive decision making; adolescent intention to use contraceptives; adolescent contraceptive attitude; adolescent

contraceptive self-efficacy and adolescent contraceptive normative beliefs. Peer reviewed articles were selected from 2000 to date to ensure quality articles for the study and sound scientific evidence relevant to the current practice.

Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB), which was developed by Ajzen in 1985, guided the study. It is an extension of the Theory of Reasoned Action (TRA) which was developed in 1967 by Fishbein and Ajzen. The theory of planned behaviour is a cognitive–affective theory from social psychology that focuses on the role of attitudes, subjective norms, and perceived behavioural control on behaviour. Behavioural beliefs underlie attitudes toward the behaviour, normative beliefs underlie subjective norms, and control beliefs underlie perceived behavioural control.

The theory of planned behaviour is a theory which predicts deliberate or intended behaviour. As a decision making theory, it is one of the most predictive persuasion theories. Before engaging or not engaging in specific behaviours, individuals give careful and deliberate consideration to the information available and then decide about their behaviour.

Several studies and research reviews have confirmed the predictive utility of the TPB in the domain of health behaviour in terms of both intent for the behaviour and the behaviour itself. Fekadu and Kraft (2001) supported the validity of the TPB in predicting intended contraception in female adolescents in the Ethiopian cultural setting. A narrative review of the TPB as predictor of condom use proved the theory as useful in predicting both intentions to use condoms and actual condom use (Bennet & Bozionelos, 2000).

The TPB fitted perfectly in this study because contraceptive use is a deliberate or planned behaviour. It can be applied to studies of the relations among beliefs,

attitudes, behavioural intentions and behaviours in various fields such as healthcare. The decision making process in adolescents may incorporate such components as beliefs and attitudes which can lead to behavioural intentions which may later be manifested in behaviour.

Background of the TPB model.

In order to explain the TPB, the TRA will be described briefly. According to the TRA, there is a high correlation of attitudes and subjective norms to behavioural intention, and subsequently to behaviour. That is, one is more likely to perform a behaviour if they have high intention to perform such behaviour. The behavioural intention is achieved when they think positively of the behaviour (attitude) and feel that their significant others would want them to perform the behaviour (subjective norm). However, it was observed that behavioural intention do not always lead to actual behaviour because of circumstantial limitations. Hence, Ajzen introduced the Theory of Planned Behaviour by adding a new component, “perceived behavioural control.” By this, he extended the Theory of Reasoned Action to cover volitional behaviours for predicting behavioural intention and actual behaviour (Ajzen, 2005 cited by Polit & Beck, 2010).

Key concepts in the TPB and their application to this study.

The key concepts in TPB are behavioural beliefs which lead to attitude towards behaviour, normative beliefs and subjective norms, control beliefs and perceived behaviour control and behavioural intentions which lead to behaviour.

Behavioural beliefs and attitude toward behaviour.

Behavioural belief is an individual’s belief about consequences of particular behaviour. The concept is based on the subjective probability that the behaviour will produce a given outcome. The behavioural belief in this study will be the adolescents’

belief about the consequences of indulging in protected or unprotected sexual activity in relation to contraceptive use.

Attitude toward behaviour is an individual's positive or negative evaluation of self-performance of the particular behaviour. The concept is the degree to which performance of the behaviour is positively or negatively valued. It is determined by the total set of accessible behavioural beliefs linking the behaviour to various outcomes and other attributes. In this study the adolescents' positive or negative evaluation of sexual behaviour will be explored in relation to the outcomes. In addition to that, the study will explore what adolescents value in life.

Normative beliefs and subjective norms.

Normative belief is an individual's perception about the particular behaviour, which is influenced by the judgment of significant others. Significant others are those people whose opinions are important to the adolescents. The study will explore adolescents' perception of contraceptive use related to the beliefs of the important people in their lives such as parents or guardians, boyfriends or girlfriends, peers, teachers as well as healthcare providers. This will address the research question on who influences adolescents' decision to use contraceptives or not.

Subjective norm denotes an individual's perception of social normative pressures, or relevant others' beliefs that he or she should or should not perform such behaviour. The social normative pressures in this study include societal, cultural and religious beliefs on the use of contraception in general or among adolescents in particular. This concept will address the sociocultural issues surrounding adolescent contraceptive use.

Control beliefs and perceived behavioural control.

Perceived behavioural control signifies an individual's perceived ease or difficulty of performing the particular behaviour (Ajzen, 1988 cited by Polit & Beck, 2010). It

is assumed that perceived behavioural control is determined by the total set of accessible control beliefs. The concept of perceived behavioural control is conceptually related to self-efficacy. That is, how easy or difficult it is for him or her to perform the behaviour. This study will explore the adolescents' perceived capability to use or not use contraceptives.

Control beliefs include an individual's beliefs about the presence of factors that may facilitate or impede performance of the behaviour (Ajzen, 2001). The TPB acknowledges that there are other behaviours that are not under complete volitional control. That is, in addition to the person's decision, the performances of other behaviours depend on time, resources and opportunities that are available. In this study, this includes some pertinent issues that can facilitate or hinder adolescents' decision to use or not use contraceptives. For instance, the perceived power of each one of the factors believed to be necessary to inhibit or facilitate the use of contraceptives. In other words, the adolescents' perceived likelihood of having the means and the opportunity to use contraceptives.

Behavioural intention and behaviour.

Behavioural intention refers to an indication of an individual's readiness to perform a given behaviour. It is assumed to be immediate antecedent of behaviour (Ajzen, 2002b). It is based on attitude toward the behaviour, subjective norms, and perceived behavioural control, with each predictor weighted for its importance in relation to the behaviour and population of interest. At this stage the adolescent is willing to make a decision to use contraceptive or not. The decision will depend on several factors such as his or her perception on the consequences of indulging in unprotected sexual intercourse and what she or he values in life. In addition, she or he will take into consideration what his or her significant others' preferences are and what

action she or he thinks they would support. The decision will also depend on whether she or he feels she has the ability and compulsion or availability of time, opportunity and resources that enables him or her to use contraceptives.

Behaviour is an individual's observable response in a given situation with respect to a given target. Ajzen stated that behaviour is a function of compatible intentions and perceptions of behavioural control in that perceived behavioural control is expected to moderate the effect of intention on behaviour. Thus, a favourable intention produces the behaviour only when perceived behavioural control is strong. This is the actual execution of the intended behaviour. In this study, behaviour is the actual utilisation of contraceptives or not.

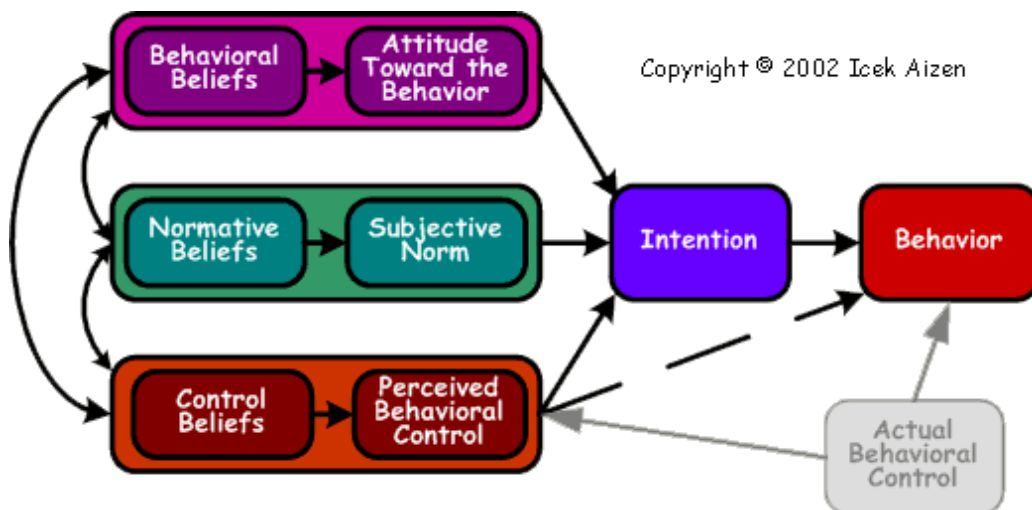


Figure 2. The theory of planned behaviour. Source: Icek Ajzen, 2002b

Additional components to the theory of planned behaviour.

Several components have been introduced to the TPB as additional determinants of behavioural intention. These include perceived moral obligation, self-identity, past behaviour and habit, affect, knowledge and perceived susceptibility. This study will only use perceived moral obligation, affect, knowledge and perceived susceptibility.

Following is the brief description and application of additional determinants of behavioural intention to the study;

Perceived moral obligation.

Perceived moral obligation refers to the person's personal beliefs about right and wrong. In this study, the adolescents' moral obligation will be explored in relation to contraceptive use.

Affect.

The intention to perform a behaviour may be affected by the person's anticipated pleasant or unpleasant reactions associated with the performance or non-performance of the behaviour. The adolescents' affect will be explored in this study as regards to their pleasant or unpleasant reactions towards contraceptive use.

Knowledge.

There is a significant relationship between the level of knowledge and the intention to engage in the behaviour. During the study the knowledge of contraception by the adolescents may determine their intention to use contraceptives and later its utilisation.

Perceived susceptibility.

Personal perception of risk and susceptibility is an important predictor for intention to behave. Adolescents usually have optimism bias which is referred to as the tendency to consider self at less risk than the average person (Johnson & Green, 1993). This may affect the intention to use contraceptives in adolescents.

Adolescent sexuality and use of contraceptives

The risks and negative consequences of adolescent sexual intercourse are of national concern. Adolescents face the risk of unintended pregnancies which end up with premarital births or unsafe abortions. A range of factors influence aspects of adolescents' sexual behaviour such as the initiation of sex, type and number of partners and the use of any form of contraception. Early sexual activity, particularly when associated with inconsistent use or non-use of contraception, has serious short and long-term health-compromising consequences because it happens before young people are developmentally equipped to handle the consequences (Godeau et al, 2008). For instance, Juarez and LeGrand (2005) found that 54% of boys in their study declared that they had had their first sexual intercourse between the ages of nine and 17. Despite their general awareness of HIV, they rarely used condoms, especially at ages younger than 15. This could be attributed to lack of adequate information on sexual and contraceptive issues.

The decline in adolescent pregnancies in the US from 1995 to 2002 was largely attributed to increased contraceptive use (77%) as compared to decreased sexual activity (23%) (Santielli, Lindberg, Finer, & Singh, 2007). Studies done on how adolescents make their decisions to use contraceptives in several countries worldwide have indicated several factors that play a role. For instance, in the United States of America a study by Ogle, Glasier and Riley (2008) found out that personal factors and social influences operate to influence contraceptive intentions among sexually inexperienced adolescents.

While adolescents in developing countries have steadily increased their use of condoms and contraception over the past 20 years, a significant number still does use contraceptive methods effectively or consistently. For instance in Africa Sahel (Chad,

Eriteria, Mali, Niger, Senegal, Namibia and Nigeria), most recent studies show a contraceptive prevalence of 20-40 % among adolescents. However, a greater portion of adolescents discontinue using contraceptives within a year of initiating and between 85 and 95 percent of sexually active adolescent women who use no method become pregnant within one year of initiating intercourse (Blanc, Tsui, Croft & Trevit, 2009). Therefore, there is need to understand how adolescents make decisions to use or not to use contraceptives for effective interventions.

Some studies have examined factors associated with adolescent decision making on contraceptive use. Findings from a cross sectional study on 98 female adolescents in Hawaii by Commendador (2007), which examined the relationship between female adolescents' self esteem, decision making and contraceptive behaviour, revealed an association between maladaptive decision making in sexually active female adolescents and the use of contraceptives. Those adolescents with higher maladaptive scores were less likely to use contraception but self-esteem did not influence adolescent contraceptive behaviour. However, other factors that influence adolescent decision making such as attitudes and sociocultural beliefs were not examined. Hence this study aims to explore decision making on contraceptive use among adolescents.

Normative beliefs and subjective norms affecting adolescent contraceptive use

These are the beliefs pertaining to significant people in adolescents' lives and sociocultural influences on contraceptive use among the adolescents. Several studies have been done on sociocultural influences on adolescent decision making on contraceptive use. Variables that have been studied include parental communication, support from parents, partners and friends, individual and family background.

A study done in sub-Saharan Africa found other important social predictors of consistent condom use such as residence, education, living arrangement and exposure

to mass media such as the radio and newspaper. The proportion of adolescents reporting consistent use of condoms in the 3 months preceding the survey was 47% in Ghana, 38% in Bukina Faso, 36% in Uganda and 20% in Malawi. The major determinant of consistent use of condoms was age difference between partners, with young men whose partner was 0-4 years younger were about two and a half times more likely to use condoms consistently than those whose partner was 5-9 years younger (Bankole et al, 2007). However, the data did not provide details on how these factors influenced consistent or inconsistent use of condoms.

Social support and communication with significant others on adolescent contraception has been studied in some communities. In a prospective cohort study in USA, of 399 female adolescents who attended contraception clinics, Harper, Callegari, Raine, Blum & Darney (2004) found that almost all adolescents (96%) reported that they communicated to their mother, a male partner or a friend of their visit. Of these, 92-96% also said that they had support from their mother or a male partner. Those adolescents who were on more effective and long acting methods, such as the pill and implants respectively, reported that their mothers were supportive. But those adolescents who were engaged in high risk behaviours were more likely than others to involve their friends rather than their mother or a male partner in their contraceptive decision making.

Similarly, Halpern-Felsher, Kropp, Boyer, Tschann, and Ellen (2004) reported that adolescents whose parents talk with them about sexual issues are more likely to delay sexual onset. When sexually active, they are more likely to use contraceptives including condoms, and they have fewer sexual partners than those adolescents for whom this communication does not occur. Thus, sexually active adolescents who reported being able to discuss sex were more likely to have safer sex. Particularly,

reports of being able to communicate with peers about sex played a role in male and female adolescents' use of condoms. The ability to communicate with parents about these issues was also found to be important for sexually experienced male adolescents' condom use.

Furthermore, Juarez & LeGrand, (2005) concluded that sustained family involvement in guiding boys is associated with later first intercourse and an increased use of condoms. In their study findings, boys who described themselves as shy with girls had later first intercourse, although the probability of their using condoms did not differ from that of other boys of their age. High socioeconomic status led to early sexual activity for boys (in contrast with girls), but also to a greater likelihood of using condoms during first intercourse. Hence, involving boys in decision making may promote contraceptive use in adolescent relationships.

In a literature search on 35 studies and 15 scholarly papers by Commendador (2010), it was found that there is an association between parental communication, parenting style and adolescent sexual activity and contraceptive use. Maternal communication has been shown to delay sexual intercourse and increase contraceptive use. Furthermore, Ryan, Franzetta, Manlove & Holcombe (2007) found that 53% of female and 45% of male adolescents in the USA discussed contraception and STIs before having first sex. The greater respondents perceived condom knowledge and the greater their communication with their parents about everyday life, the higher the odds of discussing contraception or STIs before first sex. In the study, being black was positively associated with sexual communication before first sex. However, the depth of the discussion was not explored given the methodology used in the study.

On the other hand, some qualitative studies were reviewed on family communication on adolescent contraceptive use. For instance, Akers, Schwarz,

Borrero & Corbie-Smith, (2010) assessed family communication on contraceptive use and family planning among black American parents and adolescents. Their data showed that parents more often reported helping male adolescents get condoms than helping females get contraceptives. However, the discussions between parents and adolescents were indirect and mostly focused on the negative consequences of sex. Additionally, contraceptive knowledge in the parents was low in terms of the range of available methods, risks, side effects and how to use them. This implied provision of insufficient information to adolescents as well as lack of confidence in the parents which could contribute to the indirect conversations on contraceptives.

Furthermore, a qualitative study on mother-daughter dyads explored ecological influences of sexuality among the African-American adolescents in the USA. Aronowitz, Rennels and Todd (2006) reported findings from focus group discussions among 11 to 14 year old female adolescents and their mothers which were conducted separately. They found that the sociocultural factors such as exposure and support systems influence adolescents decisions to indulge in sexual activities or not. That is, apart from peer and family processes, community factors such as the media, neighbourhood and exposure to formal and informal sex education played a major role in their sexuality status. Thus, these existing systems could enhance the use of contraceptives among adolescents.

Adolescent attitudes towards contraceptive use

One of the important variables that have been studied is adolescent attitudes toward pregnancy. Consideration of how teenagers feel about the prospect of pregnancy is important for understanding their sexual-risk-taking behaviours and for creating and evaluating interventions with the goal of preventing pregnancy among

adolescents. It is believed that attitudes are easier to change than the social and economic conditions in which the attitudes develop.

In their study on adolescent attitudes towards pregnancy and contraceptive use done in USA, Bruckner, Martin and Bearman (2004) found that sexually experienced adolescents' attitudes toward pregnancy do not influence their subsequent risk of pregnancy. Rather, attitudes toward contraception have a strong impact on contraception use and therefore, a strong impact on pregnancy. The factor most strongly associated with the risk of pregnancy among young women is contraceptive use, with non-users being significantly more likely to become pregnant than inconsistent and consistent users. The study found that the more positive respondents' attitude were toward contraceptives, the higher the likelihood that they used them either consistently or inconsistently rather than not using them at all.

Rocca, Hubbard, Johnson-Hanks, Padian, & Minnis, (2010) reported findings of a two year cohort study on 258 and 297 male and female who were mostly Latino adolescents on their attitudes towards pregnancy and actual pregnancy occurrence. Girls experienced 72 pregnancies over two years (six-month cumulative incidence was 8%), and boys reported being responsible for 50 pregnancies (six-month cumulative incidence was 10%). Most pregnancies occurred to those who had expressed no intention or likelihood of pregnancy. For instance, 73% of pregnancies occurred among girls who reported that they definitely did not want to become pregnant.

Similar findings were reported in a cross-sectional study in Kenya whereby in-school adolescents displayed conservative attitudes towards sex and contraceptive use including condoms (Adaji, Warenaus, Ong'any & Faxelid, 2010). This suggests that these adolescents, as is the case for many others, had difficulty controlling their fertility despite having negative attitudes toward teenage pregnancy. Thus,

determining how adolescents feel about pregnancy may not be a straightforward task, as many may hold ambivalent attitudes that are prone to change over time. There is need to understand other factors that may influence how adolescents view the prospect of teenage pregnancy and determinants for contraceptive use. A more exploratory method of qualitative nature could unveil the subtle factors that influence adolescent attitudes toward pregnancy and contraceptive use.

Adolescent perception of risk for unwanted pregnancy

Most adolescents engage in risky sexual activity without protection which predisposes them to many sexual and reproductive health problems including unplanned and unwanted pregnancy (WHO, 2001). There are several factors that contribute to lack of or inconsistent contraceptive use among adolescents. These include issues related to adolescent development such as reluctance to acknowledge one's sexual activity, belief that one is immune from the problems or consequences surrounding sexual intercourse or pregnancy, and denial of the possibility of pregnancy.

In fact, several studies done predominantly in developing nations reveal that most adolescents do not perceive themselves to be at risk of pregnancy despite indulging in unprotected sex. For instance, Martyn, Hutchinson and Martin (2002) studied seventeen 19-26 year old female adolescents from low -income African-American families on how they avoided pregnancy. They found that 5 of the girls were not aware of their sexual risks but were 'lucky' other people in their lives insisted they use contraceptives. Such people included parents, grandparents and partners.

Another study done in South Africa found that some girls thought that if they had multiple partners whom they could alternate regularly, they could not be at risk of pregnancy because the 'blood is different' hence it would take time for the blood of

each sexual partner to get used to each other (Wood & Jewkes, 2006). This denotes that the adolescents had lack of knowledge on the consequences of sexual activity and how conception occurs. Hence they were exposed to the risk for unplanned pregnancy and STIs including HIV.

Similarly, in another study among secondary school adolescents in Nigeria, it was found that 40% of them were sexually active. However, a comparatively high proportion of participants engaged in unprotected sex at last sexual episode (83.4% females and 78.8% males). The reasons for not using contraception were either because they did not consider or feel it was necessary (Otoide, Orosanye & Okonofua, 2001). Thus, lack of contraceptive use exposed them to the risks of pregnancy and STIs.

In the same vein, Orji and Esimai (2005) found that the adolescents did not expect to get pregnant after first sexual experience as one of the reasons for not using contraception. This reduced perception of risk could have been attributed to their source of information which was the peers who are usually ill-informed themselves. The amount and type of information adolescents get from their peers may hinder their perception of risk to pregnancy and STIs.

Similarly, in a study on contraceptive use behaviour among never married young women in China revealed that 73% of them who had never used contraceptives did not realise their risk of getting pregnant. Many respondents relied on their luck to determine the possible outcome of sexual intercourse, or simply did not think about the possibility of getting pregnant. This means that they perceived a low risk of pregnancy and hence ignored the use of contraceptives when they had unprotected sex (Wu, Wang, Raayaji & Good, 2002).

Other study findings indicate that consistent use of contraceptives is nowhere near the required 100% in most countries in sub-Saharan Africa. For instance, Bankole et al, (2007) analysed data from the 2004 National Adolescent Surveys in Burkina Faso, Ghana, Malawi and Uganda and found that consistent use of condoms was 38% in Burkina Faso, 47% in Ghana, 20% in Malawi and 36% in Uganda. Inconsistency in contraceptive use predisposes adolescents to the risk of unintended pregnancy and STIs. Yet, adolescents do not perceive their behaviour as being risky or unsafe.

In another study where data from 45 countries was analysed using quantitative methods, findings indicated that contraceptive use in adolescents was characterised by comparatively short periods of contraceptive use, high contraceptive failure and high total default for other reasons (Blanc et al, 2009). However, details for the reasons for inconsistent behaviour were not available for data analysis. Similarly, in Malawi, half the respondents felt at risk of pregnancy and STIs while the other half did not feel at risk for both the last time they had sex without use of any contraception (Munthali et al, 2006). This predisposes adolescents to unintended pregnancies.

Adolescents' perceived ability to use contraceptives

Four studies were reviewed on adolescents' perceived ability to use contraceptives. Although this concept is not widely studied, to a larger extent, contraceptive use is influenced by a person's perceived ability to use such methods. Wang and Chiou (2008), in a study on the relative contribution of intrapersonal and partner factors to contraceptive behaviour among Taiwanese female adolescents, found that self-efficacy was the most important explanatory variable in influencing contraceptive behaviour. Self-efficacy was positively correlated with contraceptive behaviour. That is, the more the adolescents felt they were able to use contraceptives, the more they used them.

This is similar to previous findings in Taiwan by Wang, Wang and Hsu (2003) who used quantitative methods to explore factors that differentiate sexually experienced teenagers who become pregnant from those who do not. Sexually active adolescents who had never fallen pregnant had significantly higher contraceptive self efficacy scores than pregnant adolescents. As the adolescents' perception to use contraceptives was low, they never used contraceptives hence predisposed themselves to unwanted pregnancy. This implied that poor contraceptive self efficacy contributed to adolescent pregnancy.

Furthermore, a multisite study on condom use self efficacy among 288 sexually active female adolescents aged 13-18 years and their parents in USA utilised audio-assisted computerised interviews. About 35% of the adolescents reported multimethod use of condoms and another method in the previous 3 months before the study. Findings highlighted self efficacy as one of the significant predictors of multimethod use of contraceptives. Adolescents who had condom use self-efficacy were 7% likely to report multi-method contraceptive use which ensure dual protection against STIs/HIV and unintended pregnancies (Lang, Sales, Salazar, DiClemente, Crosby & Brown, 2011). However, the study did not assess the concurrent use of condoms with other contraceptives commonly known as dual method which is advocated for the prevention of STIs and unwanted pregnancy. Furthermore, factors that contributed to the development of their self efficacy towards condoms and other contraceptives were not explored.

Nevertheless, a qualitative study done in Uganda by Nalwadda, Mirembe, Byamugisha and Faxelid (2010) established that young people recounted enabling factors to contraceptive use. The enabling factors could be comparable to self efficacy to contraceptive use. These included secret use of contraceptives by female

participants for fear of male partner opposition and stigma. The fear of pregnancy, abortion complications, early family and responsibility enabled young women and men respectively to use contraceptives. Some young people carried condoms for use in cases of emergency. This indicates the commitment of the respondents to use contraception consistently.

Conclusion

Many studies have been done on contraceptive use by adolescents with few covering factors that influence decision making. However, the majority of the studies used quantitative approaches to collect data such as surveys, cohorts and review of demographic and health surveys and other studies. In addition to that, most of the studies have been done in the USA, and European countries rather than in Africa, let alone Malawi. Furthermore, most studies used female adolescents as participants. It is widely known that more males than female adolescents who initiate sex early have larger proportions of being sexually active and do not use contraceptives. Therefore, this study will explore factors that apply to the context of this country on adolescents (both male and female) decision making regarding the use of contraceptives.

CHAPTER THREE

Research design and Methodology

Introduction

This section describes the study design, setting, sample and sampling method, recruitment process, data collection method and instrument, data analysis, ethical considerations and study limitations.

Research design

A research design is the overall plan for addressing a research question including strategies for enhancing the study's integrity (Polit & Beck, 2010). This study used a descriptive design employing a qualitative method. A qualitative methodology was chosen because it best fits studies on decision making processes (Sharan, 2002; Polit & Beck, 2010). The purpose of qualitative research is to see how respondents in interviews impose order on the flow of experience to make sense of events and actions in their lives (Munhall, 2007). In this study, this design revealed issues surrounding adolescents' decisions to use or not to use contraceptives. Additionally, this methodology allows discovery of ideas that may not be accurately captured using close-ended questions. Sharan (2002) stated that in a basic interpretive qualitative study, the strategy is inductive and the outcome is descriptive.

Research setting

Data collection for this study was done in four tertiary schools in Blantyre district in the southern region of Malawi, three in urban and one in the rural area. The urban tertiary schools were Malawi Institute of Journalism (MIJ), Soche Technical College and Skyway Institute of Management, Research and Development while the rural setting was Mpemba Staff Development Institute. The southern region was chosen because it has the highest proportion of teenagers who have started childbearing, a manifestation of non-use of contraception among the youth. The southern region has 48% of adolescent childbearing as compared to 33% for the northern region and 28% for the central region (Allan Guttmacher Institute, 2005).

Tertiary schools were chosen because more years of schooling are associated with having sexual experiences and consequent use of contraceptives (WHO, 2001). The lower age limit for most tertiary education in Malawi is 16 years. This means that adolescents who were aged 18 and 19 years would be found in these colleges. It is assumed that most of the students in tertiary schools live away from home in college hostels or rented houses close to the institutions. These arrangements weaken parental control and supervision of students' activities. They are often exposed to situations that encourage casual sexual relationships and/ or for financial benefits. As such, they have to take personal important decisions about their social and reproductive lives. These include decisions about sexual activity and contraceptive use.

The study used adolescents from several tertiary schools in order to ensure a sufficient variety in the background characteristics. Urban adolescents are exposed to a more diverse lifestyle which is characterised by exposure to increased social life such as entertainment as well as more information on sexual and reproductive health issues via electronic, print and other forms of media. They may have less parental

influences since most parents are busy with other activities hence less available for their adolescents. These lifestyles may have both positive and negative effects on the sexual and reproductive health of adolescent.

Study population

The study population was in-school adolescents aged from 18 to 19 years old, who are sexually active. This age group was chosen because the median age for sexual debut is 17 years (Munthali et al, 2006). Moreover, the reasoning ability for most adolescents is fully developed by this age (Johnson & Green, 1993).

Sample size

There is no sample size calculation for data collection in qualitative research. An appropriate sample size for a qualitative study is one that adequately answers the research question (Mashal, 1996). In this study the sample size was 30 adolescents; 15 males and 15 females but sample size adequacy was achieved at 23. Data saturation was reached after getting data from 19 participants (11 female and 8 male adolescents) but data collection continued from 4 more participants. Therefore the data was collected from 13 female and 10 male adolescents. Munhall (2007) acknowledges the fact that data saturation determines the sample size adequacy. This means that the sample size may increase or decrease depending on data saturation. According to Burns and Grove (2009) saturation of data occurs when additional sampling provides no new information but only redundancy of previous collected data.

This study included both male and female adolescents in order to balance the factors that influence their decision making. On one hand, male adolescents are widely perceived to need premarital sexual experience and have more power than females in relationships (Jewkes, 2001). In addition to that, male adolescents may not perceive adolescent pregnancy a serious problem because they do not carry the

pregnancy (Munthali et al, 2006) and are sometimes encouraged by the society to assume little responsibility for a pregnancy (Cohen, 2004). Yet, male adolescents play an important role in the prevention of unintended pregnancy.

On the other hand, for female adolescents, pregnancy may be a disaster if it occurs outside marriage and may mean disgrace and lead to expulsion from family and school yet may feel pressurised by male partners to have sex (Lion, Prata & Stewart, 2009). This may confuse them as they have conflicting pressures to remain chaste and to obey their partners hence may have little say in the decision to have sex or to use contraceptives (Kaufman, de Wet & Stadler, 2001). Data from male and female adolescents unveiled important issues that promote or hinder contraceptive use among the youth.

The sampling method

Purposive sampling method was used whereby participants were required to be experientially fit for the study. That is, adolescents who met the criteria and were willing to participate were considered. Munhall (2007) states that qualitative inquiry is deliberately biased hence selection is based on the participants' experiences that fit the research question and their willingness to talk. Patton (2001) further states that "the power of purposive sampling lies in selecting information-rich cases from which one can learn a great deal about issues of central importance of the research" (cited by Watson, McKenna, Cowman & Keady, 2008 p.238).

The inclusion / selection criteria

The inclusion criteria for the study included

- Tertiary in-school adolescents
- aged from 18 to 19 years old
- who were sexually active

- unmarried
- able to communicate either in English or Chichewa
- willing to participate in the study

The exclusion criteria

The exclusion criteria included

- adolescents who are married,
- out of school
- not sexually active
- younger than 18 years old and above 19 years
- not willing to participate in the study
- inability to communicate either in English or Chichewa

The recruitment process

After getting approval from COMREC and permission from the management of the colleges, a focal person was identified from several tertiary schools in Blantyre (either a head teacher, class coordinator or administration officer). The focal persons were briefed about the research and they informed the students about the research including its purpose and potential participants such as those aged 18 to 19 years and willing to participate in the study. The potential participants were asked to give their telephone numbers so that the researcher could contact them for confirmation of their interest to participate in the study and for scheduling of appointments where further information would be provided before the actual interview. This gave them sufficient time to make up their mind to participate in the study or not. The focal persons were not informed of the other inclusion criteria except age in order to avoid sampling bias and for confidentiality. The potential participants were then given different

appointment times so that they should not meet each other during the interviews.

Figure 3 summarises the recruitment process.

The potential participants were asked about sexuality and contraceptive use in the process of data collection. Where the participant was sexually active the interview proceeded to the end without any hiccups. However, when it transpired that the potential participant was not sexually active; the interview did not proceed to the end. Transport reimbursement and some refreshments were provided to all potential participants.

Below is the figure which illustrates the recruitment process.

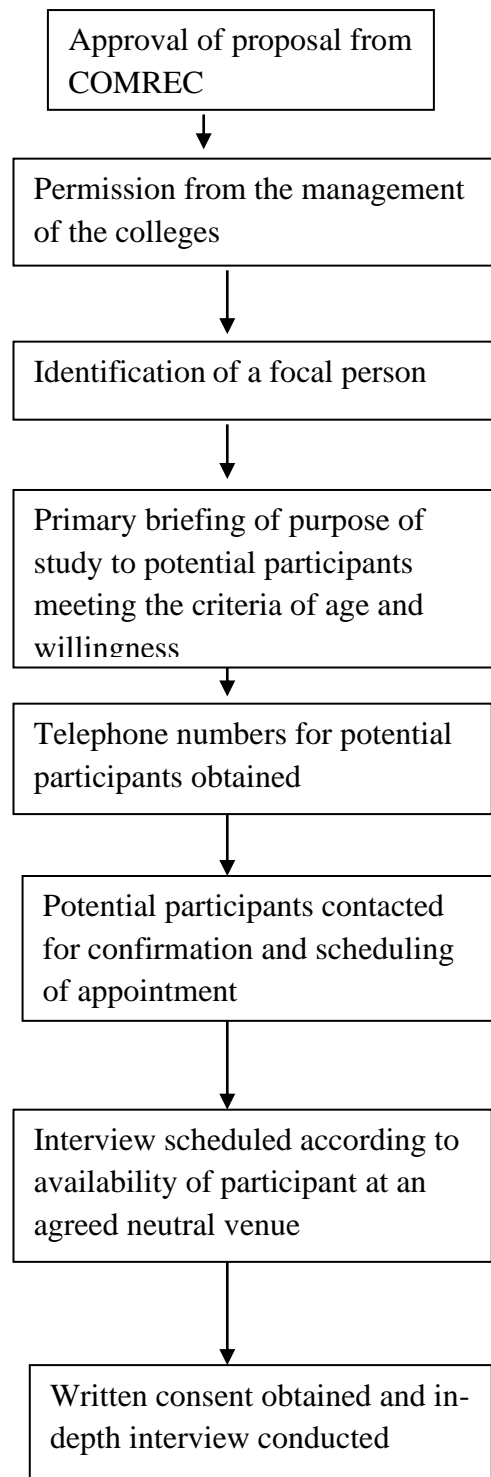


Figure 3: A summary of the recruitment process

Data collection process

Data collection instrument.

An in-depth interview guide was used to collect information from the participants. Several open-ended questions designed by the researcher were used to initiate and guide the interviews in order to extract relevant information from the participants (Appendix E). Open-ended questions were used because they provide flexibility so that the researcher could probe for more information and seek clarity where necessary. The questions aimed at achieving the research goal. The content of the guide was in line with the concepts in the theory of planned behaviour (TPB).

Pilot test was done on adolescents who were in a tertiary school in order to test out the whole process. Pre-test interviews were done in order to test the informed consent materials, find out whether participants would understand the interview questions and to check the process of data collection, analysis and interpretation for accuracy. The pre-test was thorough and this also helped to gauge how long the interview would take to cover the main topics without rushing the participants. Then, revisions were done where necessary before the actual data collection. This also helped the researcher to have an accurate estimation of time needed for interview so that appropriate appointments should be given to participants during the study.

Data collection methods.

This study used semi-structured face-to-face in-depth interviews with the adolescents in order to obtain their real life experiences on how they decided to use or not to use contraception. Data collection was done by the researcher and a data collector who was a second year male nursing student. The researcher (who is female) interviewed the female adolescents while the male nursing student interviewed male adolescents. This was done to enhance openness during the interviews.

The interviews were conducted at a neutral venue at Blantyre Youth Centre for the urban students and the church premises for the rural students. To maximize response rates, the interviewers scheduled data collection for the hours at which the participants were out of classes. A maximum of two interviews were scheduled for the morning and another two for the afternoon during week-ends, while two were scheduled in the afternoon during week days. Data collection was done from March to July, 2011. The interviews lasted between 45 and 120 minutes and were mostly held in Chichewa with a few participants combining with the English language.

Enhancing trustworthiness of the study

Trustworthiness is a process that is used to assess the quality of data and findings (Lincoln and Guba, 1985 cited in Polit & Beck, 2010). This was evaluated based on the scientific rigor criteria used in qualitative methodology. Four criteria proposed for enhancing rigor in qualitative research were used namely credibility, confirmability, dependability and transferability.

Credibility.

According to Polit and Beck (2010) credibility is the criterion for evaluating integrity and quality in qualitative research studies referring to confidence in the truth of the data and their interpretations. It is the internal validity. Credibility was enhanced by keeping notes throughout the data collection period and during the data analysis phase. During the interviews, the researcher established rapport with the respondents so as to allow for the development of trust which enhanced openness throughout data collection process. The interviews were long enough to give the respondents ample time to think and respond to the questions. This ensured substantial and satisfactory responses from the respondents.

The researcher and a research expert independently analysed the data from the interviews and there was 90% agreement between them with respect to the emerging themes and sub-themes. The report included rich and thick descriptions of information from the data in the presentation of results. Additionally, both positive and negative aspects of the issues surrounding the decision making process of adolescents was taken into consideration to avoid bias toward one aspect.

Transferability.

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck, 2010). In this study, transferability of the results was ensured by recruiting a variety of participants from different tertiary schools in Blantyre district. In addition to that, by describing sufficient details of inclusion and exclusion criteria as well as the data collection methods and contexts, consumers can evaluate the applicability of the data to other context. This study produced data that is conceptually, not statistically representative of how adolescents decide to use contraceptives or not. The conclusion from this study may be transferable to other similar contexts.

Confirmability.

Confirmability is the potential congruence between two or more independent people about the data accuracy, relevance and meaning (Polit & Beck, 2010). According to Ulin, Robson, Tolley and McNeill (2002), confirmability requires that the researcher as a co-participant in the enquiry should be able to distinguish his own personal values from those of participants. Thus confirmability is the assurance of objectivity of the study. This was achieved by the review of the findings by the researcher's supervisors and research expert to ensure neutrality. However, follow-up of the respondents to confirm findings was not done due to time limitation.

Dependability.

According to Lincoln and Guba (1985), dependability is the stability (reliability) of data over time and over conditions (Polit & Beck, 2010). Dependability gives another researcher the ability to follow the methods and conclusion of the original researcher. This was achieved by specifying how the participants were selected. The comprehensiveness of the report of this study may give chance of getting similar results if the inquiry were replicated with the same or similar participants and contexts.

Data management

Each interview was monitored and audiotaped by the interviewers. Notes were also taken to record any other observations, such as tone of voice or facial expression or where participant did not want to be audiotaped. Taking note of the non-verbal data can affect how the interviews are interpreted. The interviews were transcribed verbatim by the researcher as soon as possible after the interview. Ulin et al (2002) suggest that audiotapes should be transcribed as early as possible in order not to miss subtle, non-verbal points and give timely opportunity for the researcher to clarify ambiguities, investigate new leads and follow-up emerging issues. The transcripts were translated from Chichewa into English and thereafter examined for accuracy by an independent person to ensure back interpretation validation.

The researcher assigned identification codes to all individual records including audiotapes, transcripts and any other data. Documents would then be stored in a secure location with access only by the researcher. A lever arch file was used to keep field notes, interview guides, informed consent forms, interview transcripts and other study materials. This was kept in a locked cupboard while the electronic data had secret passwords which were known by the researcher alone.

Data analysis

The interview data was analyzed manually by manifest content analysis. This method is suitable when identifying core meanings such as predominant patterns or themes that emerge through interview transcripts. The researcher initially read the transcribed text in order to get a feeling for the essence of the material.

The analysis was done using the following steps according to Schilling (2006):

- **Step 1: from transcription to raw data.**

Words and sentences containing information relevant to each interview question were identified by the researcher. In the process of categorizing data, the following aspects were taken into consideration: frequency of comments (the number of times a topic surfaced in the interviews), extensiveness of comments (how many people talked about the same issue), and intensity of comments (voice volume, speed, and emphasis on certain words) and the emerging themes.

- **Step 2: from raw data to condensed records.**

During this step, defining units of analysis was done. A unit of analysis is a segment of text that is comprehensible by itself and contains one idea or piece of information. The process of condensing content analysis begins in order to reduce the material while preserving the essential content. The next action of this step involved paraphrasing whereby the material was reduced to its basic content by deleting all the words that are not necessary to understand the statement. This allowed transformation of the sentences into a short form. The remaining statements were now generalised and reduced.

- **Step 3: from condensed to structured protocols and a preliminary category system.**

Preliminary categories were created by the researcher. The content and boundaries of each category were noted and defined by the researcher.

Changes and redefinitions of the categories were made in an ongoing creative process. With regard to amount and form, the text material was succumbed to structuring content analysis. Structuring means that each statement is attached to one of the defined dimensions.

- **Step 4: from a preliminary category system to coded protocols.**

All recording units with information relevant to the interview questions were referred to mutually exclusive categories, which in turn were referred to as themes by the researcher. The themes reflected the purpose of research and were exhaustive.

- **Step 5: concluding analyses and interpretation.**

The researcher developed concluding analyses and interpretation. This is reported in chapter 4 and 5 of this report respectively.

Ethical considerations

Approval to conduct this study was sought from the College of Medicine Research and Ethics Committee (COMREC) (see Appendix A). Permission to use the tertiary schools mentioned above was sought from the respective institution management (see Appendices B and C). A written consent was sought from adolescents aged 18 to 19 years. The participants were informed of the objective and importance of the study. The participants' right to privacy was ensured by complete anonymity.

Anonymity in the dissemination of research encourages objectivity throughout the research process and the participants may be willing to provide information on sensitive issues (Oliver, 2003). The data collected was kept confidential as it was accessible to the researcher and the supervisor only. In addition to that, the respondents' identities were not revealed in the report of the study. The participants were informed of their right to withdraw from the study at any point (Appendix A, B, C, and D - client information sheet and consent form).

Conclusion

This chapter has discussed the research design and methodology used to collect data in this study. The data management, analysis and ethical consideration have also been discussed.

CHAPTER FOUR

Presentation of findings

Introduction

This chapter presents the findings for the study. The broad objective of the study was to explore the intention and decision making regarding contraceptives acceptance among tertiary school sexually active adolescents. Data collection was carried out between May and July, 2011. The results are presented under the following major themes: adolescents' attitudes toward contraceptive use; normative beliefs and subjective norms regarding contraceptive use; perception of risk to unwanted pregnancy; perceived ability to use contraceptives; adolescents' intention to use contraceptives; decision making to use contraceptives. The demographic data is reviewed to identify the characteristics of the participants.

Demographic data

The respondents of this study consisted of sexually active in-school adolescents regardless of whether they have ever used contraceptives or not. There were more female than male respondents who participated in the study. All respondents were single and Christians from different denominations (Table 1).

Table 1: Summary of the Demographic Data

Characteristic	Category	Male %		Female %		Total %	
Age	18	3	13	7	30	10	43
	19	7	30	6	26	13	57
Religion	Seventh Day Adventist (SDA)	1	4	2	9	3	13
	Church of Central African						
	Presbyterian (C.C.A.P)	4	17	5	22	9	39
	Roman Catholic (RC)	4	17	4	17	8	35
	Living Waters Church (LWC)	1	4	2	9	3	13

Attitude towards contraceptive use

Attitude towards contraceptive use was a major theme that emerged from the data. Both positive and negative attitudes emerged as major themes from the study as clearly stated by the respondents.

Positive attitude.

The positive attitude was categorised in relation to responsibility to use contraceptives, prevention of pregnancy, STIs including HIV and AIDS, prevention of the responsibility to raise children during adolescence, the readiness to use contraceptives and motivation to use contraceptives

Contraceptive use as a responsibility.

Majority of the respondents thought it was their responsibility to use contraceptives if they could not abstain from sex. Most respondents shared this observation on contraceptives use. They noted that current lifestyle demanded the use of contraceptives so that the youth are able to achieve their goals. As one female respondent put it:

With the current lifestyles practiced by the youth, young girls are having sex by 13 years... I feel I only am responsible for my life and I think of my future so that I have a bright future. I use condoms. (FP13)

Using contraceptives offers protection from pregnancy.

Some respondents were of the view that contraceptives were of great importance in the lives of the youth owing to the advantages that they have. The advantages of contraceptives that were coming frequently in the data included delayed motherhood and opportunity to continue schooling especially for girls. Contraceptive use also reduces forced or early marriages that unwanted pregnancies can bring. In addition to that, contraceptives assist girls to avoid unwanted pregnancy and hence unsafe abortion.

In summary, one male respondent had this to say:

There are several complications when it comes to giving birth early. For one thing, the person is disturbed psychologically. When one gets pregnant at an early age, they feel ashamed. Hence they may opt for abortion which is very dangerous because it can result into death or if not, then their reproductive organs are affected. Even if the child is born without any complications, you may also face some problems if you are not financially stable. In most cases, the youth are forced into marriage and they meet several financial constraints which make it difficult for the male adolescent to take care of the child or even the mother.

(MP05)

Protection from STIs including HIV and AIDS.

Adding to this view, most respondents thought it was wise to use contraceptives especially condoms because they were the only method that also provided protection

against STIs including HIV and AIDS. The benefits of using condoms, hence, included a healthy life, which is an attribute to the development of the nation. Thus, fewer resources could be used to treat those infections while more would be spent on other developments.

One male respondent who was using male condoms had this to say:

.. As future leaders, we need to use contraceptives because contraceptives lead to healthy and strong life.. With condom use, we can avoid diseases because when we are sick, we cannot develop this country. Instead, we will make the government and our relatives spend a lot of money to take care for us. (MP07)

Prevention of responsibility to raise children.

Most respondents thought that children were a burden during adolescence. Thus, contraceptive use delayed the responsibility of raising and supporting children in their teenage. A female respondent also had this to share in line with shouldering early responsibility of taking care of a child during adolescence:

.. So it's better to use contraceptives than to have a child while at school and I don't think a child can take care of a child. It is not fun to have a child because to raise a child demands a lot of responsibility from both parents. (FP12)

Readiness to use contraceptives.

Most respondents shared the view that if adolescents were ready for sex it meant that they were ready to use contraceptives as well. They reported that it was best to abstain but when that failed then they had no choice but to use contraceptives. Thus, contraceptives provided a solution to prevent unplanned pregnancies. A female respondent narrated: "When you decide to have sex, always use contraceptives because once you risk not using contraception you are risking your whole life." (FP11)

Motivation to use contraceptives.

Adolescents' motivating factors for contraceptive use emerged from what they valued in life such as the desire for higher education, stable and future family, prosperous future, independence and good health.

Desire for higher education.

Respondents valued education as very important for their future. Generally, respondents said they wanted to complete their education first before they could think of getting married or having children. Thus they developed positive attitude on contraceptive use. One male respondent said: “.. my great wish is to have a PhD in my current field of study.” (MP02)

Desire for a stable future family.

The respondents noted that contraceptive use prevents early childbearing. They highlighted the desire to have a stable and future family. The respondents stated the need to postpone childbearing at this time. They wanted to marry later so that they would have their desired number of children that they thought they could manage to take care of and be good parents. A male respondent had this to say:

... complete my education and start working for a number of years eh then I should get a wife who should be faithful. And my parents advised me that I should not marry anyhow but that the wife I should get should be faithful and that I should follow the right process not just to marry her because she is pregnant with my child. I should make sure I am well-prepared for marriage so that I have peace for the rest of my life. They said that ‘if you marry just because you have impregnated a girl then you encounter problems in future. (MP03)

Desire for a prosperous future.

The respondents reported that contraceptive use ensured them of a successful and prosperous future. They indicated their desire for leading a luxury life. One male respondent commented:

What I value in my life is success; I have to succeed in life and that's all. When it comes to child bearing, mmh I don't want to impregnate my girlfriend at an early age, I don't want that.... I don't want to marry young, have children that I cannot manage to take care of and become so poor. (MP01)

Desire to be independent.

Independence was valued among the respondents as they noted that with contraceptive use, they could achieve their goals. Another female respondent also said:

I wish I could be somebody who is hardworking so that I should stand on my own and be independent. Whether in business or employment, I will work hard so that I get promotion for higher position. (FP10)

Desire for good health.

Good health was cited by most respondents as what they valued in life. It was rated highly among the respondents as the basis for their future life. They noted that with condom use they prevented pregnancy and STIs including HIV and AIDS hence this helped them lead a healthy life. One male respondent underscored this in the following sentiment:

...I even think about diseases. Good health is the first thing for all my dreams to be accomplished. So, I need to make sure that I am in good health and with that everything will just follow. (MP09)

Negative attitude.

Nevertheless, negative attitudes towards contraceptive use were also portrayed. The categories under this sub-theme included: that contraceptive are not for the youth; contraceptives have bad side effects; contraceptives promote the spread of STIs including HIV and AIDS; cheating future husband. There were also other categories specific for condom use that elucidated negative attitudes such as condom use denoted mistrust, condoms reduced sexual pleasure, the need for immediate gratification and misconceptions about condom use.

Contraceptives are not for the youth.

Some of the respondents thought that the messages on contraceptives should not be given to the youth at all because contraceptives are meant for married people and other adults. While other respondents felt they could get the messages on contraceptives at their age, they thought the information was not for them to use immediately but at a later stage when they become adults. Yet, some respondents felt the youth were left out in favour of adults who had special programs targeting them. One female respondent had this view of how the youth react to messages on contraceptive use:

..When I hear the messages about contraceptives that are aired on the radio, they target adults especially women. In hospitals there are also special programs for women to go and have contraceptives. At these clinics, they are taught more about the methods that are available and hence adults have double advantage. (FP05)

Contraceptives have bad side effects.

Some respondents said it was not proper for them to use contraceptives because of their side effects. Some of the side effects commonly mentioned were weight gain, development of pimples, menstrual disorders such as experiencing no menses,

interrupted and heavy menses due to hormonal methods; and local discomforts such as pain, sores and irritation with condom use. Other female respondents thought contraceptive pills were not right for adolescents because they caused problems that could manifest later in life. One female respondent had this to say:

.. the pill .. and other methods are meant for married people or those who already have children because they cannot cause much damage to them. But for the youth, I feel that these contraceptives can damage their reproductive organs and they may become barren in future. (FP01)

Contraceptives promote the spread of STIs including HIV/AIDS.

Other respondents were of the view that use of contraceptives encouraged premarital sex, promiscuity thereby promoting the spread of STIs including HIV and AIDS. One male respondent had this to say on girls who use contraceptives:

.. there are some girls who would go for the pill and since they know that they cannot get pregnant, it makes them wild and may have many relationships hence they can be easily infected with sexually transmitted diseases. (MP01)

Cheating future husband.

Despite being sexually active, respondents thought using contraceptives made them appear innocent of having sex as they could not get pregnant. They regarded this as cheating their future partners that they didn't have sex before meeting them. A female respondent said: “.. using contraceptives is one way of hiding whatever you are doing from your future husband so that he should find you without a child.” (FP07)

Condom use denote mistrust.

Another misconception concerning condom use was that it denoted mistrust between lovers despite the length of the relationship. Most respondents were of the

view that condom use communicated lack of trust in the relationship. A female respondent gave the following comments:

When you are using a condom, it shows that you do not love that boyfriend or girlfriend. Moreover, others say that when you are using condoms, it means either you do not trust your partner or else you are admitting that it is you who is untrustworthy and that is why you want to use condoms. (FP03)

Condoms reduce sexual pleasure.

Reduced sexual pleasure, in fact, emerged paramount in the data as almost all respondents cited it as the reason for inconsistent and non-use of condoms. The respondents shared the view that condoms reduce sexual pleasure because it acts as a barrier hence reduces the impact of contact (friction). So, for them to enjoy sex, they prefer having plain sex. For instance, one male respondent said:

.. but still there is also a problem with condoms, some say that you can't eat a sweet while it is still in its wrapper meaning that they don't feel good when they put on a condomand I feel that it takes a longer time for you to reach orgasm when you are using a condom due to reduced friction... (MP10)

Immediate gratification.

Some male respondent however said that it is possible not to use a condom even when it is available because a person may just be taken up by the heat of the moment. These respondents reported that sexual pleasure overrode the need to use condoms to prevent pregnancy and other STIs:

I think I would say that sometimes it's just by luck that you use a condom. It may happen sometimes that you have gone out and you want to have sex yet you don't have a condom. So, you put yourself at risk and have plain sex and say whatever happens! But in most cases, it's just by chance that you use a condom. (MP09)

Misconceptions about condom use.

Respondents who displayed negative attitude towards contraceptive use had misinformation on the methods. Some of these misconceptions were shared among both male and female respondents. These included the views that condoms are not for beautiful girls, heroes and long-term relationships but that they should be used for new or casual lovers only.

Condoms are not for beautiful girls.

Beauty was mentioned as one of the reasons for not using condoms. Male respondents reported that they wanted to enjoy every bit of sex with beautiful girls. One male respondent had this to say:

..when a boy wants to have a relationship with a girl he will propose one who is beautiful.. To use a condom with a beautiful girl is not on ..Even your friends will mock you about it.. They look at the beauty of the girl and say how can you use a condom on this beautiful girl? ..It is a loss. (MP8)

Condoms are not for heroes.

Another misconception that emerged in the data was that boys who did not use condoms were labelled as heroes. Results from this study revealed that using a condom was contrary to current lifestyle of showing off among the youth. Hence those who used condoms were considered cowards while those who did not use them were rated highly by their fellow friends. One male respondent who said he used condoms stated the following sentiments in line with the same issue:

... we talk a lot of nonsense when we are together as youth. For instance, when somebody does not use condoms, we call him a hero or a real man but if you say

that you use condoms, it's only a few friends who will encourage you that you are doing the right thing. Most of them will look at you as old-fashioned. (MP02)

Condoms are not for long term relationships.

Respondents said that condoms should not be used on somebody whom one really loved especially if they had been in the relationship for more than three months. Respondents reported that condoms created a barrier between lovers. This psychologically affected both partners as they felt they were not loved. Some respondents felt they were just fed up with the use of condom in long term relationships and thought of having a taste of sex without the use of condoms. There were several reasons that respondents mentioned for this behaviour. For instance some respondents felt that being in a relationship for a long period of time made them develop trust with each other hence no need to continue using condoms. Other respondents felt that if condoms had been used for a long period of time then they did not enjoy sex as much as they should have.

One male respondent who did not use any contraceptives because he had a stable girlfriend of 2 years explained:

.. I think it's the psychological part that plays a great role whether you use a condom or not because you feel that when you use a condom its like you don't really love that person or I can say it's like you are putting a barrier between the two of you, some sort of a wall between you. (MP09)

Condoms are for casual/new lovers.

Some male respondents thought that a condom should be used on strangers and prostitutes. Another male respondent further said: “.. It's better to use condoms when you have sex with prostitutes because it makes sense.” (MP10)

Similarly, other male respondents said that the common practice with condoms was that they were used consistently in new relationships only. This implied lack of trust among the lovers. Thus, later into the relationship they saw no need to use condoms. A male respondent commented on this issue:

I always use condoms in new relationships because I feel I don't know the person fully in terms of what she had been doing in the past before she met me. And even when I know I also think about how she behaves when I am not around or when we are not together. But when you have known each other for long it's when you develop that trust and you stop using condoms. (MP04)

Normative beliefs and subjective norms regarding contraceptive use

This was another theme that was important in influencing respondents in their decisions to use contraceptives or not. It was clear that the respondents' beliefs and norms stemmed from different perspectives in diverse aspects of their lives. These included religious, cultural, societal beliefs and those of their significant others such as parents, peers, sexual partners, relatives, family and other elderly members in the society.

The results revealed sociocultural expectations and contradictions that had both positive and negative influences on adolescents' contraceptive use.

Religious sectors' expectations and contradictions.

Religion played a role in the development of beliefs towards contraceptive use. However, there were contradictory messages from the religious sectors such as that sex is regarded as a sin for unmarried men and women. But some respondents said they got counsel from the church that they should use contraceptives while for others, this was implied indirectly.

Sex is a sin.

In some churches sex was regarded as sin therefore all members forbidden from it except in marital relationships. One female respondent said although the church she attended discouraged them from having sex, she felt using contraceptives is important when you do not abstain from sex. She narrates:

We had a youth conference at ...Church and we were told that we should not have sex with any man or woman until you are ready for marriage because it is a sin before God. As youth however, we still do it... Like nowadays it (sex) has become the order of the day.. it becomes embarrassing to find a God knowing Christian falling pregnant. It is even worse when you have a certain role in the church. For example, I am a member of the praise team, so it's so embarrassing (becoming pregnant) in the presence of God. (FP06)

A male respondent shared his sentiments by saying that at their church, if a girl is pregnant, they castigate her as well as the boy responsible for the pregnancy. So, in order to be spared from the embarrassment of being castigated he thought it wise to use contraceptives.

Contraceptive use advocated in cases of failure to abstain.

Some respondents reported that they were told directly to use contraceptives if they could not abstain. This is what one female respondent narrated:

..because at our church, the youth have different teachings whereby we are told that we are the future. I value this a lot that's why I decided that if I am not abstaining then I should better use condoms because this is what they tell us at such youth gatherings. If we cannot abstain then we are told to use condoms or other contraceptives. (FP04)

Societal expectations.

Abstinence among adolescents is largely expected in the society therefore contraceptive use is not approved in most communities. Some female respondents expressed fear on how the society would react to their using contraceptives. One female participant put it “what will people be thinking about me when they see me using contraceptives?” (FP08)

Respondents mentioned about how prevalent the issue of abstinence is. They noted that generally, people did not freely discuss sexual and contraceptive issues. Particularly, society did not approve contraceptive use among adolescents since the expectation was that they would abstain.

Respondents recommended abstinence and use of condoms if they could not abstain. One female respondent reported how uncomfortable she felt when having sex and using contraceptives. She had this to say about her decision to start abstaining from sex again after a period of being sexually active:

Abstinence is the best.. if I continue having sex using condoms I always think that maybe this relationship will end one day and in the end I will find that I have slept with many men in the name of using condoms. So I am afraid that sex may lose its value if I can do it with anybody provided I use condoms. (FP11)

On the contrary, some respondents said they were encouraged to use contraceptives by observing the situation in the society. They cited the high teenage pregnancy rate which is rampant in the society and the effects of having large families. Two female respondents had this to say:

In my neighbourhood a lot of girls drop out from school. For instance, I had about 20 friends whom we started school together, but now there are only three to four

girls who do not have children. Most of them didn't get this far (tertiary education). Some did not even reach secondary school level. (FP04)

We have so many problems as some people are coming from very big families (families that have many children). People used to have many children in the past before these modern methods of family planning were introduced. So, the youth now are willing to use contraceptive methods in order to control the population growth. (FP10)

Family influences.

Family members and other relatives played a role in influencing respondents to use contraceptives. Respondents reported the roles parents, siblings and other relatives played in their decision making on contraceptive use. Some respondents reported to have had open discussions while others reported silence on sexual and contraceptive issues.

Open discussions with parents.

Parents were mentioned among the key people who influenced the respondents to use contraceptives or not. Some respondents said their parents advised them on sexual and contraceptive issues. The messages were primarily on abstinence and use of contraceptives came as an alternative for failure to abstain. More importantly, some respondents specifically mentioned the specific parent who encouraged them either directly or indirectly to use contraceptives. Some cited the mother while others the father. One female respondent had this to say about her mother:

My mum doesn't say it directly like telling you that you should use condom. No, she doesn't talk like that. She just says it like a story and then she will say you know what, if you can't wait it's just better to use condoms. I don't understand why people will just do it without a condom. If you can't wait use a condom! It's

stuff like that. For instance, in an indirect way, last time she said that “you know what, I am not asking you to tell me whether you are or not having sex but please eeh use condoms. (FP13)

Another female respondent said that it was usually her father who advised her on the use of contraceptives. She had this to say:

One other thing that made me to use condoms is the influence of my father. He said that he knew that I may lie to him that I don't have a boyfriend. He told me that he knew ..maybe from my behaviour at home maybe I had changed in some way.. but he advised me that if I would want to have sex then I must use a condom. (FP07)

One female respondent said that despite her mother being very open with her, she (daughter) felt restricted from telling her (mother) everything about sexual and contraceptive issues. She advised her on having sex after marriage which she promised but could not keep her virginity. Hence she felt compelled to use contraceptives to avoid unwanted pregnancy which would disappoint the mother as she still thought she was a virgin.

Silence on sexual and contraceptive issues.

Some respondents pointed out that their parents did not want to talk about sexual and contraceptive issues at all. One male respondent said:

As a matter of fact it is very rare to talk about such issues (sex and contraceptive use) in our family. I think my parents (raised tone) don't even want to talk or discuss with their children. I don't know what they think but for example if we start talking about something related to these issues...they will say 'shut up'. (MP04)

Nevertheless, other respondents said that when the issues about sex and contraceptives come up parents would not give direct or specific advice to them. One female respondent had this to say:

As for my mother, she does not talk much (laughs). There are some religious families where the children are given advice but that is not the case with our family. They only just warn me that I don't have to hang around with boys, but they don't tell me how I can avoid early pregnancy. (FP05)

Sibling influence on contraceptive use.

Siblings were mentioned by respondents as some of the people who clearly encourage them to use contraceptives. These included brothers and sisters of the respondents. Most of the respondents discussed sexual and contraceptive issues with their siblings openly. A female respondent said that she observed that her sister was using contraceptive pills so this was enough communication for her to use contraceptives.

One male respondent was encouraged to use contraceptives by observing the consequences of his brothers' non-use of contraceptives. Here is what he said:

I learnt from my brothers' experiences because we were staying together. They all had experienced unwanted pregnancies with their girlfriends because they were not using contraceptives. Hence, they had to marry the girls and this was a wake-up call for me. I decided to use condoms. (MP03)

In the same vein, one female respondent was encouraged to use contraceptives because she said that she had observed that none of her relatives had experienced unwanted pregnancy. Hence she did not want to be the first one to experience such ordeal.

Peer influence.

Peers were also mentioned by the respondents to have influenced their decision to use contraceptives. For instance, the respondents revealed that they discussed sexual and contraceptive issues amongst themselves. They shared their sex experiences and the use of contraceptives and some respondents felt obliged to follow what their peers were doing. One male respondent who used condoms had this to say:

Initially they (adolescents) feel that they should abstain but due to peer pressure they fail to do so. They may just decide to use condoms in order to protect themselves from STIs and unwanted pregnancy. Sometimes it is by just imitating what their friends are doing. So, if their friends are using condoms they will also do that. (MP07)

However some respondents stood by their decisions to use contraceptives despite negative talk about contraceptive use. For instance, a male respondent observed that some of his friends engaged in repulsive talk regarding contraceptives just to gain popularity. Despite that, he still used condoms as a contraceptive method. He said: “Most of us the youth say that you cannot enjoy sex with a condom.. I know of friends who can boast that they do it plain in order to gain popularity when in actual fact they use condoms”. (MP09)

Other respondents learnt from the consequences of their peers who met their ordeals from negligence. Since they did not use contraceptives they got pregnant and some were even infected with HIV. One male respondent narrated:

...I know of some friends who have been having plain sex and aaah they are now having the HIV virus so, it is people like them that who give me the picture that it is good to use condoms so that one can protect him or herself from HIV... (MP02)

Influence from sexual partners.

Respondents reported that in addition to friends and family members, they were discouraged by their sexual partners to use contraceptives. One female respondent reported that her friends, family members and sexual partners discouraged her from visiting the clinic to get counsel on contraceptives hence she used condom as a contraceptive method.

Adolescents' perception of risk to unwanted pregnancy

This theme was related to how they perceived their risk of pregnancy and STIs regarding consistency in contraceptive use. The information from the respondents revealed that some of them used contraceptives consistently while others did not. For instance, it was clear that only few respondents used condoms consistently while most of them narrated inconsistent use. Generally, the inconsistent condom users said that they regretted for not using any contraceptives during some sexual encounters because they knew they were at risk of both pregnancy and STIs. Respondents' perceptions of risk to unwanted pregnancy and STIs were categorised as hidden, postponed, perceptible risk of pregnancy and STIs including HIV and AIDS and gender differences on risk perception.

Risk postponement.

Some respondents seemed not to care about the consequences of not using any contraceptives during sexual encounters. They felt nothing mattered at that moment as long as they quenched their sexual desires. They reported that they thought they would deal with any outcome of their actions in due course whatever it would be. Abortion was one way they thought of managing unwanted and unplanned pregnancy.

A male respondent shared his views on why the youth took such a risk:

..of course the risk is there but at that particular time they don't care and they pretend the risk is not there. They will just say 'we will see when we reach that bridge' and they regret afterwards. Still others are of the view that once the girl falls pregnant they will go for abortion. (MP03)

Hidden risk.

Other respondents however, mentioned that they utilized other non-hormonal methods such as the withdrawal and calendar methods to avoid pregnancy. One female respondent had this to say: “..they know they are at risk that is why they would use natural methods of pregnancy prevention such as calculation of safe days and use of the withdrawal method by the boy”. (MP01)

Perceptible risk for pregnancy and STIs including HIV and AIDS.

Some respondents acknowledged the fact that the calendar and withdrawal methods were less effective than other contraceptive methods in the prevention of pregnancy. Hence, they recognized that the use of the withdrawal and calendar methods did not protect them from STIs including HIV and AIDS. Therefore, on this issue, some male and female respondents shared the view that they go for VCT and have HIV testing and when they test negative for HIV they continue to have plain sex. One female respondent observed the following:

.. But I still think it's not safe because it is not at all times that the boyfriend may be able to withdraw. Sometimes, he may forget to withdraw on time because of the pleasure he is experiencing at the time. (FP02)

A male respondent further shed some light on why they do not worry about contracting STIs including HIV and AIDS:

.. you go for VCT several times. Maybe the relationship has lasted for 2 years or 3 years and you have been attending VCT and have been testing negative for HIV, it makes you develop that trust. Looking at the long period you have been together as well as the results from the VCT (that you are still testing negative for HIV) then you trust each other and become assured that you can have sex without using condoms. (MP07)

Gender differences on risk perception.

Both female and male respondents indicated that girls feared pregnancy more than STIs including HIV while boys were more concerned with STIs than pregnancy prevention. A female adolescent explained the reason for fearing pregnancy more than STIs:

A lot of girls are so much afraid of getting pregnant than contracting diseases, they think that if they fell pregnant they would be a disgrace to their parents and they would probably be chased from their homes and end up being frustrated in life once they are chased from their homes. (FP12)

A male respondent had this to comment:

In my opinion...boys are more afraid of getting HIV than making a girl pregnant... as boys we take each and every girl that she is not straight meaning that girls have many relationships...so we have to make sure we also protect ourselves from diseases. (MP08)

Adolescents' perceived ability to use contraceptives

Most respondents felt that they were able to use contraceptives especially condoms. Two sub-themes emerged under adolescents' perceived ability to use contraceptives namely perceived ability to use condom and accessibility of the contraceptives.

Perceived ability to use condoms.

Respondents expressed their ability to use contraceptives due to the wide availability of condoms. They affirmed that condoms were readily available hence any adolescent willing to use them could do that without any problems since they were found in shops, clinics and public toilets. The condoms were said to be affordable to adolescents because they were cheap. They also said that they had enough knowledge on how to use the condoms correctly and properly.

Some respondents read the instructions on the condom packet and internet but others were shown on how to use them at health facilities and youth groups.

A male respondent narrated: "... there are some instructions on the packet and I just follow them and I am confident I use them correctly and properly and I have never met any problem when using condom regarding on how to use them." (MP03)

One female adolescent however, thought the instructions on condom packets were unclear to her:

...I read the instructions and I think they are not as clear. They are not very clear especially for people who have never used condoms before...but at least they told him (boyfriend) how to use them at the clinic but basically I just read the instructions on the internet. (FP13)

Access to contraceptive methods.

Resources were one of the determinants of perceived behavioural control in addition to self-efficacy in TPB. The results indicated that condoms were their most preferred contraceptive method. However, some respondents reported some challenges with access to condoms and include shyness, short supply of special brands of condoms and preference for free condoms.

Shyness.

Some male respondents however, noted that one of the problems he experienced in accessing condoms was shyness. One of them narrated: "... For me it is easy to buy from PTC shops than in local shops that are found in different locations because I am shy." (MP01) Another male respondent nevertheless, had a different view: "... I do not have problems to buy condoms from anywhere regardless of location and who is selling I am not shy." (MP09)

To overcome the problem of shyness which prohibits some youth from buying condoms in other shops, a female respondent had this to say: "... Condoms are in every shop therefore you don't have to go to a certain shop more than once because you can get them anywhere." (FP08)

Short supply of condoms or special brand.

Other respondents cited lack of seriousness to ensure they have a consistent supply of condoms. One male respondent said: "... depends on how things are at that moment. If you have the intention to use the condom but it's not available then you cannot abandon the whole thing. That's why you find yourself having sex without using a condom." (MP06)

Some respondents admitted that they were found in situations that they did not have condoms it is because of lack of seriousness and negligence on their part to be well prepared for contraceptive use every time they have sex. As one female respondent said: "... we use a special brand of condoms and these may run out unexpectedly if you keep using them without checking how many are remaining." (FP03)

Preference for free condoms.

Some respondents narrated that they preferred to have free condoms than buying them hence if they run short of supply, they have plain sex. A male respondent also added: "... due to lack of seriousness on my part I did not have a condom at hand and I am not ready to buy condoms because I prefer to get them for free." (MP02)

Adolescents' intention to use contraceptives

Adolescents' intention to use contraceptives was revealed in the respondents' knowledge of contraceptives and how respondents prepared for sexual contact and use of contraceptives.

Contraceptive knowledge.

The theory of planned behaviour acknowledges a significant relationship between the level of knowledge and the intention to engage in the behaviour. Despite getting contraceptive information from a wide range of sources both formal and informal, other respondents felt that the information they got was inadequate both in depth and breadth. Some respondents did not know other contraceptives such as the female condom, pills, injection, norplant, vasectomy, loop and tubal ligation. They reported that they lacked details on the contraceptive methods such as how they work, advantages, disadvantages, side effects, effectiveness and how to use them effectively.

This created a knowledge gap among the respondents which made them uncomfortable to use other methods except the male condom, which they were more familiar with.

Correct knowledge on contraceptives.

A few respondents seemed to have correct knowledge about contraceptives while others had lack of knowledge and still others had incorrect and inaccurate information. Most of the contraceptives that the respondents knew were the male condom in addition to the natural methods like the calendar and withdrawal methods. One male respondent who had correct knowledge had this to comment on the calendar method:

...use the calendar method whereby they observe the menstrual cycle and calculate the days of the girl's menstrual cycle and determine when she is most fertile so that they avoid having sexual intercourse and have it when they think the girl is not fertile meaning she cannot get pregnant. (MP02)

Limited knowledge on contraception.

Although respondents knew some of the contraceptives, their knowledge about pregnancy prevention was limited. One female respondent narrated:

I only heard from my friends at school that you can get pregnant when you have started menstruations. I don't really know exactly what happens in the menstrual cycle for you to get pregnant and therefore sometimes you doubt if you are in a state when you can become pregnant. You think aa maybe this time of the month I cannot get pregnant. (FP06)

The male condom and calendar methods popular among the youth.

The male condom and calendar methods were identified as popular methods among the youth. The respondents stated that some of the reasons for condom acceptance among their circles were the ability to protect against sexually transmitted infections including HIV and AIDS as well as pregnancy. In addition, respondents

said that condoms had less adverse side effects than other contraceptives. Therefore adolescents felt free to talk about them and use them. Hence, condoms were rated higher than other contraceptives.

A female respondent shared this observation on her decision to use the male condom:

.. As for the other methods, I think I will just wait for the right time when it will be okay for me to use them but not now especially the implants. I feel at my age it is not right maybe if I am older I can use it. (FP12)

Demerits of natural methods.

However, other respondents commented on the demerits of natural methods such as the calendar and withdrawal which included reduced effectiveness and unreliability. Hence, they cited the need to use more effective and reliable methods like the hormonal contraceptives and condoms. One female respondent had this to say:

...this date (calendar) method is also not 100% effective because the dates can change sometimes when one misses her periods or has irregular dates especially the ovulation days where eggs are released. Then, it is difficult to calculate the safe days and most girls find themselves pregnant. As for me, maybe just God allows me not to become pregnant while using the date method which is not reliable but what I can say is that a great percentage of the youth use this method and condoms and we are safe. Those who have become pregnant, they go for more reliable methods such as injection or pills. (FP06)

Female condoms not popular among the youth.

Respondents preferred male to female condoms saying that male condoms are widely discussed both in the media and other circles. The female condom, however, was not widely discussed and only one female respondent mentioned that she and her boyfriend use both the male and female condoms in their relationship.

Misinformation on post-coital contraception.

Respondents however, had some misinformation on the available contraceptives that were used after unsafe sex or contraception failure. Nobody mentioned emergency contraception which is used in cases of unprotected sex or contraception failure. A male respondent stated that sometimes the girl takes penicillin tablets soon after intercourse in order to prevent pregnancy.

They (young girls) even say that if things are not okay, I will drink penicillin. They do have their own beliefs and things that they do.. they take penicillin within certain hours of having plain sex then they say they are safe from conception. (MP04)

Preparation to use contraceptives.

This sub-theme surfaced as respondents narrated how they prepared for sexual intercourse with their lovers. Adolescents' intention to use contraceptives depended upon how they planned for sexual intercourse. The respondents said that most sexual encounters they had occurred without prior planning. It was clear that mostly the decisions to have sex were made by the boys. Sometimes it also followed that it was the same boys who had to plan for contraceptive use.

Both male and female respondents identified boys as the ones who mostly initiated sex and hence prepared for it. On the contrary, some male respondents reported that they did not have intentions to use contraceptives. For instance those who planned for sexual intercourse had chance to plan for contraceptives but those

who did not plan found themselves having sex without using contraceptives.

Preparation for contraceptives was categorised into long-term, short-term and no preparation.

Long term preparation for contraceptives.

Some respondents said that they planned for sex and contraceptives. Thus, some respondents said that they made sure that they always carried condoms so they used them when needed. Actually, other respondents had decided to use contraceptives every time they had sex. One female respondent, who used dual method of calendar and condoms, narrated it this way: “Because we are very open I tell my boyfriend about my ‘safe days’ so we plan together when to have sex and each one of us brings condoms because we still use them”. (FP02)

Other respondents however, reported that although they did not plan for sexual intercourse they still had made the decision to use contraceptives every time they would have sex. These were the ones who would postpone sex if they did not have any condoms at the time. Additionally, some respondents said they usually planned for contraceptives by having condoms ready with them whether they had planned for sex or not. One male respondent had this to say: “I usually do not plan for sex but make sure I always carry a condom or two.” (MP10)

Most female respondents said they did not plan for sex, but some said that they had a clue that they may have sex or not depending on where they would meet their boyfriends. Some female participants had this to say:

Every time my boyfriend calls me that we should meet in town, I know that there will be a chat or we will go out shopping. But if he tells me to meet him at his house then I don't rule out the possibility of something happening at his place. I

know that we will chat but it is a given fact that we will have sex.... So I prepare to have condoms with me. (FP05)

I make sure that I have female condoms. Sometimes, I put them on when going to meet him because I tell myself that I am not sure of what will happen during our meeting. So, I feel I should be ready for anything I have to be prepared for that. (FP07)

Short-term preparation for contraceptives.

However, one respondent said that although he did not plan for sex, he used condoms because he just remembered one of the radio messages on condom use. Fortunately, he got a condom from a friend who was nearby. He described thus:

It is not that I planned in advance (for sex), no and I didn't even have any idea that I would use a condom. It just happened that time. I just remembered the messages on use of condoms and I decided to use one. (MP06)

There were other respondents who said that they just found themselves in situations where they did not plan to have sex but they had condoms readily available for use. A female respondent also commented, "...both of us didn't have a clue that it could end like that ..we didn't even plan that we would have sex... we were with a friend so the friend gave him the condom." (FP09)

No preparation for contraceptive use

Some respondents reported that they did not have plans for sex and contraception such that when they found themselves in situations where they had sex, usually contraceptives were not used. However, some of them said that although they had the intention to use contraceptives they were not able to use any contraceptive due to other reasons. For instance, the respondents were taken by the heat of the moment since sex is spontaneous and impulsive so much so that using a condom was seen as being

interruptive to the process. This narration by a female participant confirms: “.. it happened so fast, .. we were kissing, cuddling each other and it just happened so fast ... and we failed to control ourselves and it just happened that we had sex without using a condom.” (FP11)

Decision making to use contraceptives

This theme will be discussed under the sub-themes of factors affecting decision making among lovers such as communication among lovers which included openness and lack of openness in relationships, desire to please their lovers and fear of deception; fear of stigma, desire to please their friends and desire for methods that do not require hospital consultation.

Factors affecting decision making in relationships.

Communication among lovers.

Some respondents discussed contraceptive issues in their relationships while others did not. It was interesting to note that some male and female respondents felt that boys were the ones responsible for decision making on whether to use contraceptives or not without discussing it with their lovers. A male respondent commented this way: “I feel I am the one to make decision not my girlfriend I feel girls are weak-minded and take whatever boys will say.” (MP02)

Openness in relationships.

Interestingly, other respondents said that they had open discussions on sex and contraceptive use in their relationships. A female adolescent described her experience:

... We usually discuss sex and contraceptives with my boyfriend. He asked me to tell him when am ready for sex...he pleaded with me to reconsider my principle of having sex after marriage.. And we finally decided to start having sex using condoms. (FP01)

Lack of openness in relationships.

Some respondents said that there was no openness in most relationships. Boys and girls were not free to discuss sex and contraceptive use in their relationships. The reasons they gave for this inability to discuss openly about contraceptive issues included mistrust and lack of negotiation skills. One male respondent said:

We do not discuss this issue (contraceptive) in our relationship because I am afraid that maybe my girlfriend will ask me why I keep condoms. As such, I may have problems to convince her because she may ask that ‘whom do you use the condoms with?’ and she would think that maybe that I was planning to use them with somebody when she is not there. So I think about that and I feel it is difficult to discuss about these issues with my girlfriend. (MP04)

In addition to that, some respondents thought that lack of communication between lovers arise due to shyness on both parties. Some girls opt to take the decisions made by their boyfriends because of shyness or fear of being rejected. One female respondent narrated: “Usually it’s the boy who initiates sex therefore the girl does not say much, girls trust boys to bring up the issue of contraceptives such as use of condoms.” (FP07)

Ironically, results revealed that even some boys are seen to be shy when it comes to having discussions on sexual and contraceptive issues. A female respondent had this to say: “..Some boys are shy; they don’t say anything, so when you are in a room you just find yourself doing it without uttering any word at all.” (FP04)

Nevertheless, a female respondent who had used the injectable contraceptive for sometime said she did not discuss this with her boyfriend:

He wasn't aware of it, I was advised by my friends (to use an injection). They said that sometimes guys have a tendency of denying pregnancies, so for my own safety it could be better if I use an injection without telling him. (FP05)

Desire to please their lovers.

Other respondents revealed that they decided not to use contraceptives because they wanted to please their boyfriends. A female respondent said: “.. My boyfriend says that we should have plain sex. I don't like it but I only do it because the boy loves me but I am afraid that next time I may become pregnant.” (FP06)

Another female respondent commented in this way:

... the girl will be pressurised to agree with what the boy is saying thinking that if I don't agree to what he is saying he will think that I don't love him. So, in order to avoid disappointing him, she will agree to have sex without using a condom with the aim of pleasing the boyfriend. (FP09)

Fear of deception.

Some female respondents highlighted the issue of deception by boyfriends whereby they pretended to use condoms when in actual sense they do not. This defeated their intention to use condoms as a method of contraception. One female respondent had this to say:

...nowadays boys have become very clever. They can tell you that, we have used a condom but some two or three months down the line you discover that you are pregnant. Boys are becoming traitors and this habit is very common among them nowadays. (FP04)

Another female respondent had this to share on the same issue:

.. I have a living example of my other sister who told me she was using condoms but right now she is pregnant. I don't know why. Maybe her boyfriend cheated her that he used one when he didn't (laughs). So, she is very worried and regretting because she has even stopped going to school. (FP08)

As a confirmation to this trend, one male respondent who said his girlfriend forced him to use condoms said:

.. When she is pressurising you to use a condom, you may pretend to put it on or indeed put it on but immediately remove it and lie to her that you have used a condom when in actual sense you did not use it. (MP07)

Fear of stigma.

Respondents had their reasons for their decisions to use contraceptives or not. They felt that the only method that is used openly is the condom otherwise most adolescents are secretive about the use of the other contraceptives. They were afraid of how everyone around them would react to their using contraceptives. One female respondent had this to say in relation to use of injectable contraceptives she once used:

... For the injection I didn't tell my friends because I thought that they were going to say that I have sex more often than them. So, in order to avoid the negative attitude of the youth, I did not tell them. I would talk about condoms openly because everyone knows that there are condoms out there, as such people talk about condoms freely. We even discuss condom flavours unlike other contraceptives such as injections or tablets. (FP05)

A male respondent narrated the following about his girlfriend when he suggested that she uses contraceptives: "... She denied it fully and she told me frankly that I should never raise that issue again. She asked me what people will be thinking about her when they see her using contraceptives." (MP05)

Desire to please their friends.

Other respondents cited peer influence for not using condoms. They decided not to use contraceptives because their friends did not approve of them. One male respondent had this to say:

I feel that the youth have got the ability to use contraceptives but because of what their friends say and regard them as not in line with them they fail to use the methods. As for me, it is difficult to use condoms when my friends are discouraging me from using them. (MP07)

Desire for methods that do not require hospital consultation .

Other respondents revealed that they decided to use contraceptive methods that do not require them to visit the hospital or clinic for supply. One female respondent had this to say:

...we use male condoms ...I cannot take pills because I forget a lot... injection makes you fat and am already fat. The female condom looks dangerous to me ... for me I don't want any method that requires me to go to the hospital. (FP13)

Conclusion

This chapter presented the study results according to the major themes that emerged from the data analysis regarding use of contraceptives among adolescents. The themes were: adolescents' attitudes toward contraceptive use; normative beliefs and subjective norms regarding contraceptive use; perception of risk to unwanted pregnancy; perceived ability to use contraceptives; adolescents' intention to use contraceptives and decision making to use contraceptives or not.

CHAPTER FIVE

Discussion on findings

Introduction

This chapter presents a discussion of the findings of the study whose purpose was to explore the intention and decision making regarding contraceptive acceptance among tertiary school sexually active adolescents. The discussion will focus on the demographic data as well as the themes which emerged in the results namely adolescents' attitudes toward contraceptive use, normative beliefs and subjective norms regarding contraceptive use, perception of risk to unwanted pregnancy, perceived ability to use contraceptives, adolescents' intention to use contraceptives and their decision making among lovers to use contraceptives or not.

Demographic data

Age of participants.

The respondents were all in late adolescence which is characterised by the ability to reason coherently hence make decisions independently. At this stage, the adolescents are generally capable of understanding the consequences of their actions and can make more sophisticated judgments (Huebner, 2009). This is the age where most of the adolescents are sexually active hence the respondents in this study had the ability to make decisions to use contraceptives or not, depending on contextual factors in their lives.

Educational level.

All the respondents were in tertiary education at different colleges. Cognitively, late adolescence is symbolized by the development of abstract complex thinking which assists the adolescents to develop the ability to comprehend how current health behaviours affect long-term health status (Neinsten, 2008). This provided a uniform pattern of reasoning skills as respondents were in the process of developing their future careers.

Religion.

All respondents in the study were Christians. This is not surprising as the majority of Malawians are Christians (86% of women and 84% of men) according to the Malawi Demographic Health Survey 2010 (NSO, 2011). This denotes that despite different teachings in their respective denominations, the respondents shared a common background in the foundation of their faith.

Attitude towards contraceptive use

The study revealed several factors that indicated adolescent positive attitude to contraceptive use. The respondents recognised the important role contraceptives play in the prevention of unwanted pregnancies and STIs including HIV/AIDS. The respondents expressed desire to postpone pregnancy beyond adolescence. This supports previous findings in studies done on adolescents (Ryan et al, 2007; Stevens-Simon, Sheeder & Harter, 2005). Personal feelings, attitudes and skills play a great role in motivating adolescents to use contraceptives. This was evident in the present study as respondents expressed the desire for good life in terms of high education, stable and prosperous future family and good health.

It is noteworthy that adolescents expect to achieve their goals in life hence plan to delay pregnancy and childbirth until they have accomplished their ambitions. High

aspirations for adolescents to complete college education and have prosperous future are a motivation to use contraceptives when they are sexually active. These values in adolescents were responsible for the development of the intention to use contraceptives which later translated into the actual behaviour of using contraceptives.

This finding supports results from previous studies. For instance, a study on 1,142 adolescents found that those adolescents who were more motivated and self-determined and those with positive attitudes towards school were less likely to have premarital pregnancy (Witwer, 1993). In addition, a qualitative study revealed that young adult men often cited not wanting to miss out on life opportunities as a reason to use contraceptives for pregnancy prevention.

Most sexually active adolescent women and men do not want to have children because they are in school, too young or not married. Premarital pregnancy is bad for both the mother and the baby. Evidence indicates that compared to non-pregnant peers, 6 in 10 adolescent mothers are likely to do worse in education and ultimately drop out of school. In addition, an adolescent who has a baby has an increased risk of having a subsequent baby. That is 25% of adolescent mothers deliver again within 2 years. 80% of adolescent mothers are not married and they are less likely than their non-pregnant peers to ever get married. Hence, premarital pregnancy is frequently associated with poverty. A young mother with little education struggling to raise one or more toddlers on her own faces a gloomy financial future (Viner & Booy, 2005).

Findings from this study indicated that using contraceptives helps sexually active adolescents in many ways. Firstly they acknowledged that contraceptives helped them achieve their goals in life as there is no school interruption especially for the girls. Secondly, adolescents are protected from psychological problems that arise due to unintended and unwanted pregnancy. For instance, the girl felt ashamed and may

opt for an unsafe abortion which would lead to serious complications such as permanent damage to reproductive organs or death.

Other reasons for acceptance of condoms among the respondents in this study included the dual effect they have of protecting against STIs including HIV and AIDS as well as pregnancy. The fact respondents felt that condoms had less perceived adverse effects than the other contraceptive methods added to its appeal. For most respondents, the condoms were easily accessible, did not require hospital consultation, easy to carry and use, convenient and reliable. Indeed, male condoms have several other advantages for adolescents, including involving males in the responsibility of contraception, easy accessibility and availability to minors, use without a prescription, and low cost (Blythe & Diaz, 2007).

This is consistent with findings from previous studies done in resource-poor countries such as Malawi and other countries in the sub Saharan region where adolescents' knowledge on contraceptives is not detailed. For instance, current data show that 12.5% of married women and sexually active girls aged 15-19 years use male condoms, while 9% use injectable contraceptive among the 19.5% who use modern family planning methods in this age group (NSO, 2011). In Ghana, the most common method of contraception among 15-19 year old was the male condom, used by 53% of males and 56% females which was followed by pills in 14% of those in union and 9% for those not in union (Hessburg, Awusabo-Asare, Kumi-Kyereme, Nerquaye-Tetteh, Yankey, Biddlecom & Croce-Galis, 2006).

Studies conducted in resource-rich countries, findings show a variety of methods used by unmarried adolescents such as the dual use of condoms and contraceptive pills or condoms and implants. For instance, results from 24 European and North American countries on contraceptive use by 15 year old students revealed that

condoms was the most frequently used, ranging from 52.7% in Sweden and 89.2% in Greece. Dual use of contraceptive pills and condoms was relatively common and ranged from 2.6% in Croatia to 28.8% in Canada. Contraceptive pills were most frequent in Northern and Western Europe ranging from 3% in Croatia and Greece to around 48% in Belgium and Netherlands (Godeau et al, 2008). This may be due to systems that enhance adolescents efforts to reduce unintended pregnancy such as comprehensive sex education in schools and tools that they need to protect themselves with, if and when they choose to become sexually active (Finer, 2010).

There is evidence that comprehensive sex education promotes contraceptive use among adolescents. Comprehensive sex education includes prevention of pregnancy, effects of early pregnancy and sexually transmitted infections including HIV/AIDS; knowledge, attitudes and practice of adolescents on sexuality and reproductive health education and rights and contraception. Contrary to the fears of some parents, providing information about contraception does not increase adolescent sexual activity. Rather, appropriate education has been shown to delay the age of first intercourse and is associated with consistent use of contraceptives as well as lower pregnancy rates (Nusbaum & Rosenfeld, 2004 cited by Holcomb et al, 2009). Findings from a national survey on heterosexual teens aged 15-19 years provided compelling evidence about the value of comprehensive sex education when it compared adolescents who received no sex education, abstinence-only education and comprehensive sex education. Adolescents who received comprehensive sex education were 60 percent less likely to report becoming pregnant or impregnating someone than those who received no sex education (Kohler, 2008).

One of the factors that encouraged respondents to develop positive attitude towards contraceptive use was the prevention of the responsibility to raise children

during adolescence. Sometimes the adolescents are forced into early marriage when they become pregnant which put strain on their lives as they struggle to raise the children as well as take care of the family since mostly they are financially dependent. These findings are consistent with other previous studies in Malawi and Uganda. Munthali et al, (2006); Neema, Moore and Kibongo (2007) found that most adolescents had negative feelings on non marital pregnancies since it brought shame and disgrace to their families in addition to school interruption and financial burden in order to care for the mother and child.

Respondents developed negative attitude for contraceptive use because of lack of adequate information on most of the methods. It was worth noting that despite getting the information from a diversity of sources, the respondents still felt that they had received inadequate information on contraceptives. This could be attributed to the fact that most of the respondents felt the information they had received lacked such details about contraceptives such as the advantages, disadvantages and how the methods can be effectively used.

Furthermore, data from the respondents indicated some misinformation about contraceptives such as that they were not trustworthy and could cause cancer and barrenness. The methods mentioned to have these problems were condoms, pills, and injectable contraceptives. For instance, condoms were said to have small pores where some viruses and sperms can pass through rendering them ineffective. This is consistent with previous findings of a study which was done in Malawi on barriers to condom use (Munthali et al, 2004). There is need to provide adolescents with adequate and accurate information so that myths and misconceptions are dispelled so as to promote the understanding and use of contraceptives.

The results from this study also have indicated that adolescents felt that girls who used contraceptives would have problems in future during child birth. Thus, they recommended contraceptive use to adults, those who already have children and married. Misinformation about contraceptives can hinder their acceptance of contraception and their intention to use contraceptives. According to the theory of planned behaviour, this can affect the adolescents' perception about contraceptive intention and use. In this study, lack of adequate and accurate information was found to be a major barrier to the use of contraceptives among the adolescents.

One of the misconceptions revealed in this study was that condoms cannot be used on a beautiful girl. This implies that beautiful girls are free of the STIs including HIV and AIDS. This is a gross misrepresentation of facts on condom use and has grave impact on sexual and reproductive health of adolescents because they can easily get unintended pregnancy or contract and transmit STIs including HIV and AIDS. There is need for adolescents to be provided with information on sexual and reproductive health which includes HIV transmission, prevention and disease progression.

Another misconception was that condoms were used on casual or new lovers. This led to inconsistent contraceptive use among adolescents. Inconsistency in contraceptive use has been widely found in most research (East, Jackson, O'Brien & Peters, 2007; Bankole et al, 2007; Manlove et al, 2007; Blanc et al, 2009; Bearinger, Sieving, Duke, McMorris, Stoddard & Pettingell, 2011). Both male and female respondents in the present study attributed this behaviour to trust and love they have for their partners. Some girls had to submit to the demands by their boyfriends not to use condoms while some boys used condoms in new relationships only.

This is consistent with recent research findings where there is an increased willingness to use condoms when the partner was not trusted and decreased usage in trusting relationships (Brady, Tschann, Ellen & Florence, 2009; Rosenbaum 2010). Condoms have become associated with one-night stands and as such in order to demonstrate trust and commitment many adolescents insist on not using condoms (Rosenbaum, 2010). Furthermore, Civic (2000) found that condom use in established heterosexual relationships was inconsistent and declined with relationship progression. Long-term relationships may result in partners believing that they know each other well enough to forgo the use of condoms.

However, this contrasts findings by Kabiru and Opinus (2009) where they reported consistent condom use in romantic and steady relationships. This could be attributed to the fact that young people in steady relationships may likely be aware of the likelihood of engaging in sexual intercourse and thus be prepared and have condoms available. This is true especially to those adolescents moving from previous relationships. In addition, there may be improved communication in romantic sexual relationships which could be associated with greater negotiations for safer sex.

Another factor that brought negative attitude towards contraceptive use arose from fear of side effects of contraceptives. Evidence shows that there is an impact of side effects on continuation and use of contraceptives. Side effects, the perception of side effects, anxiety about possible side effects, and myths and misinformation about side effects affect correct and consistent contraceptive use. For instance, acne development was the reason for discontinuation of injectable contraceptives. Acne development altered the body image of a respondent to the extent that she discontinued the method. A study on continuation rates among injectable contraceptive users indicated that only 23% of those eligible for a full year of

contraceptive protection (four injections) obtained all four (Westfall, Main, & Barnard, 1996). Another study on progestin only contraceptives noted that each of these methods not only has specific advantages, but also specific drawbacks that can result in discontinuation of treatment if users are not given adequate information about what to expect in terms of side effects (Freeman & Shulman, 2010).

The study revealed that despite the wide availability of condoms, there were barriers which affect their use. The reluctance associated with condom use is complex. It is well documented that, for a variety of reasons, men of all ages do not like to use condoms (Flood, 2003; East et al, 2007). One of these reasons was reduction of sexual pleasure.

Reduced sexual pleasure was reported as the main reason for inconsistent use of condoms in this study, in addition to pain and irritation. This contributed to the development of negative attitude towards condom use. Condoms interpose a mechanical barrier between sex partners, limit physical contact, reduce tactile sensation, and attenuate heat transduction; all of which reduce sexual pleasure. This reduction in pleasure is one of the main reasons most people cite for avoiding condom use (Albarracín et al, 2000; Choi, Rickman, & Catania, 1994; Flood, 2003; Crosby et al, 2005; Crosby, Yarber, & Meyerson, 1999; Norton, Bogart, Cecil, & Pinkerton, 2005 cited by Randolph, Pinkerton, Borgat, Cecil & Abramson, 2007).

Similarly, in their study of older college Asian and white students whose mean age was 22.29 years, Randolph et al (2007) found that both women and men believed that the use of condoms during vaginal intercourse significantly reduced sexual pleasure. Men highly valued unprotected sex and appeared to believe that condoms reduced pleasure more often than did women. Perceptions that condoms decrease

sexual pleasure are an alarming but not undefeatable barrier to public health efforts to increase condom use among sexually-active youth.

In another study by Kinsey Institute for research in Sex, Gender and Reproduction found that incorrect use of condoms can cause lack of sexual enjoyment which may contribute to poor sexual satisfaction. Almost half of the participants (N= 436 men) reported using badly fitting condoms during the previous three months before the study. These participants were more likely to report problems associated with the use of condoms. Actually, they were 2.5 times likely to report breakage and slippage, 5 times likely to report penile irritation, and 2 times likely to report that the condoms made it difficult for them and their partners to reach orgasm and that this curbed sexual pleasure for both parties (Oguntola, 2010).

In a similar vein, another study was conducted to find out if men who allowed ample time to apply condom are less likely to report problems that are associated with condoms of which reduced pleasure was one of them. Results included that men reporting that they did not have sufficient time for condom application were three times more likely to report breakage and 2.4 times more likely to report slippage. In addition, men who reported that they lacked time for condom application were 3.4 times more likely to report difficulty with erection, 2.1 times more likely to report reduced sexual pleasure, 2.2 times more likely to report reduced sexual pleasure of their female partner and 2.6 times more likely to report that the condom irritated their partner's vagina (Crosby, Graham, Yarber, & Sanders, 2010).

Additionally, since sex is spontaneous and impulsive; it may be very difficult for partners to 'slow down' to properly apply condoms. One qualitative study suggested that men may be concerned that the interruption caused by putting on a condom may lead their female partner to change their minds about having sex. However, messages

should urge men to take ample time to apply condoms. Men and women can be informed that ‘slowing down’ may enhance sexual pleasure by increasing sensation for partners, promoting female orgasm and reducing problems with erection and penile irritation (Crosby et al, 2010).

Furthermore, issues of gender and power in relationships also affected the use of contraceptives. The present study revealed that male adolescents felt that they had the mandate to decide on their own whether or not to use contraceptives in their relationships. This supports findings from literature review on condom use whereby it is documented that men often hold the balance of control within heterosexual relationships including the decisions about whether or not a condom will be used (East et al, 2007). In relationships which women are typically viewed as being subordinate to the male, women lack the power to assert condom use.

On the contrary, female adolescents feel more positive towards condoms and are more committed to their use than men. Unfortunately, the male condom and even the female condom to some extent are controlled by men. Men do not necessarily need to negotiate condom use whereas women may have to initiate, negotiate and insist on its use (Enrhardt, Exner, Hofman, Silberman, Yingling, Adams-Skinner & Smart-Smith, 2002). Condom negotiation requires women to have high self-efficacy, perceived autonomy within the encounter and acceptance of sexuality and effective communication skills (de Visser & Smith, 2001, Ehrhardt et al. 2002). According to Dehne and Rieder (2005 cited by East et al, 2007), women of all ages find it difficult to negotiate condom use and young women and adolescents find it even more difficult because of their age and probable inexperience in such negotiations. This power imbalance and inequality limits female assertiveness. This puts girls at risk of

unintended pregnancies and STIs should their boyfriends decide not to use condoms or any other contraceptive method.

Nevertheless, the introduction of the female condom and other female controlled methods has given women the possibility to facilitate consistent condom use. However, the use of female condoms is still reliant on partner negotiation. Hence the power inequity in most sexual relationships negates its use. In addition, it is suggested that the male condom is more widely used and preferred as compared to the female condom. Apart from being relatively new, the female condom is bulkier and more obtrusive than the male condom, not widely available and perceived to be difficult to use (Ehrhardt et al, 2002) especially on insertion (Blythe & Diaz, 2007).

In addition to the reduction in tactile stimulation that condoms have, the female condom is also reported to be unsightly and noisy (Blythe & Diaz, 2007). Therefore, this has a negative impact on its potential use as both tactile and visual sexual stimulation inevitably reduces the romantic aspect of sexual encounters (Flood, 2003). Hence, there is need to emphasise the use of the female condoms in both genders so as to promote use among the youth.

It is worth noting that there are reports on the positive aspects on the use of condoms related to sexual pleasure. For instance, the report of the Planned Parenthood Federation of America (PPFA, 2006) asserts that using condoms makes some people focus better on their sexual pleasure without distractions about unintended pregnancy and STIs. This can enhance sexual excitement. Hence, civic education should emphasise on these positive aspects of condom-induced pleasure to the public in general and particularly adolescents in order to increase their awareness which can affect the intention to use and the actual condom use.

Normative beliefs and subjective norms regarding contraceptive use

Adolescents' intention and decision to use contraceptives was influenced by several factors such as normative beliefs and subjective norms. These beliefs and norms came from parents and other family members, sexual partners, friends, health care workers, religious and community factors. The community factors included the media and exposure to formal and informal education.

Family members, peers, health care workers, religious and cultural beliefs and the media influence adolescents' intention to use contraceptives as well as the actual contraceptive use. Parents, guardians, siblings, other elders in the community and friends are regarded as informal sources of information. These sources remain unreliable as they have either good or bad information about contraceptives depending on where they got the information themselves. However, if they got the information from reliable sources then, these people can play a vital role in the provision of sexual and contraceptive issues.

The findings from this study indicated mixed reactions from the respondents on their parents as sources of information and encouragement to contraceptive use. The respondents acknowledged the parental role in information giving about contraceptive use. Indeed, parents have an influence on the sexual and reproductive health of adolescents. Previously, parents were not regarded as sources of information in Malawi on sexual and reproductive health issues due to the traditional practices whereby the extended family members such as aunts, uncles, grandmothers and other relatives were expected to play this role. Hence, a study by Wittenberg et al, (2007) found that parents were not preferred sources of information on reproductive health including contraceptives, HIV and other STIs. But currently, due to urbanisation, the extended family ties have been broken hence it is hard to reach the extended family

members most of which are still in the villages. As a result parents have attained the responsibility of informing their children about issues on contraceptives and reproductive health in general.

Even though it is generally accepted that parents and guardians are responsible for the health and well-being of their children, there are limitations to the extent to which sexual issues are discussed in different families. Some respondents observed that their parents did not feel comfortable to speak to them on contraceptive issues to the extent that when such issues come up they shut them out therefore no discussions prevailed. Other respondents shared the view that the parents made efforts to communicate to them and that although the discussions were not very open and deep, they conveyed the message that it was better to abstain but if not possible then they should use condoms.

On the other hand, some respondents indicated some reservations as to what they could discuss with their parents freely. Sexual and contraceptive issues reportedly brought discomfort to both parties (the respondents and the parents). Data from this study showed that some parents initiated conversations on sexual and contraceptive issues but the respondents were not comfortable to engage in such discussions so it was more of parental advice being given to the respondents than discussion. The nature of the conversations was like a one way system where the respondents did not contribute much to the dialogue. This is not a healthy situation in adolescent reproductive health because this is the stage where adolescents may appreciate the importance of their parents' values which makes it possible for them to seek and accept parental advice (Neinstein et al, 2008).

In other settings however, parents, including significant others in adolescent social life, provide support for contraceptive use. Evidence indicates that maternal

communication has been shown to delay sexual intercourse and contraceptive use (Commendador, 2010). In a study on adolescents' social support for contraceptive use in a low-income community in the US, it was found that mothers, male partners and friends were supportive of the adolescents' clinic visit for contraceptive use. This implied that it was important to ask adolescents about who is involved in their contraceptive decisions and encourage them to communicate more with those people with whom they feel comfortable seeking support from (Harper et al, 2004). In the same vein, adolescents whose parents talk with them about sexual issues are more likely to delay sexual onset, and when sexually active, are more likely to use contraceptives, use condoms, and have fewer sexual partners than those adolescents for whom this communication does not occur. Greater ability to communicate with parents was also related to greater condom commitment and use among male adolescent. (Halpern-Felsher et al, 2004).

Aronowitz et al (2006) in their study on African-American adolescents in the US found out that both mothers and daughters shared that mothers should have a primary role in sexuality education. However, in a study done in four African countries of Burkina Faso, Ghana, Uganda and Malawi, unmarried adolescents reported moderate to high levels of parental monitoring and low levels of parent-child communication about sexual matters. Parent-child communication about sexual matters was positively associated with contraceptive use in two countries, namely Ghana and Uganda.

Biddlecom, Awusabo-Asare and Bankole (2009) argued on the extent to which parents can be involved for the benefit of their children's adolescents' sexual and reproductive health given the context of sociocultural factors surrounding such relationships. Suggestions were made on how some aspects of parental involvement, but probably not all, likely play key roles in helping adolescents establish and

maintain healthy sexual and reproductive lives. Suggested roles of parents include provision of advice on sex related matters and assisting adolescents in obtaining methods to avoid unintended pregnancy rather than assuming the teaching role about contraceptive methods with their children. Additionally, there is need for improved open and supportive communication channels with parents and other parent figures as well as exploring other strategies like use of relatives and other elders for such roles.

Furthermore, it is worthy noting that as primary sex educators, parents need to be equipped with accurate information on contraceptives so that they are able to disseminate the correct facts to their children. In their study, Einsenberg, Bearinger, Sieving, Swain and Resnick (2004) found that parents did not have accurate information on contraceptives. For instance, fewer than half of the parents thought that correct and consistent use of condoms is highly effective for pregnancy and STI prevention. This means that they would not encourage their adolescents to use condoms as they thought they were not effective against pregnancy and STI prevention. This can hinder their self efficacy to provide contraceptive education to their children and adolescents. When they are equipped with adequate and accurate information however, it may increase their confidence and this may affect the parent-child communication positively.

On the other hand, in a study done in Uganda, adolescents reported that parents, guardians and elders did not provide them with information about sexuality and contraceptive use. On their part, parents and guardians, especially mothers, reported that girls failed to confide their problems to them, which made it difficult for them to offer advice. Instead, these girls preferred to get advice from their peers (Sekuwinga & Whyte, 2009).

Peers are considered an important group as they influence the decisions made by adolescents concerning sexual and contraceptive issues. Adolescents feel more comfortable to confide in and get advice from their peers than parents and elders. Nwankwo and Nwoke (2009) found that peers mainly influenced adolescents to indulge in risky sexual behaviours. Similarly in another study, it was found that adolescents' perceived ability to communicate with peers was related to more positive attitudes towards the condom, which in turn were associated with greater condom commitment and use. These findings suggest that efforts to enhance adolescents' perceived self-efficacy to communicate about sexual issues with parents and peers may be helpful not only to improve communication, but to improve attitudes about, intentions to use, and actual use of condoms (Halpern-Felsher et al, 2004).

On the other hand, there is evidence that adolescents' perceptions that their peers support condom use is associated with more consistent condom use (Halpern-Felsher et al, 2004). That is why some adolescents in the present study decided not to use condoms when their friends reported that they did not use them. Therefore, it is reasonable to expect that conversations among adolescent peers about contraceptive use would also play a critical role in adolescent sexual risk behaviour.

In a similar vein, some studies have examined the simultaneous influence of parent and peer communication on adolescent sexual behaviour. Holtzman and Robinson (1995) found that high school students who talked to their parents about HIV were less likely to have unprotected sex, while students who reported discussing HIV with peers were more likely to have unprotected sex. Furthermore, Whitaker and Miller (2000) found that for both engaging in sexual behaviour and condom use, parental communication about sex and condoms moderated the peer norm-behaviour relationship. Specifically, the relationship between perceived peer norms regarding

sex and condom use and teens' actual sexual behaviour and condom use was stronger for those adolescents who had not discussed condoms or sex with a parent. These findings suggest that poor parent-adolescent communication regarding sexual issues may cause greater reliance on perceptions of peer norms as a guide to sexual behaviour. Hence, there is need to reinforce parental involvement in the counselling of adolescents regarding sexual and contraceptive issues.

Religious, cultural and societal beliefs influenced adolescents' decisions to accept contraceptives or not either directly or indirectly. Most churches encouraged abstinence among adolescents citing premarital sex as sin. Hence issues about contraceptive use are generally not discussed in religious circles. However, some churches castigate youth who become pregnant outside marriage. Indirectly this makes the youth utilise contraceptives such as condoms when abstinence fails so that they are not excommunicated from the church.

To a lesser extent some churches encouraged the youth to use contraceptives such as condoms in order to prevent pregnancy and STI including HIV and AIDS. This echoes prior findings by Munthali et al, (2006) that religious teachings encouraged abstinence and, less commonly, condom use. Similarly, Manlove, Logan and Moore (2008) reported a negative association religiosity and contraceptive use for male adolescents which suggested dual message of abstinence and the need for contraception if they become sexually active.

In the same vein, cultural and societal beliefs prohibit premarital sex and consequent use of contraceptives among adolescents. Yet, despite adolescents adopting this negative attitude towards sex, they still have sexual relationships. This is consistent with findings from in-school adolescents in Kenya who had conservative attitudes towards premarital sex and contraceptive use. Indeed, abstinence is the only

100% effective method of preventing unintended pregnancy (Holcomb et al, 2009) and STIs. Although it is advocated in many circles such as the family, church and society in general, in practice, many adolescents who intend to be abstinent often fail and have sex. Adolescents are faced with social and biological pressures to engage in sex, and it is difficult to match their attitudes with their practice (Kangara, 2005 cited by Adaji, Warenius, Ong'any & Faxelid, 2010). Therefore, adolescents need to know about other contraceptive options before, or if, they decide to have intercourse.

Adolescents' perception of risk to unwanted pregnancy

This study found that most of the respondents perceived themselves to be at risk of becoming pregnant and impregnating their girlfriends when they are not using contraceptives. They reported that unprotected sex predisposed them to unwanted pregnancy and STIs including HIV. This is contrary to previous findings where participants perceived themselves being at low risk for pregnancy despite engaging in unprotected sex (Wu et al, 2002; Martyn et al, 2002; Munthali et al, 2006).

Despite their perception of being at risk to unwanted pregnancy, inconsistency in contraceptive use was evident in the respondents in this study. This finding may seem counterintuitive but it is consistent with previous studies showing that teenagers who are, or who perceive themselves to be, at high risk have a reduced likelihood of using condoms and an elevated likelihood of engaging in sexual risk-taking behaviours such as having multiple partners (Kirby, Laris & Rollen, 2006; Ryan et al, 2007). Hence, teenagers who perceive themselves to be at high risk for acquiring an STI may be an especially vulnerable group in need of services.

Furthermore, there are differences in the way adolescents perceive sexual relationships. Young men equate sex with physical pleasure whereas young women equate it with trust, intimacy and commitment. Condom use therefore implies

mistrust while unsafe sex is often seen as a declaration of one's love. These sentiments yielded risk postponement among respondents. Female respondents felt they would rather place themselves at risk than face the potential abandonment by an actual or potential romantic partner. This is echoed in findings by Critelli and Suire (1998), which suggested that perceived trust, desire for intimacy, holding a relationship in positive regard, belief in monogamy within relationships among other issues overrode the concerns about STI risk.

The present study revealed that respondents had hidden risk as they went for VCT to check for their HIV status. If they tested negative for HIV for several times they started having sex without using condoms. Consequently, they resorted to use of natural methods such as calendar and withdrawal methods to avoid unintended pregnancies. Nevertheless, these adolescents were still at risk for both STIs and pregnancy due to the unsafe sex and unreliability of natural methods.

Perceptible risk for pregnancy and STI including HIV/AIDS was apparent in respondents who consistently used contraceptives. This is consistent with evidence that the perception of risk in late adolescence is associated with the ability to comprehend how current behaviours affect long-term health status of individuals (Heubner, 2009). Worries and fear about contracting STIs and getting unplanned pregnancy can serve as a motivation for adolescents to employ ways of reducing their risky behaviours.

This study revealed gender differences on risk perception. Male and female adolescents hold different opinions regarding concerns about pregnancy and STIs prevention. This study revealed that boys fear STIs including HIV and AIDS more than pregnancy and that the girls fear pregnancy more than STIs. They said that female adolescents are concerned with pregnancy more because it shows; they cannot

hide it hence everyone would know about it. They thought if they had a child while at school, they might have problems finding a suitor for marriage in future because he might not want a girl who already had a child. As for STIs including HIV and AIDS, on the other hand, respondents thought that they could hide it and get treated secretly. With antiretroviral therapy (ART), it is uncommon to see people who look emaciated unless they are terminally ill of AIDS. So, nobody knows they are infected hence some adolescents are not concerned much about STIs including HIV and AIDS.

Similar findings were reported by Sekiwunga and Whyte (2009) in their study about teenagers' views on adolescent pregnancy and HIV. Likewise in another study, teenagers suggested that pregnancy was more immediately evident and shameful than HIV and had abrupt consequences for both girls and boys because it was morally condemned (Bukuluki, Walakira, Sengendo, & Mugumya, 2005). Indeed, teenage pregnancy is more common than adolescent HIV infection, which may be the reason for the corresponding greater concern. Recent data show that the HIV prevalence among girls and boys aged 15-19 years is 4% and 1% respectively (NSO, 2011). However, there is need to emphasise the importance of preventing both pregnancy and HIV in the promotion of sexual and reproductive health and rights of adolescents. Due to inconsistency and non use of contraceptives, most acts of premarital sexual intercourse are unprotected or coerced. Sexually active adolescents are increasingly at risk of unwanted pregnancy, abortion or contracting and transmitting sexually transmitted infections (STIs), including HIV/AIDS due to gender power imbalances (Nwankwo & Nwoke, 2009).

A study done among Ugandan adolescents (Kibongo et al, 2007) revealed that significantly higher proportions of male adolescents are engaged in high risk sexual behaviour compared to females. Although most adolescents perceive themselves to

be at great risk of getting infected with HIV, this perception is much stronger among females regardless of their current sexual behaviour. Given that risky sexual behaviour among males translates into risk for the opposite sex, it is perhaps not surprising that significantly higher proportions of females perceived themselves to be at great HIV risk compared to the males. Hence it is recommended that programs should target both male and female adolescents in the prevention of HIV from household, community to program levels.

Adolescents perceived ability to use contraceptives

Perceived ability is conceptually related to behavioural control in the theory of planned behaviour. Adolescents' perceived ability to use contraceptives has been studied in several researches. Most studies have found that peoples' perceived ability increases their intentions to use condoms and the actual condom use. Adolescents who had high perceived ability to use condoms, for instance, felt comfortable to buy and carry one or more condoms with them in case they might need to use them. A study by Alarape, Olapegha and Chovwen (2008) found that students with high perceived ability to use condoms reported using condoms more than students who had low perceived ability for condom use. Similarly, Wang et al, (2003) and Wang and Chiou (2008) found that self-efficacy was positively correlated with contraceptive behaviour.

Nevertheless, during an evaluation of an intervention, Health-Wise South Africa, it was noted that the program increased adolescents' perceived ability to condom use for both boys and girls. But the study did not indicate a direct effect on reported frequency of condom use probably because it was not accurately measured (Coffman, Smith, Flisher & Caldwell, 2011). Similar results were found in two separate studies where there was no significant relationship between condom use self efficacy

(perceived ability) and condom use because they omitted measures for condom use as they were not part of the study goals (Crosby et al, 2001; Farmer & Meston, 2006).

Condoms were widely available in many settings such as shops, pharmacies, clinics and public conveniences. This made them easily accessible to adolescents. Respondents considered the cost of condoms to be low. However, some challenges met by respondents were shyness as some of them could not buy from local shops for fear of being seen by familiar persons. Some found themselves in situations where they did not have their preferred brand of condoms. Other respondents did not like the idea of buying condoms since they preferred to get them free of charge from different settings.

Adolescents' intention to use contraceptives

Adolescents' intention to use contraceptives stemmed from the knowledge and the preparation they had for contraceptive use during sexual encounters. The contraceptive information that the respondents received affected the knowledge that they had on contraceptives. All of the respondents indicated having knowledge about the advantages of using contraceptives in order to prevent unintended pregnancy. Most of them indicated that it was not right to have children at this stage of life when they were still at school.

The results of this study indicated that adolescents' intention to use contraceptives was impeded by inadequate information about these contraceptives which resulted in less understanding on how they work. There is rich evidence from studies in sub-Saharan Africa which shows that adolescents are concerned about and want to protect themselves from unplanned pregnancy and HIV. But due to misinformation about sex and its consequences, many adolescents do not get the education and services they need (Boonstra, 2007). Worse still is the fact that the

adolescents themselves are unaware of how incomplete their information is hence they cannot proactively come with questions to health educators, teachers or parents. Therefore, there is need for the health educators, teachers, parents and others to reach out to the adolescents with accurate information about sexual and contraceptive issues (Neema et al, 2007).

Rock, Ireland, Resnick and McNeely (2005) examined the roles of both objective and perceived knowledge on adolescent sexual behaviour and use of condoms among in-school adolescents. Their findings supported the inclusion of perception of knowledge as an antecedent to adolescent sexual behaviour. Objective knowledge showed an inconsistent ability to act as a predictor of adolescent sexual behaviour whereas perceived knowledge, in concert with objective knowledge, seemed to play a significant role in condom use at first intercourse among male adolescents.

Lack of information and misinformation on other contraceptives than condoms affected their use among the respondents. Results revealed that the male condom was the most popular method among the respondents. This is because it was widely spoken about in both formal and informal circles. This finding is consistent with the nationally representative survey of 12-19 year old adolescents' sexual and reproductive health practices in four sub-Saharan African countries of Uganda, Burkina Faso, Ghana and Malawi where use of modern methods, apart from the male condom, was much less common in all the four countries (Biddlecom et al, 2007).

Respondents shared the view that condoms were well-accepted as compared to other methods such as pills, norplant and injectable contraceptives. The use of barrier methods is consistent with findings by Raine, Harper, Pauku and Darney (2002) where black adolescents were more likely to choose barrier methods over hormonal methods. Similarly, results from the recent demographic survey (NSO, 2011)

revealed that the male condom was widely used (44%) among the unmarried women aged 15-19 years. This was followed by the use of traditional methods (11%), namely withdrawal (9.1%) and rhythm or calendar method (3.4%). This could be related to higher perceived risk for STIs including HIV as well as cultural concerns about the safety and or adverse effects of hormonal methods. Furthermore, Abma, Martinez and Copen (2010) report on data from the US National Survey of Family Growth among never-married teenagers from 2006 to 2008 indicated that the condom remained the most commonly used method (95%) followed by withdrawal (58%), oral contraceptive pill (55%) while the use of calendar method was at 17% (an increase from 11% in 2002).

In addition to condoms, the respondents expressed that they used non-hormonal contraceptive methods such as coitus interruptus (withdrawal method) and fertility awareness-based methods (calendar methods). Although non-hormonal contraceptive methods are most appropriate, sexually active adolescents are less likely to consistently and correctly use them. The withdrawal method, which involves the male partner's attempt to withdraw the penis before ejaculation, is still widely used by adolescents in sexual relationships. Adolescents should receive counselling that emphasizes the high failure rate of withdrawal for pregnancy prevention which is at 19% during the first year of typical use. It is important to stress that pre-ejaculatory fluid can contain enough sperm to cause pregnancy. Pregnancy is also possible if semen or pre-ejaculate fluid leaks out onto the vulva. In fact, a study by Wu et al, (2002) showed that using the calendar and withdrawal methods led to 75% of the unwanted pregnancies in female adolescents.

Using fertility-awareness method as a contraceptive option depends on several factors and requires a strong knowledge of the menstrual cycle and reproductive

fertility. This method involves the identification of fertile days within each menstrual cycle when intercourse is most likely to result in pregnancy. Couples can abstain during the fertile times of a woman's cycle or use a combination of either barrier or withdrawal methods.

However, fertility awareness method has a failure rate of 25% within the first year of use, with some estimates of the pregnancy rate even higher. The major disadvantage of this contraceptive method for adolescents is menstrual cycle irregularities and the fact that ovulation is not predictable in the few years after menarche (Blythe & Diaz, 2007). As a matter of fact, the use of less effective methods such as these (calendar and withdrawal) results in a high risk of contraceptive failure (Wu et al, 2002).

None of the female respondents knew about emergency contraception hence had never used it. Instead, some respondents mentioned that they used penicillin tablets a few hours after unprotected sex to avoid pregnancy. This lack of appropriate information put them at risk of pregnancy where it could have been avoided. Lack of awareness and access to emergency contraception has been reported as hindrances to adolescents' learning about and using it (Parker, 2005). It is necessary that young people be aware of emergency contraception because they tend to have unplanned sexual intercourse, contraceptive failure due to inexperience and are exposed to coerced sex including rape. Emergency contraception is an important option for sexually active adolescents in the efforts to avoid unintended pregnancy.

The intention to use contraceptives was also affected by the preparation respondents made to sexual encounters. Those respondents who made long and short term arrangements for contraceptive use registered their intention to use contraception. For instance a male respondent had to make last minute efforts to get a

condom just before having sex because he remembered a radio advert which had a message on condom use. This reflects the impact that the media has on the promotion of safe sex which protects against pregnancy and STIs.

However, other respondents made no effort to prepare for sex and contraceptive use. They reported being taken by the heat of the moment hence could not use any contraception. This is consistent with a study done by Mantell, Smit, Beksinska, Sorgie, Milford, Batch... and Stein (2011). In their study on the consistency use of condoms, they found that one of the reasons for non-use of condoms was when sex occurred in the heat of the moment and condoms were unavailable.

Decision making to use contraceptives

While communication among lovers was reported to be present in some relationships, it seemed to be a problem in other relationships. When sexual partners are involved, they provide social support on issues of contraception (Commendador, 2003; Harper et al, 2004; Manlove & Holcombe, 2007). On the contrary, failing to communicate on matters concerning sexuality and contraception has been associated with sexual-risk-taking behaviours and inconsistent or non-use of contraceptives. For instance, youth who reported failure to discuss contraceptive use prior to sex also reported inconsistent contraceptive use and had elevated odds of having an unintended birth during young adulthood (Ryan et al, 2007; Scott, Wildsmith, Welti, Ryan, Schelar & Steward-Streng, 2011). Inter-spousal communication is related to contraceptive decision-making and positively affects contraceptive uptake and continued use, whereas failure to communicate reproductive intentions limits couples' effective and sustained contraceptive use (Shattuck, Kerner, Gilles, Hartmann, Ng'ombe & Guest, 2011).

Communication among sexual partners is also related to how prepared they may be for the sexual act as well as contraceptive use. Most adolescents do not plan their sexual encounters hence it becomes difficult for them to plan for contraceptive use during such encounters. Discussing contraception before sex can help adolescents plan their sexual intercourse and consequent use of contraceptives. The findings from Ryan et al, (2007) support the idea that a key focus of pregnancy and STD prevention programs should be to help both male and female teenagers become comfortable with initiating conversations and communicating about pregnancy and STD prevention, especially before they engage in sexual intercourse for the first time. Manlove et al, (2007) found out that consistency in contraception improved in relationships whose partners discussed use of contraceptives before having sex for the first time and with the use of hormonal methods.

One of the reasons that respondents reported for not using the other common hormonal contraceptives such as the pills, injectable contraceptives (medroxyprogesterone or depo-provera) and implants such as norplant or jadelle was that these methods require the adolescents to visit a health facility and concerns about the safety and adverse effects of hormonal methods. Hospital consultation is required for hormonal contraceptives because of the need to screen for contraindications before use such as undiagnosed abnormal genital bleeding and known or suspected pregnancy.

Hormonal methods, when used correctly, are very effective at preventing pregnancy. These methods are the most clinically appropriate methods for adolescent girls. However, one of the respondents stopped using this method due to the side effect of acne. The other hormonal method available, such as the progestin-only mini pill, is not suitable for the adolescent patient. The mini pill is not as effective as

combined oral contraceptives (COCs) and requires strict adherence to a daily dosing schedule. Intrauterine devices and implants have proven to be an effective method of birth control; however, the upfront cost is expensive in the US (Holcomb et al, 2009). These methods are available free of charge in public health facilities in Malawi.

Fear of stigma prevented some respondents from using some contraceptives apart from the condom. The results showed that the few female respondents who once used pills and injectable contraceptives hid the information from friends and even their boyfriends for fear of being discriminated against. In addition to that, the respondents indicated that they would encourage their friends to use condoms and discourage them from using the other methods.

Social stigma surrounding adolescent sexual activity and contraceptive use has been previously reported in some studies. For instance stigma and guilt was reported among out of school adolescents in Uganda (Batwala, Nuwaha, Mulogo, Bagenda, Bajunirwe & Mirembe, 2006). Society regard contraceptive use as acceptable for married people with 'enough' children hence condemns early sex, pregnancy and contraceptive use by young people (Nalwadda et al, 2010). This deters adolescents from seeking contraceptive information and services.

Some respondents' intention to use contraceptives was marred by the practice of deception among male adolescents. The issue of deception to the use of condom in adolescent relationships was reported widely by respondents. Male adolescents deceived their partners that they had used a condom when in actual sense they had not. Consequently, this had contributed to unintended pregnancies as reported by respondents and is a potential hazard to the acquisition of STIs.

According to Rosenbaum (2010), deception creates substantial tension for adolescents when it comes to sex, particularly regarding the motivations of their

partners and the extent to which they trust them. Both males and females are generally aware of the possible deceptions of other adolescents. Hence, there is need for adolescents to ensure that their partners have used a condom correctly and properly. In addition, it is imperative to include male adolescents in matters of contraceptive use. Boys should be included in efforts that aim at delaying pregnancy in girls. Cowley and Farley (2001) found that the strongest predictor of an adolescent girl's attitude was her stated belief about whether her boyfriend wanted a baby or not.

Limitations of the study

This study had several limitations. Firstly, time and financial limitations were the major constraints that were experienced in this study. This was a very important study that should have covered all the three regions of the country in order to get the underlying factors that influence adolescents' decision making regarding contraceptive use in different contexts. This is because adolescents face different challenges in different geographical and cultural backgrounds.

Secondly, the study did not include out of school and married adolescents whose intentions and decision making could be compared to those in-school adolescents.

Thirdly, the study was conducted around the period whereby most tertiary college students sit for international examinations. So, the study had a prolonged phase of data collection because there was need to conduct the interviews after the students had completed their examinations. Consequently, there was loss of contacts for some potential participants due to logistical problems and some had gone for holidays. As such, a new crop of potential participants were identified in the same colleges.

Lastly, owing to the fact that data was self-reported, there was possibility of subjectivity and social desirability bias which could limit the results despite the attention paid to ethical concerns during the study.

Conclusion

This study has added insights to the factors that influence adolescents' intentions and decision making to accept contraceptives. Contrary to the common socially accepted messages on abstinence, which is the only most effective method of preventing unintended pregnancy and STIs, adolescents are faced with pressure to engage in sex. A number of factors contributed to contraceptive acceptance among adolescents such as positive attitudes toward contraceptive use; subjective norms and normative beliefs that promote contraceptive use; high self-perception of risk to unwanted pregnancy and high self-efficacy for contraceptive use.

Positive attitudes towards contraceptives were developed from the desire to postpone pregnancy beyond adolescence motivated them to use contraceptives. Motivating factors included the values that adolescents have in terms of desire for high education, stable and future family, prosperous future, independence and good health. Respondents acknowledged the benefits of contraceptives which included protection against pregnancy and STIs including HIV. Respondents noted that it was their responsibility to use contraceptives whenever they are ready to engage in sexual activity. Normative beliefs and subjective norms influenced adolescents to use contraceptives especially when there was open communication with family members such as parents and siblings; other relatives and guardians; other elders in the community; teachers, health care workers, peers and their sexual partners. Some religious, cultural and societal expectation comprised abstinence messages and use of contraceptives if that fails.

Central to contraceptive acceptance was the use of condoms as well as calendar and withdrawal methods among the adolescents. These methods are less effective in the prevention of pregnancy and STIs including HIV except for the male condom. The

male condom was widely used and accepted in adolescent circles due to among other reasons, the dual effect it has in the prevention of pregnancy as well as STIs including HIV and AIDS. The study also indicated that condoms were easily accessible, available, affordable, convenient and do not require hospital consultation for adolescents to use. Respondents reported that they had self efficacy to use condoms. Long-term preparation of sex denoted intention to use contraceptives hence led to the actual use of contraceptives. Both male and female adolescents put effort to have condoms ready for use regardless of whether their sexual encounters were planned or not.

Negative attitudes towards contraceptive use developed mainly due to inadequate and inaccurate information on contraceptives. This affected the respondents' knowledge about contraceptives hence led to inconsistent contraceptive use. Respondents held beliefs that contraceptives are meant for people who already have children, married couples and adults. Fear of bad side effects of contraceptives and other myths on condoms deterred consistent contraceptive use. For instance, beliefs that condoms are not used on beautiful girls, in long-term and romantic relationships due to trust and love puts adolescents at risk of pregnancy and STIs including HIV and AIDS.

Reduction of sexual pleasure associated with condom use was mostly reported by respondents hence need to be addressed as evidence suggest that it is a common problem which often occurs due to improperly fit condoms and incorrect use of condoms. Societal, cultural and family expectations of abstinence among adolescents brought social stigma to contraceptive use. This deterred them from seeking contraceptive information and services. Furthermore the study found that boys are practising deception on the use of condoms whereby they pretend to use condoms

when they did not hence rendering both adolescents at risk for unintended pregnancy and STIs including HIV and AIDS.

Therefore, using the theory of planned behaviour, this study has found that the use of contraceptives is affected by the intention to use contraceptives which is further influenced variously by adolescent values and attitudes towards contraceptive use; normative beliefs and subjective norms of significant others, and, religious, cultural and societal norms and expectations and their perception of risk to unintended pregnancy and STIs including HIV and AIDS. Thus, the concepts that were used in the study conform to the theory of planned behaviour.

Recommendations

This study has identified several gaps in adolescent contraceptive use hence recommendations are made in order to address them.

Inadequate information dissemination about contraceptives targeting adolescents.

There is need for evaluation of existing information avenues such as the life skills curriculum in both primary and secondary schools. Research should not only cover the content but also how it is delivered and the impact it has on the adolescents. This will identify specific gaps that can be further dealt with in order to close them.

There is need to develop programs on information and education services with comprehensive education on sexuality and contraceptives; develop tool kit for sexuality education in order to equip young people with the knowledge, skills and positive attitudes and values they need to determine and enjoy their sexuality physically, individually and emotionally. Topics include relationships, love and emotions, individual and societal attitudes toward sexuality, sexual roles, gender relations, social pressures, sexual and reproductive rights, information about sexual and reproductive health, services and communication skills training.

Information on sexual and reproductive health should include;

- reproductive physiology
- HIV and STI transmission and prevention methods
- family planning methods
- pregnancy prevention

Adolescents' reluctance to use contraceptives that require hospital consultation/ limited use of more effective contraceptives.

There is demand for contraceptive supplies and services for adolescents. Hence there is need to evaluate existing youth friendly health services and identify gaps so that remedies can be made to promote sexual and reproductive health of adolescents.

There is need to establish adolescent clinics in the existing health facilities that can serve the sexual and reproductive health needs of adolescents.

Encourage adolescents to use more effective contraceptive methods. Use of hormonal methods such as pills and injectable contraceptives as well as long-acting reversible contraceptives which includes implants and intrauterine devices provide more effective protection from pregnancy.

Establishment of more places where the youth can have information pertaining to their sexual and reproductive health issues can help those who feel reluctant to visit hospitals for information on sexual and contraceptive issues.

Reluctance by male adolescents to use contraceptives.

Men are often involved in decision making, and a number of studies have noted that teaching adolescent males about contraceptive use beyond condoms is important. For example, males' contraceptive knowledge is positively associated with their partners' oral contraceptive use. Adolescent males' ignorance about, and negative attitudes toward, contraceptive methods can be a fundamental barrier to their partners' contraceptive use. Hence there is need to involve male adolescents in programs that promote contraceptive use among the youth because they can influence utilisation of the methods in their relationships in order to prevent unwanted pregnancies.

Lack of open communication between parents, guardians and significant others and adolescents on sexual and contraceptive issues.

There is need to involve parents in adolescent programs to enhance communication between parents and adolescents. Equipping them with accurate and adequate age-specific information will empower them with confidence to communicate openly with their adolescents on sexual and reproductive health issues.

Adolescents will also feel free to talk with parents and guardians if they are involved in such programs.

Lack of accurate information among peers.

Encourage peer involvement in programs on adolescent sexual and reproductive issues because adolescents listen to their peers as they are the same age and have the same interests and activities. When peers have accurate information about contraceptives, it will positively influence their intentions and decisions to use them.

**Lack of negotiating skills and empowerment for female adolescents/
deception by male adolescents.**

There is need to empower girls to be autonomous on contraceptive use and have negotiating skills for condom use. When girls are empowered intellectually, they can negotiate for and ensure correct and consistent use of contraceptives. They can also be assertive and tactful hence ensure their male sexual partners have actually put on condoms during sexual activity in order to eliminate the issue of deception without hurting the emotions of their partners.

Reduction of sexual pleasure by condom use.

There is demand for thin condoms which provide more natural feel because the thin layer allows for more friction than the regular types. This will curb the common problem of reduced sexual pleasure that condoms are usually associated with.

There is need to refocus condom promotion campaigns (and condom marketing) to emphasize the pleasure-enhancing aspects of condom use such as condoms' ability to prolong sexual intercourse, thus increasing sexual tension, and ultimately sexual pleasure could help overcome perceptions that condoms significantly diminish pleasure, allowing the other benefits of condom use to come to the forefront.

Emphasis should be made on correct use of condoms as this can promote proper fit hence enhance sexual pleasure.

Need for motivation of contraceptive use.

Adolescents need to be assisted to have goals in life which can help them focus on their future hence delay pregnancy beyond adolescence.

Disapproval of adolescent sexual activity and contraceptive use by religion and society.

There is need to develop programs that should target different religious groups and the community where information on sexual and reproductive health and rights of adolescents can be tackled. Community involvement ensures that cultural issues are discussed and strategies that are workable are drawn and implemented.

Lack of generalisation of study findings.

There is need to replicate this study to a larger scale so that nationally representative samples are achieved for generalisation of the findings.

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CLIENT INFORMATION SHEET**Introduction**

You are being invited to take part in a research study on the intent and decision making regarding contraceptive acceptance. Before you participate in the study, it is important for you to understand why the research is being done and what it will involve. Please ask if there is anything that is not clear or if you would like more information. Participation is voluntary.

What is the purpose of the study?

The aim of this study is to explore factors that influence adolescents' decision making to use or not to use contraceptives. Adolescent pregnancy leads to school interruption and contribute to maternal and neonatal morbidity and mortality due to pregnancy and early childbearing. Contraceptives prevents adolescents from unwanted pregnancy which will result into improvement of the quality of life through completion of school, better job prospects and women empowerment. The international community advocates for promotion of responsible sexual and reproductive health among the youth thereby avoiding risky behaviour. Findings from this study will help identify what influences contraceptive acceptance among the adolescents. These findings will guide policy and development or improvement of strategies which can aim at finding solutions to deal with factors that do not favour and strengthening those that promote contraception use. In other words, this study will result in improved interventions that will promote contraception use among adolescents.

Who will participate in the study?

18-19 year old tertiary school students are eligible to participate in this study. Up to 30 male and female teenagers will participate.

Do I have to take part?

You are free to take part in the study or not or to withdraw at any time you feel like without giving reasons. Your refusal to take part in the study will not affect you in any way. If you agree to take part, you will be asked to sign a consent form if 18 or 19 years.

If I take part in the study, what will happen to me?

As a participant of this study, you will meet the investigator at a place where there will be audio-visual privacy. The investigator will use an audio tape to record your information if you grant permission. Detailed notes will also be taken where necessary. You are free to tell the investigator to turn off the recorder at any point in the conversation if you are not comfortable with the information you are giving. You are free not to answer any question you feel uncomfortable to answer. You will be asked to give information on your experiences towards the use of contraceptives. You will be required to narrate your own experiences, giving explanations and descriptions where necessary. You have to give true information and to the best of your knowledge. The interviews will take about 45 minutes to 1 hour. After the interview, the tape will be transcribed. You may see the transcript upon request and delete

anything you do not want included in the interview. At anytime during the interview you may decide to withdraw, you are free to do so. If you withdraw, no more information will be collected from you. When you indicate your wish to withdraw, the investigator will ask if the materials already collected so far can be used in the study. Information about you will be confidential and no one will identify who gave which information. Codes will be used instead. The tape recorders used to record information from you will be destroyed at the end of the study.

How will my privacy be ensured?

Participation in this study may result in your loss of privacy in that other people may see the results. Only the researcher, her supervisor and her researcher assistant may view the study results. They are required to maintain confidentiality regarding your identity. Results of this study may be used for teaching, research, publication or presentations at scientific meetings. If your individual results are discussed your identity will be protected by using a study code number rather than your name or other identifying information.

What are the possible risks for taking part?

There are no known risks associated with the study. The probable risk include long period for the in-depth interview and you may be uncomfortable with some of the questions and issues about your personal situation. Some of your information may be embarrassing if other people found out. You may skip any information that makes you uncomfortable.

What are the possible benefits of taking part?

There are no direct benefits to you. The findings of the study, however, will assist in identify strategies to promote contraceptive use among adolescents in order to avoid unwanted pregnancies.

Is there any financial benefit for me if I take part in this study?

Unfortunately you can not be paid for participating in this study. However, in the event that you have spent money to travel to the place of interview, the researcher will reimburse the transport money.

If something goes wrong, what will happen?

Complaints or concerns regarding how you have been treated during the course of the study can be forwarded to Kamuzu College of Nursing.

Contact for further information

If you need further information or you are worried about any aspect of the study, please contact Mrs. Esnath Kapito (Tel 01 989884 or cell number 0888 861 333), Dr. A. Kazembe (Tel 01 751622). The chairperson, College of Medicine Research Committee (COMREC), on telephone number 01871 911

(Chichewa version of client information sheet)

Mawu oyamba

Mulikupemphedwa kutenga mbali mu kafukufuku wofufuza za “mmene achinyamata amapangira ziganizo zawo zokhudza kulera.” Inuyo ngati mmodzi wachinyamata mukupemphedwa kutenga mbali mu kafukufukuyu. Koma musanatenge mbali mukafukufuku amneyu ndipofunika kuti mumvetse chifukwa cholinga chake. Muli oloedwa kufunsa mafunso pamene simukumvetsa. Kafukufuku amneyu siokakamiza ayi muli ndi uflu osnkha kutengapo mbali kapena ayi.

Kufunika kwa kafukufuku ameneyu

Kafukufukuyu ndi ofunika kwambiri chifukwa adzapeza zimene zimachititsa kuti achinyamata azilera kapena ayi. Achinyamata akakhala kuti sakugwiritsa ntchito njira zolera, atsikana amapezeka ndi pakati. Kukhala ndi pakati akadali ang’ono kumachititsa kuti adukize maphunziro awo komanso chifukwa choti matupi awo sanakhwime amakumana ndi mavuto ambiri nthawi yoyembekezera, yobereka komanso mwana obadwayo amakhala pa chiopsyezo chamavuto osiyasiyana monga kubadwa masiku osakwana, kubanika pobadwa ngakhalenso kupitilira kumene. Komatu kulera kumathandiza kupewa mavuto amenewa. Achinyamata akalera amakhala ndi mpata opitiliza maphunziro awo zomwe zimachititsa kuti amalize bwino lomwe ndi kukhala ndi maphunziro apamwamba mopanda kudukiza choncho amatha kupeza ntchito zabwino moti amatha kudzisamala okha ngakhalenso mabanja awo. Atsikana akaphunzira amakhala ndi mwayi okhala mmaudindo akuluakulu motero kukhala ndi gawo loyendetsa nawo ntchito zachitukuko mdziko. Dziko lonse lapansi likufunafuna achinyamata atakhala ndi umoyo wabwino pankhani za ubereki kuti apewe makhalidwe amene ambweretsa chiopsyezo pamoyo wawo wa ubereki. Zotsatira za kafukufuku ameneyu zidzaunikira zinthu zomwe zimachititsa achinyamata kutsata njira zolera kapena kusatsatira njira zolerazi. Zotsatira zakafukufukuyu zidzathandiza kuyika ndondomeko zoyenera kuti mavuto amene achinyamata amakumana nawo kuti asalere achepe ndi kupititsa patsogolo zinthu zomwe zimathandiza kuti achinyamata alere. Mwanjira ina, zotsatira zimenezi zidzadzathandiza kupaza njira zomwe achinyamata angathandizidwire kuti akhale ndimwayi wochita chisankho choti azilera kotero izi zidzathandizanso kupititsa patsogolo moya wawo waubereki.

Amene angatenge mbali pakafukufuku ameneyu ndi ndani?

Achinyamata onse amuna ndi akazi amene ali ndi zaka zakubadaw 18 ndi 19 ali ndi ufulu atenga nawo mbali pakafukufuku ameneyu.

Kodi ine ndikhoza kutenga mbali mukafukufuku ameneyu?

Muli ndi ufulu kutenga mbali pakafukufuku ameneyu kapena ayi. Ngakhale mutasankha kutenga mbali muli ndi ufulu kusiya kutenga nawo mbali ngakhale mutayamba kale popanda kupereka chifukwa chilichonse. Inuyo mutasankha kuti musatenge nawo mbali mukafukufuku ameneyu palibe chilichonse chingakuchitikireni popeza ndi ufulu wanu kusankha chochita. Koma ngati musankhe kutenga mbali mukafukufuku ameneyu, mudzafunsidwa kusonyeza chisankho chanucho polemba (kusayina) dzina lanu pamalo amene mudzauzidwe. Opangitsa kafukufukuyi adzwiritsa ntchito nambala yachinsinsi pojambula ndi kulemba zimene mudzafotokoze.

Chidzachitike ndi chiyani pochita kafukufukuyi?

Inu monga mmodzi otenga nawo mbali mu kafukufukuyu, mudzakumana ndi amene akupangitsa kafukufukuyu pamalo oduka mphepo. Wopangitsa kafukufukuwa adzakujambulani mau ndi kulemba zina papepala. Zonsezi zidzachitika pokhapokha inu mutavomereza. Inu ndinu omasuka kuwauza ochititsa kafukufukuwa kusiya kujambula ngati simukusangalatsidwa ndi zimene akukambazo. Atatha kukujambulani, opangitsa kafukufukuwa adzazitanthauzira zojambulazo mu mau polemba papepala. Ndinu omasuka kuwerenga ngati mukufuna, komanso kufafanizitsa zomwe sizinakusangalatseni. Nthawi ina iliyonse mukhale omasuka kutuluka mukafukufukuyu ngati zomwe zikukambidwazo simukugwirizana nazo. Ngati mutasintha maganizo anu, ndipo mukufuna kutuluka mukafukufukuyu, opangitsa kafukufukuyu adzkufunsani ngati angathe kugwiritsa ntchito zomwe ajambula kalezo.

Kusunga chinsinsi

Kutenga nawo mbali mu kafukufukuyu kutha kupangitsa kuti kukusungirani chinsinsi kwanu kutaike chifukwa anthu ena adzaona zotsatira za kafukufukuyu. Amene akupangitsa kafukufukuyu, mphunzitsi wamkulu ndi omuthandiza ndi amene adzaone zotsatirazo. Iwowa adzayesetsa kukusungungirani chinsinsi posaulula kuti munatenga nawo mbali mu kafukufukuyu. Zotsatira za kafukufuku ameneyu zidzagwiritsidwa ntchito pophunzitsira, kupangira a kafukufuku ena, kulengezetsa m'mapepala a za sayansi, komanso ku misonkhano yokambirana za sayansi. Ngati patafunika kuti tifotokozere za zimene inu mwatiuza muli mukutsimikizidwa kuti sitidzagwiritsa ntchito dzina lanu, koma nambala yachinsinsi ija.

Kodi ndi zovuta ziti zomwe zingakhalepo?

Kutenga mbali kwanu mu kafukufukuyu kungakupangitseni kukhala ndi timavuto pang'ono. Timavutoti ndi monga; kukutayirani nthawi yanu pang'no poyankha mafunso, komanso mafunso ena akhoza kukhala okupangitsani kusowa mtendere.

Ngati mutaona kuti mukusowa mtendere ndi mafunso ena, khalani omasuka kusawayankha mafunsowo, kapena kutuluka mukafukufukuyu.

Pali cholowa chimene chingakhalepo potenga mbali pakafukufukuyu?

Palibe cholowa chilichonse chimene mudzapeza chifukwa chotenga mbali mukafukufukuyu. Kungoti, mukatenga nawo mbali mukafukufukuyu, zidzathandiza opangitsa kafukufukuyu kumvetsa mmene achinyamata amapangira ziganizo zawo kuti alere kapena ayi. Zotsatira za kafukufukuyu ameneyu zidzawathandiza omwe amakonza ndondomeko za ubereki wa achinyamata kukonza njira zoyenera kuthandiza kuti azilera ndipo asamadukize maphunziro awo.

Kodi ndifunika kuwononga kapena kupeza ndalama potenga nawo mbali mu kafukufukuyu?

Simukusowa kupereka ndalama kuti mutenge mbali mu kafukufukuyu. Komanso simulipidwa chifukwa chotenga mbali mu kafukufuku ameneyu. Koma ngati mwagwiritsa ntchito ndalama zanu kuyendera pobwera ku kafukufukuyu, ndalama zimenezo tikubwezerani.

Kodi ndingatani ngati ndili ndi mafunso kapena ndakumana ndi zovuta zilizonse pamene ndikutenga mbali mukafukufukuyu?

Ngati muli ndi mafunso kapena mwakumana ndi zovuta zili zonse zokhuzana ndi kafukufukuyu mukhoza kuyimba foni kwa a Esnath Kapito pa nambala izi: 0888861333 kapena 01989884. Mukhozanso kuyimbira foni aphunzitsi anga a Dr A. Kazembe a ku Kamuzu College of Nursing pa manambala awa: 01 751 622 kapena 0888396530.

APPENDIX D

Chilolezo (chichewa version of consent form)

Ndawerenga zomwe zalembedwa mukalatayi, komanso andifotokozera ndondomeko yonse ya kafukufukuyu.

Ndapatsidwa mwayi ofunsa mafunso ndipo mafunso anga anayankhidwa. Komanso ndapatsidwa maina ndi manambala amafoni a anthu amene ndingathe kuwafunsa ngati ndili ndi mafunso ena

Ndamvetsa kuti ndili ndi ufulu osiya kutenga mbali nthawi iliyonse popanda kupereka chifukwa chilichonse

Ndamva kuti zonse zomwe ndidzafotokoze mu kafukufukuyu zidzatetezedwa posungidwa mwachinsinsi ndipo sizidzagwiritsidwa ntchito motsutsana nane.

Ndamvetsetsa kuti palibe cholowa chomwe ndingachipeze potenga mbali mukafukufukuyu ku nkhani ya ndalama

Ine ndikuvomera kutenga nawo mbali mu kafukufukuyu ndipo ndilandira kalata yosonyeza kulola kwanga ndikatha kusayina kalata ya chilolezoyi

Ine ndikupereka chilolezo changa kuti akhonza kundijambula mau pamene akundifunsa mafunso.

Dzina la otenga mbali ndi saine yake.....

Tsiku

Dzina la opangitsa kafukufuku (kapena omuthandizira) ndi saine yake

.....

Tsiku

**Ngati muli ndi mafunso kapena dandaulo lemberani kalata kwa; Wapampano,
College of Medicine Research Committee (COMREC), Private Bag 360,
Chichiri, Blantyre 3 kapena imbani foni pa 01871 911**

APPENDIX E – INTERVIEW GUIDE

Code Number

Date of interview

Name of interviewer

Sex of participant male / female

Age years Religion

Have you received any information on contraceptives?

In what circumstances did you receive information on contraceptives?

Do you feel you have adequate information on contraceptives?

What is your attitude toward contraceptive use?

What are your views about contraceptive use and the youth?

What do you value in life? What do you really want to be, to do or to have?

Why would you think your fellow adolescents you know would want to use contraceptives? Or why would you think they would not use contraceptives?

What would you recommend for adolescents regarding contraceptive use?

What underlies your perception of not being at risk of unwanted pregnancy?

How could contraceptives help someone like you?

How do you plan for sexual intercourse?

How do you feel after having sexual intercourse without use of contraceptives?

How do you consider yourself able to use contraceptives?

Do you know anyone who has used contraceptives?

Have you used contraceptives yourself?

How do you think others would react to your using contraceptives?

What encourages you to use contraceptives?

- Access to contraceptives
- Affordability
- Time
- Opportunity
- Competence or skill to use

Do the contraceptives meet your expectations?

Is there anything that prohibits you from using contraceptives?

- Access to contraceptives
- Affordability
- Time
- Opportunity
- Competence or skill to use

What beliefs influence your acceptance to contraceptives? Family (including guardians, parents), significant others (including peers, sexual partner, teachers, health providers etcetera), religious, societal or cultural?

Why did you decide to use contraceptives?

Or why did you decide not to use contraceptives?

APPENDIX F- MLOZERA WA MAFUNSO

Nambala yachinsinsi

Tsiku lokambirana

Dzina la ofunsa

Chilengedwe chawachinyamata mwamuna / mkazi

Zaka Chipembedzo

.....

Kodi unauzidwako za njira zakulera?

Kodi unauzidwa munjira yotani kapena kuti chinachitika ndi chiyani kuti uuzidwe za njira za kulera?

Unaphunzitsidwa bwino za njira zonse zakulera zomwe zilipo?

Kodi malingaliro ako pa nkhani yolera ndiotani?

Kodi ndemanga yako kapena maganizo ako ndi otani pa njira zolera?

Chifukwa chiyani ukuganiza kuti achinyamata anzako akhoza kufuna kugwiritsa ntchito njira zolera?

Nanga chifukwa chiyani ukuganiza kuti achinyamata anzako sangafune kugwiritsa ntchito njira zolera?

Kodi ukuona kuti chimene chimapangitsa achinyamata kuona ngati Sali pa chiopsyezo chotenga pakati pamene akugonana ndi chiani?

Kodi njira zolera zingathandize motani achinyamata?

Kodi umakonzekera bwanji kugonana?

Nanga umamva bwanji pamene wachita zogonana popanda kugwiritsa ntchito njira zolera?

Ndi zikhulupiriro zANJI zimene zimakuchititsa kuti uzigwiritsa ntchito njira zolera kapena ayi?

Kodi umagwiritsa njira zolera?

Chifukwa chiyani unaganiza kumagwiritsa ntchito njira zolera?

Kodi ukuganiza kuti achinyamata anzako akhoza kuyilandira bwanji nkhani yoti umagwiritsa ntchito njira zolera?

Nanga ndi zikhulupiriro zANJI zimakuchititsa kuti upange chiganizo choti usagwiritse ntchito njira zolera?

- Za kubanja kwanu?
- Za ena monga amene akulera, anzako, chibwenzi chako, aphunzitsi ako, ogwira ntchito kuchipatala?
- Chipembedzo?
- Miyambo?
- zina?

Kodi achinyamata amadziona kuti ali ndi kuthekera kotu akhoza kugwiritsa ntchito njira zolera?

Kodi alipo achinyamata amene ukuwadziwa omwe amagwiritsa ntchito njira zolera?

Kodi chimene chimakulimbikitsa kugwiritsa ntchito njira zolera ndi chiyani?

- Kupezeka kwa njira zolerazi?
- Kukhala ndi nthawi yogwiritsa ntchito njirazi?
- Kukhala ndi mwayi ogwiritsa ntchito njirazi?
- Kukhala ndi kuthekera kapena kudziwa kagwiritsidwe ntchito koyenera ka njirazi?

Nanga ndi chiyani chimene chimakulepheretsa kugwiritsa ntchito njira zolera?

Ndimavuto otani amene umakumana nawo pogwiritsa ntchito njira zolerazi?

- Kusowa kwa njirazi?
- Kudula mitengo yogulira?
- Kusadziwa kagwiritsidwe ntchito koyenera ka njirazi?

POMALIZA

Kodi umalalaka chiyani mmoyo wako?

- Umafuna utadzakwanitsa chiyani mmoyo mwako?
- Nanga m'moyo wako wa ubereki?

Maganizo ako ndi otani kwa achinyamata anzako pankhani za kulera?



University of Malawi

Kamuzu College of Nursing

P.O. Box 415

Blantyre

1st February, 2011

To : Whom It May Concern

College of Medicine

Private Bag 360

Chichiri,

Blantyre 3.

Esther Mwayiwawo Kapro is a postgraduate student in Reproductive Health at Kamuzu College of Nursing. She is submitting the research proposal titled "Intention and decision making regarding contraception acceptance among tertiary school adolescents in Blantyre district, Malawi". This proposal is being submitted for review and approval.

Sincerely Yours

Abigail Kazembe PhD
Maternal and Child Health department
University of Malawi/ KNCV Blantyre
0888356530



UNIVERSITY OF MALAWI

Principal
K.M Maleta, MBBS PhD

Our Ref.:
Your Ref.: P.02/11/1033

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 877 245
01 877 291
Fax: 01 874 700

Email: comrec@medcol.mw

15th March 2011

Mrs. E. Kapito
KCN
P.O Box 415
Chichiri
Blantyre 3

Dear Mrs Kapito

RE: P.02/11/1033 - Intention and Decision Making Regarding Contraceptive Acceptance among Tertiary School Adolescents in Blantyre , Malawi

I write to inform you that COMREC reviewed your proposal mentioned above which you resubmitted for expedited review. The following points have been dealt with:

1. COMREC format has been followed and the literature review has been placed in the body of the proposal.
2. A question that asks participants if they have received any education on family planning has been included in the interview guide.

I am pleased to inform you that your protocol **was approved** after considering that you addressed all the queries raised in the initial review.

As you proceed with the implementation of your study we would like you to adhere the amer protocol ICH GCP requirements and the College of Medicine Research requirements as indicated the attached page.

Yours Sincerely,



Prof. J.M Mfutso Bengo
CHAIRMAN - COMREC

JMMB/ck

Approved by
College of Medicine
13 MAR 2011
COMREC
Research Ethics Committee

APPENDIX G- LETTERS

A LETTER SEEKING PERMISSION TO CONDUCT PILOT STUDY

Kamuzu College of Nursing

P. O. Box 415

Blantyre

24th January, 2011

The Principal

MIJ Training College

P. O. Box 30165

Chichiri

Dear Sir,

REQUEST TO CONDUCT A PILOT STUDY AT MIJ TRAINING COLLEGE

I am a postgraduate student pursuing a Master of Science degree in Reproductive Health majoring in adolescent reproductive health at the above- mentioned college. In partial fulfilment of the degree, I am required to conduct a research.

The title of my study is “**Intention and decision making regarding contraceptive acceptance among tertiary school adolescents in Blantyre district**”. The results from this study will assist in the planning of improved interventions that will promote contraception use among adolescents hence reduce the prevalence of teenage pregnancy and its effects.

I hereby request to your permission to conduct a pilot study at the college in April, 2011. I am targeting adolescents from 18 to 19 years. I would like to interview 6 students, 3 males and 3 females.

Please contact me for further clarification where necessary on 0888 861 333.

Yours sincerely,



Esnath Mwayiwawo Kapito (Mrs.)



MALAWI INSTITUTE OF JOURNALISM

P. O. Box 30165, Chichiri, Blantyre 3, Malawi Tel: (265) (Academic) 01 875 154 (Radio) 01 875 649

(Feedback) 01 613 042

(Reception) 01 875 087

Fax: (265) 01 879 343

E-mail: mij@journalist.com

Web: www.mij.mw.net

Kamuzu College of Nursing
P.O. Box 415
BLANTYRE

28TH April 2011

Dear Sir/Madam,

RE: REQUEST TO CONDUCT A PILOT STUDY AT MIJ

Referring to your letter dated 23rd March 2011. We accepted Mrs E. M. Kapito to conduct a pilot study through our Diploma students, three male and three female to participate on the title 'Intention and Decision Making Regarding Contraceptive Acceptance among Tertiary School Adolescents'.

Should you need to verify this information, you may contact the Course Manager on 01 605 661.

Your cooperation is greatly appreciated.

Yours faithfully

D. Nkunika
Course Manager



Board of Directors

Dr. G. Kululanga (Chairman), Mr. G. Mang'anda, Mr. D. Mlanzie, Mrs. R. Hanif, Mrs. Z. Mitole

PROMOTING MEDIA INDEPENDENCE AND PROFESSIONALISM

LETTER SEEKING PERMISSION TO CONDUCT STUDY

Kamuzu College of Nursing

P. O. Box 415

Blantyre

24th January, 2011

The Principal

Soche Technical College

P. O. Box 5034

Limbe

Dear Sir,

REQUEST TO CONDUCT A STUDY AT SOCHE TECHNICAL COLLEGE

I am a postgraduate student pursuing a Master of Science degree in Reproductive Health majoring in adolescent reproductive health at the above- mentioned college. In partial fulfilment of the degree, I am required to conduct a research.

The title of my study is “**Intention and decision making regarding contraceptive acceptance among tertiary school adolescents in Blantyre district.** The results from this study will assist in the planning of improved interventions that will promote contraception use among adolescents hence reduce the prevalence of teenage pregnancy and its effects.

I hereby request to your permission to conduct the study at the college in April, 2011. I am targeting adolescents from 18 to 19 years. I would like to interview 16 students, 8 males and 8 females.

Please contact me for further clarification where necessary on 0888 861 333.

Yours sincerely,



Esnath Mwayiwawo Kapito (Mrs.)

Telephone: 01845384
Facsimile: (+265) 1 845401
E-mail principal@sochetechn.org
Communication should be addressed to:



In reply quote file no: STC/
THE PRINCIPAL
SOCHE TECHNICAL COLLEGE
PRIVATE BAG 515
LIMBE

15th April 2011

Kamuzu College of Nursing
Blantyre Campus
P.O. Box 415
BLANTYRE

Dear Madam


PERSMISSION GRANTED TO CONDUCT THE STUDY

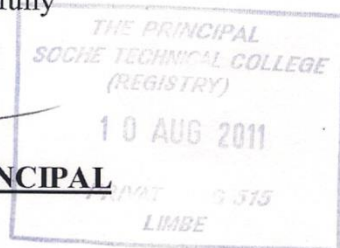
Reference is made to the request dated 16th March 2011 in which you expressed wish to conduct a study at this Institution.

We are pleased to inform you that permission has been granted.

Wishing you all the best in your study

Yours faithfully


C. Lodzeni
FOR: PRINCIPAL



LETTER SEEKING PERMISSION TO CONDUCT STUDY

Kamuzu College of Nursing

P. O. Box 415

Blantyre

24th January, 2011

The Director

Mpemba Staff Development Institute

Private Bag 1

Mpemba

Dear Sir,

REQUEST TO CONDUCT A STUDY AT MPEMBA SDI

I am a postgraduate student pursuing a Master of Science degree in Reproductive Health majoring in adolescent reproductive health at the above- mentioned college. In partial fulfilment of the degree, I am required to conduct a research.

The title of my study is “**Intention and decision making regarding contraceptive acceptance among tertiary school adolescents in Blantyre district.** The results from this study will assist in the planning of improved interventions that will promote contraception use among adolescents hence reduce the prevalence of teenage pregnancy and its effects.

I hereby request to your permission to conduct the study at the college in April, 2011. I am targeting adolescents from 18 to 19 years. I would like to interview 16 students, 8 males and 8 females.

Please contact me for further clarification where necessary on 0888 861 333.

Yours sincerely,



Esnath Mwayiwawo Kapito (Mrs.)

Our Ref. No.....**ADM/1/52**
Your Ref. No.....
Tel.: 01 691 766 / 785
Fax: 01 691 750
E-Mail: sdi@sdi.ac.mw



STAFF DEVELOPMENT INSTITUTE
PRIVATE BAG 1
MPEMBA
BLANTYRE
MALAWI

24 March 2011

Mrs Esnath Mwayiwawo Kapito
Kamuzu College of Nursing
Blantyre Campus
P.O. Box 415
Blantyre

Dear Madam

**REQUEST TO CONDUCT A STUDY AT MPEMBA STAFF
DEVELOPMENT INSTITUTE**

Please refer to your letter dated 16th March 2011 on the above subject.

I would like to inform you that SDI has a no objection to you to conduct a study at Staff Development Institute provided that there will be people voluntarily ready to participate in your study.

Staff Development Institute will not force people to participate or be involved in choosing who to participate.

Yours faithfully

JJM Zumani
For: **DIRECTOR**

LETTER SEEKING PERMISSION TO CONDUCT STUDY

Kamuzu College of Nursing

P. O. Box 415

Blantyre

24th January, 2011

The Director

Skyway Institute of Management, Research and Development (SIMARD)

Private Bag A156

Lilongwe

Dear Sir,

REQUEST TO CONDUCT A STUDY AT SIMARD BLANTYRE CAMPUS

I am a postgraduate student pursuing a Master of Science degree in Reproductive Health majoring in adolescent reproductive health at the above- mentioned college. In partial fulfilment of the degree, I am required to conduct a research.

The title of my study is “**Intention and decision making regarding contraceptive acceptance among tertiary school adolescents in Blantyre district.** The results from this study will assist in the planning of improved interventions that will promote contraception use among adolescents hence reduce the prevalence of teenage pregnancy and its effects.

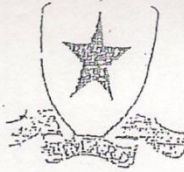
I hereby request to your permission to conduct the study at the college in April, 2011. I am targeting adolescents from 18 to 19 years. I would like to interview 16 students, 8 males and 8 females.

Please contact me for further clarification where necessary on 0888 861 333.

Yours sincerely,



Esnath Mwayiwawo Kapito (Mrs.)



SKYWAY INSTITUTE OF MANAGEMENT, RESEARCH AND DEVELOPMENT
The Giant of the Nation

Head Office
Private Bag A155
Lilongwe.

Marangalanga Old Town
Opposite Min Bus Depot
Pict Number 37145/46

Tel: 01-727 420
Fax: 01 727 663
Cell: 09 950 461

skywayinstitute@melawi.net
skywayinstitute@yahoo.com
www.skywayinstitute.com

Ref : LTR/ACK/SIM

Mrs. E. M. Kapito
Kamuzu College of Nursing
P. O. Box 415

Blantyre

29th June, 2011

Dear Madam,

RE: REQUEST TO CONDUCT A STUDY

Reference is made to your letter dated 22nd June, 2011 in which you were asking to conduct a study at our college. I am pleased to inform you that your request has been accepted.

I wish you all the best in your study.

Yours faithfully,

Daniel Mwakameka
(ACADEMIC PRINCIPAL)

LETTER SEEKING PERMISSION FOR VENUE TO CONDUCT STUDY

Kamuzu College of Nursing

P. O. Box 415

Blantyre

30th March, 2011

The Regional Sports Development officer

Blantyre Youth Centre

P.O. Box 452

Blantyre

Dear Sir,

REQUEST FOR SPACE TO CONDUCT INTERVIEWS FOR STUDY

I am a postgraduate student pursuing a Master of Science degree in Reproductive Health majoring in adolescent reproductive health at the above- mentioned college. In partial fulfilment of the degree, I am required to conduct a research. The research proposal has been approved by College of Medicine Research and Ethics Committee (COMREC).

I hereby request your permission for space to conduct the study at the centre in April, 2011. I am targeting adolescents from 18 to 19 years. I would like to interview about 16 adolescents in total in the afternoon from 1-4pm for approximately 5 days. They will be interviewed in a one-to-one approach which translates to 3 people per day (for about an hour each).

The youth centre is appropriate because nobody can question youngsters visiting the centre at any time since there are a lot of activities happening most of the times. In addition to that, being a neutral venue, the youth cannot feel threatened and their privacy is assured.

Please contact me for further clarification where necessary on 0888 861 333.

Yours sincerely,



Esnath Mwayiwawo Kapito (Mrs.)

REGIONAL SPORTS DEVELOPMENT OFFICE (S)

"SPORTS KEEPING THE NATIONAL HEALTH & FIT"

PO BOX 452

BLANTYRE

TEL: 01 880 170

REF NO: RSDO/ADM/15/Vol/3/23

1st April 2011

Alt. E.M. Kapilo,
Kamuzu College of Nursing
Po Box 415
BLANTYRE

Dear Sir,

BOOKING OF BLANTYRE YOUTH CENTRE

Your letter dated 30th March 2011 refers,

Please be informed that approval has been granted to enable you proceed with your research.

We are of the view that your research would be of a help to the nation as well.

Wishing you the best during your undertakings

Yours faithfully



Alice Kumilonde (Mrs.)
For/ REGIONAL SPORTS DEVELOPMENT OFFICER (S)