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A Literature Review of Contraceptive Usage Among Adolescent Females

Joseph Olanrewaju Ilugbami[1*], Oluwadamisi Tayo-Ladega[2] and Funmilayo Mary Ilugbami[3]

[1]*Rufus Giwa Polytechnic, Owo, Ondo State, Nigeria, Rector Office*

[2]*University of Bangor, United Kingdom*

[3]*Department of Social Sciences, Rufus Giwa Polytechnic, Owo, Nigeria*

[*]Corresponding Author
Joseph Olanrewaju ILUGBAMI, Rufus Giwa Polytechnic, Owo, Ondo State, Nigeria, Rector Office.

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Abstract

The adolescent stage is characterized by sexual exploration, sexual maturation, and rapid growth. Individuals in this category are between the ages of 10 and 19 years old. As a result of their characteristics, sexually active adolescent girls are exposed to a greater risk of unintended pregnancies, unsafe abortions, and sexually transmitted infections. Adolescent girls who use contemporary contraceptives effectively can postpone their first pregnancies, lower the risk of maternal death, and have better mother and offspring outcomes when they have early female children. This study aimed to conduct a literature review of contraceptive usage among adolescent females with the view to revealing the empirical evidences in different countries based on already published works, thereby uncovering the most popular modern methods of contraception, exploring the knowledge and awareness of contraceptive services, identifying the factors affecting awareness of contraceptive services, revealing the approaches to utilizing contraceptives, and identifying the factors influencing the utilization of contraceptives, and the barriers militating against its usage.

Keywords: Literature Review, Contraceptive, Contraceptive Usage, Adolescent Females

List of Abbreviations

STDs: Sexually Transmitted Diseases
STIs: Sexually Transmitted Infections

1. Introduction

According to the UNFPA (2012) reports, adolescent development includes cognitive, physical, behavioral, and psychological changes that are marked by high levels of individual autonomy, the development of a sense of identity, high levels of self-esteem, and a gradual separation from adults. Making sure that teenagers can safeguard their health is a crucial priority for world health [1]. Such expenditures have the potential to reduce poverty, postpone the first pregnancy, lower maternal mortality, and enhance maternal health outcomes for mothers and their offspring. Girls between the ages of 15 and 19 make up one-fifth of all women worldwide who are of reproductive age, according to [1].

Every year, two million girls between the ages of 15 and 19 give birth [2]. Also, one in three females in the world's poorest regions gives birth to children by the time they are 18 years old, according to reports (WHO, 2014) [3]. In comparison to adults, adolescents have the highest risk of maternal mortality, with the risk of death from pregnancy being twice as high for girls between the ages of 15 and 19 years and five times greater for girls between the ages of 20 and 29 years. The major cause of death among teenagers in middle- and low-income nations is complications from pregnancy and delivery.

Adolescents who are pregnant are more likely than adults to seek risky abortions. Around three million unsafe abortions among teenage females between the ages of 15 and 19 have been performed each year [2]. Almost forty percent of unsafe abortions globally are performed on people between the ages of 15 and 24 years, and early childbearing affects the infants of these women as well. Infants born to teenage mothers have birth-related problems and neonatal fatalities at a rate that is fifty percent greater than that of children born to moms between the ages of 20 and 29. Adolescent women are more likely than older mothers to have low-birth-weight babies [2].

Also, according to Hagan and Buxton (2012), adolescent girls who become pregnant are more likely to drop out of school and be unable to care for their offspring [3]. Tautz estimates that in 2008, there were 16 million births of girls between the ages of 15 and 19, or roughly 11 percent of all births worldwide. Many of these births took place in underdeveloped countries, and 6.1 million of them were unplanned. According to Tautz (2011), sub-Saharan Africa reports 2.2 million unwanted adolescent pregnancies per year. By decreasing the number of women who are at risk and preventing unwanted pregnancy, which accounts for roughly thirty percent of all births in sub-Saharan Africa, the

use of contraceptives can lower the number of fatalities among women [5].

In underdeveloped nations, women who don't utilize contraceptives account for almost fifty percent of unwanted pregnancies. According to estimates, there are between 123 and 200 million unmet contraceptive needs worldwide. Over 113 million women in poor nations have unmet contraceptive needs [6]. About half of the pregnancies in the United States are unplanned, resulting in 3.1 million unwanted pregnancies and 1.3 million abortions per year (Raine et al., 2005). Young women have the highest rate of unexpected pregnancies, with 79 percent of pregnancies occurring between the ages of 18 and 19 years and 60 percent of pregnancies occurring between the ages of 20 and 24 years [7].

According to a different American survey, the percentage of unplanned births decreased from 51 percent in 2008 to less than 45 percent in 2011 [8]. In the United States, the percentage of unwanted births among females aged 15 to 17 years declined by roughly 25 percent, in contrast to the findings seen in developing countries. Therefore, in South Africa, two-thirds of young girls between the ages of 15 and 24 are engaged in sexual activity; half of these women have had at least one unwanted pregnancy [9]. Most unexpected births are caused by women who desire to prevent getting pregnant but aren't utilizing an effective form of contraception. The vast majority of teenage girls' pregnancies in Nigeria are unintended.

Girls who have their first sexual experience when they are young are more vulnerable to STIs, unexpected pregnancies, and unsafe abortions. Over the world, 79 million girls have unwanted pregnancies, which causes around 40 percent of them to drop out of school [4]. Moreover, it is predicted that 33.9% of this population will have STDs, while 18.75% will have unsafe abortions. These issues are especially prevalent in Sub-Saharan Africa, where it is predicted that 2.2 million girls (2.8%) will have unwanted pregnancies, 13.7% will have STIs, and 19% will have unsafe abortions annually [10].

Teenagers are susceptible to getting pregnant, contracting STIs, and getting HIV. Contraception can help young ladies avoid the problems of unwanted pregnancy and STIs. For young girls, it will be crucial to offer sexual health and contraception treatments in a setting that is suitable for their age. Adolescent girls who use contemporary contraceptives effectively can postpone their first pregnancies, lower the risk of maternal death, and have better mother and offspring outcomes when they have early female children. The purpose of this study was to conduct a literature review on contraceptive usage among adolescents.

2. Contraceptive Methods

The following discussion covers the most popular modern methods of contraception, including dermal patches, vaginal rings, implants, intrauterine devices, condoms, and oral contraceptives.

2.1 Patch and Ring

Transdermal patches and vaginal rings are two new hormonal contraceptive delivery methods [11]. Each day, the patch releases 150 ug of norelgestromin and 20 ug of ethinyl estradiol. Three weeks in a row of one patch per week dosage are followed by one without. In 2001, the FDA gave the go-ahead for the vaginal ring to be used as a combination estrogen/progestin contraceptive in the USA. The flexible vaginal ring is constructed from ethylene vinyl acetate copolymer. Each day, it delivers 120 ug of etonogestrel and 15 ug of ethinyl estradiol. Three weeks with the ring in the vagina are followed by one week without it to allow for normal menstrual menstruation. As far as WHO Medical Eligibility Criteria are concerned, the patch and ring are similar to the combined oral preparation [12].

2.2 Injectable Contraception

This is done through an intramuscular injection of 150mg of medroxyprogesterone acetate, introduced in 1963, and protected against pregnancy for at least three months. Depot injections of progesterone have a strong inhibitory effect on ovulation. Norestrat is usually given every two months [11].

2.3 Oral Contraceptives

Modern contraceptives became popular after the introduction of oral contraceptives in the 1960s. This was the turning point; since then, approximately 200 million women have been using combined oral contraceptive pills. According to Scott and Glasier (2006), oral contraceptives act by inhibiting ovulation, while progestogen-only pills act by altering cervical mucus to reduce sperm penetration and the endometrium to reduce implantation [11].

2.4 Implantable Contraception

Subdermal contraceptive implants deliver a continuous low dose of progesterone from the polymer rods. Norplant contraceptives contain levonorgestrel in six implantable rods for removal after the fifth year. Implanon has two four-centimeter-long rods with a total dose of 150 mg levonorgestrel for three to five years. A levonorgestrel implant prevents sperm movement through the female genital tract, and etonogestrel leads to anovulation [11].

2.5 Emergency Contraception

Emergency contraception (EC) is any method of pregnancy prevention used after unprotected or inadequately protected intercourse and before implantation. It is a safe and effective post-coital contraceptive method that can reduce the risk of unintended pregnancy after unprotected sexual intercourse within 72 hours of intercourse. Research has shown that EC pills are effective when started between the third and fifth day after unprotected sexual intercourse, with effectiveness rates ranging from 72% to 87% [13]. The contraceptive effect is estimated to be due mainly to the inhibition or delay of ovulation or preventing the implantation of a fertilized egg; however, it does not interfere with an established pregnancy because they are ineffective after implantation. Emergency contraception is not as effective as other contraceptives' consistent and correct use. Emergency contraceptive pills may contain only progestogen in the form of Levonorgestrel (0.75 mg), which is repeated after twelve hours, or a combination of estrogen and progesterone (Ethinyl estradiol 0.1 mg and Levonorgestrel 0.5 mg), which are taken twice, twelve hours apart, within 72 hours of exposure to unprotected [14].

2.6 Condom Method

There are two types of condoms: male and female condoms. The male condom is the most commonly used form of a condom. It

creates a physical barrier, preventing sperm from reaching the ovum, and decreases the risk of sexually transmitted infections. Male condoms may be polyurethane, latex, or treated animal tissue. It covers the penis, thus preventing the sperm from meeting the egg [15]. The female condom, or vaginal pouch, has been developed and is a relatively new method that gives women control over a barrier method and provides protection against sexually transmitted infections. The condoms are made of a polyurethane sheath that contains two rings. One ring is inserted into the top of the vagina, and the other ring sits outside the opening of the vagina to fit the shape of the vagina [15]. The male penis then goes inside the female condom during intercourse.

2.7 Other Contraceptive Methods

Other contraceptive methods include lactation amenorrhea, rhythm withdrawal, diaphragms, cervical caps, and other natural family planning methods. Male and female sterilization are irreversible forms of contraception and are not commonly used by young people [11,15].

3. Knowledge and Awareness of Contraceptive Services

Education programs on contraceptive services should reach out to both males and females and provide correct information on the risks of unintended pregnancy, possible side effects of contraception, the benefits of birth spacing, and safety to encourage positive attitudes toward family planning [16]. 10 Various safe and effective contraceptives are available, and stakeholders are trying to increase their availability and access. However, unintended pregnancy remains a considerable social and public problem [17]. Lack of adequate knowledge and awareness is associated with a lack of contraceptive use among young women. Its use is associated with previously being pregnant, meaning that young girls are only being educated about the contraceptive services offered after becoming pregnant [9].

A study carried out among adolescents reported that some pregnant adolescents got pregnant due to a lack of knowledge about and accessibility of contraceptives [18]. Poor knowledge and a lack of contraceptive awareness are common among young girls seeking abortion services [17]. Moreover, it is necessary to ensure the dissemination of accurate information to young women about contraceptives. The major sources of information for young women about contraceptive services are the media, peers, friends, and nurses. Clients seeking family planning services have received prior counseling about the side effects of the methods they have chosen and how to counteract them [17].

In a study conducted in Nigeria, the awareness level of contraceptives was noted to be high in some communities; however, a good understanding of different contraceptive methods was lacking [19]. Therefore, there is a need for young women to get information concerning contraceptives and to promote their right to control reproductive health, create awareness, and eliminate myths about contraceptives [20]. The adolescent need for HIV and pregnancy prevention information has been a sensitive issue in sub-Saharan Africa, which has led to policy and political debates about what information should be given to adolescents and the age at which to start such interventions [21].

Various stakeholders have argued that teaching adolescents about sex and reproductive health would encourage them to indulge in sexual activities. However much contraceptive use among adolescents is considered a sensitive issue, there is increasing consensus and acknowledgement that it is essential to institute effective sex education programs to equip young people with information and skills to help them make informed and responsible decisions on their sexual and reproductive health matters. The low levels of in-depth knowledge of HIV/AIDS and pregnancy. Adolescents receive information about HIV, STIs, and contraceptive methods from various sources, and they do so from more than one source. Of these three topics combined, mass media is the most used source of information for young adolescents.

The need for effective intervention programs to safeguard the next generation of productive and reproductive adults in Sub-Saharan Africa has been highlighted by emerging evidence highlighting the particular vulnerability of young people, particularly females, to HIV infection and unintended pregnancies. The discovery that 12–14-year-olds are not as naive on sexual topics as one may believe justifies arming young teenagers with enough and correct knowledge on how to protect themselves from STIs and pregnancy. For instance, in Malawi and Uganda, boys and girls aged 12 to 14 reported engaging in some type of intimate sexual behavior at least 3 out of 10 times.

The need for family planning will rise as young people reach reproductive age, and programs must be set up to meet this demand. In a study of American college students, virtually all of the participants (94%) claimed to have heard about emergency contraception before taking the poll. Although 45% of respondents said emergency contraceptives must be used within three or 72 hours after having unprotected intercourse, 12% of respondents said they were unsure of the most prolonged time frame for efficacy. Just 5% of respondents agreed that it was necessary to use emergency contraception within five days or 120 hours [22]. Emergency contraception was among the topics that respondents first learned about via a range of sources, such as the media (43%), acquaintances or peers (22%), and school-based curricula (18%).

While the general public and university students have heard of emergency contraception, studies on their understanding and use reveal that they often lack adequate knowledge about what they are, how they function, and how to acquire them [23]. Just a small percentage of young individuals using contraceptive techniques have a correct and thorough understanding of emergency contraception, and even those numbers are low. Few people recognized the proper time to take emergency contraceptives, and many people who claimed to be familiar with them were discovered to be misinformed. It has been shown that a lack of thorough and accurate information about contraceptives has led to a reluctance to use family planning techniques since some people would want to know their adverse effects and contraindications [24].

Just over 44% of university students in Ethiopia had even heard of emergency contraception. Nevertheless, only 10% of people are aware of how to utilize it properly [25]. The significance of contraceptive knowledge in determining contraceptive usage

has been the subject of previous research that targeted pregnancy prevention among the teenage population. Other studies have revealed no connection between young women's awareness of contraceptives and their use of them. Young women are often well-informed about fertility and contraception, but their education is insufficient to guarantee continuous, reliable contraceptive use [24].

4. Factors Affecting Awareness of Contraceptive Services

To investigate the knowledge and awareness of contraceptive services, several research studies have been conducted in many different regions of the world. The elements that affect people's knowledge and awareness of contraceptive services have been discovered, as will be covered here.

4.1 Age Group

Adolescents had the lowest rates of knowledge of contraceptive techniques, while those aged 20–34 had the highest rates [26]. According to Parkes et al. (2009), women were more likely to receive reproductive health messages through house visits, meetings, and community communication the older they were and the less educated they were [27,28].

4.2 Level of Education

Earlier studies have found that education is the primary factor that influences fertility. They found that women's awareness levels are at 100% when they have completed secondary school or above. For instance, a study in Pakistan found that educated women had a 95% awareness level, compared to 73.0% of illiterate women [29]. Education was shown to be the primary variable and influencing factor in decisions about family planning and contraceptive awareness in a similar study carried out in Bombay [30]. The results of a different study conducted among rural Indians revealed that a high level of education facilitates greater adoption of contraceptive services [31].

4.3 Area of Residence

The women's urban backgrounds have a significant impact on their degree of awareness about contraceptives. According to a DHS study conducted in Pakistan, it was discovered that women residing in urban and rural regions had quite different levels of knowledge. In big cities, 94.0% of presently married women were aware of at least one modern method of contraception, compared to just 71% of women in rural regions [29].

5. Approaches to Utilizing Contraceptives

Throughout the past 50 years, there has been a significant rise in the prevalence of contraception. There are noticeable variances between nations in terms of contraceptive options. Age and stage of life are important factors in choosing a contraceptive method [11]. While consistent reliance on an effective method of contraception has remained low, the use of contraceptives among young women has grown recently. Even though consistent, appropriate contraceptive use throughout all risk periods can significantly reduce the likelihood of unintended pregnancy, many women find it difficult to stick to such a routine for a longer period, according to, as they are diverse and complex [32].

The programs and regulations meant to decrease unplanned pregnancy will be strengthened if there is a greater understanding of why young women find it challenging to use contraception continuously, even when they do not want to get pregnant. Factors that influence the use of contraceptive services include women's perceptions about avoiding pregnancy, clients' experiences with contraceptive techniques, socioeconomic background, and the characteristics of their sexual partners [33]. Teenagers in various societies have been shown to rarely utilize contemporary contraceptive techniques. In a survey conducted in Nigeria, it was shown that just 30.4% of sexually active teens used any type of contemporary contraception, and only 6.2% used condoms. Many used conventional techniques like intermittent abstinence and coitus disruption [34].

The use of contraceptives among young female undergraduates in Ethiopia was found to be quite low, despite the high risk of unintended pregnancy and forced abortion [25]. Convenience and efficacy were key criteria that users considered when choosing a contraceptive method, so if consumers are provided with a variety of products that are both efficient and practical, adoption is likely to rise. 88.5% were reported to be content with the available contraceptive options [17]. Family planning clinics have discovered that the majority of women already know which forms of contraception they prefer and that not being able to get that method is likely the main barrier to adoption and long-term usage [35].

It has been discovered that adding a new technique increases overall usage frequency and draws in new users [6]. The increasing difficulty of adherence and continuation rates is similar to that of other kinds of extended therapy [36]. Despite being sexually active, the majority of teenagers either don't always use or use them infrequently with measures like condoms [37]. Greek females aged 16 to 45 were included in a 2001 national household survey to examine their usage of contraception. The sample of 797 women was typical of Greek women overall. 6.9% of the survey respondents who identified as non-sexually active were not included in the study.

It was also discovered that the condom, which is used 33.9% of the time, is the most popular form of contraception today, followed by withdrawal (28.8%), oral contraceptives (OC), 4.8%, and IUDs, 3.6%. 40% of those who used oral contraceptives did so for medical purposes. In addition, participants were asked to list any strategies they had ever utilized. Condoms had been used by 9.3% of all responders, withdrawing 66.4%. IUD: 10.8%, oral contraceptives: 30.8%, and occasional abstinence: 21.9% [38]. In the United States, it was discovered that forty percent of young women are at risk for unwanted pregnancy and that ninety-eight percent of condoms being utilized help prevent STDs (n = 168). Twenty-three percent of women used no technique (n = 87), compared to 32 percent of those who utilized hormonal treatments (oral contraceptive pills, injectables, and implants) (n = 123).

Just 28% of the women used both hormonal and barrier treatments during their most recent intercourse. When compared to women without a history of abortion, those with a history of abortion were substantially more likely to use no form of contraception and less likely to utilize barrier methods (35% vs. 21% and 29% vs. 47%, respectively). Much fewer women who were

reared religiously (27% vs. 39%) used hormonal contraception, and the likelihood of not using a form of contraception was much higher among women whose moms had their first child before the age of 20 (42% vs. 19%), as well as ladies who thought they couldn't conceive. In the research, fifty percent of the women had their first vaginal sex before the age of 15 years, and these women were less likely to employ barrier measures than their counterparts who had their first sex after the age of 15 years (38% vs. 50%, respectively).

In comparison to women who felt they had some probability of developing an STI in the coming year, they were much less likely to use no technique and significantly more likely to utilize hormonal methods (19% vs. 29% and 37% vs. 26%, respectively). In comparison to their counterparts who had only one partner or believed their partners were monogamous, women who had multiple partners or believed their primary partner had additional partners in the previous six months were significantly more likely to use barrier methods (52% vs. 40% and 54% vs. 40%, respectively) [7]. Teenage females aged 16 years or less who reported using solely oral contraceptives during first intercourse were more likely to become pregnant than those who reported using condoms exclusively, according to research on the subject matter.

The failure to utilize contraception during the initial sexual encounter is also linked to future pregnancies. Yet, the risk of conception was the same whether condoms were used alone or in conjunction with oral contraceptives. It was shown that the inefficient use of oral contraceptives had been caused by a dislike of the side effects, issues with concealment, or erratic sexual activity. Also, it was discovered that a lack of awareness of oral contraceptives may have led to an incorrect risk assessment. Some girls may have received the pill as a prescription for menstruation issues but may not have had the necessary education to utilize it effectively as a contraceptive. According to the study, condoms may be easier for young teens in their first sexual engagement to use properly than oral contraception [27].

Access to family planning services is frequently not guaranteed by inadequate community-based family planning programs, and a gap between understanding contraceptive methods, being able to obtain them, and actual effective usage has been noted [39]. Communication between partners affects contraceptive choices. Young women are less likely to continuously use contraceptives if they discuss preventive difficulties with their sexual partners less frequently. Young women are more likely to take risks when access to correct, protective information is restricted by a culture that discourages openness and honesty about using contraception [32]. As a remedy to restricted contraceptive use, male partners must be involved, and effort must be made to improve a young adult's communication skills in sexual relationships. Young women need to be motivated, and ambivalence about pregnancy interferes with effective contraception [9].

6. Factors Influencing the Utilization of Contraceptives

The use of contemporary contraceptives varies depending on several circumstances, especially in poorer nations. In its most recent study, the UNFPA observed that the majority of people who live in rural areas lack access to contemporary contraceptive options due to poverty. More than 200 million women who want to take contraceptives are unable to do so due to the ongoing difficulty in contacting these groups of individuals [40]. The factors that influence the use of contemporary contraceptives across the continent of Africa, notably in Nigeria, are frequently shared by different nations. The most recent DHS comparison analysis lists some circumstances that could or might not drive someone to take a contraceptive.

The paper claims that uptake was impacted by geographic location, whether it was rural or urban. Contraception was used by city dwellers far more frequently than by country dwellers. Also, it supported the results of other studies that showed education had a good impact on usage. Higher education showed a statistically significant connection with contraceptive use among women aged 15 to 24. However, in nations like Burkina Faso, Liberia, Mauritania, and Senegal, education and utilization had the opposite connection. Additional elements cited in the study were personal wealth and income, parity, and awareness of contraception [41].

Similar characteristics were identified as contributing to usage in sub-Saharan Africa in research on the contextual impacts of contemporary contraception use in that region. Age, marital status, and gender were identified as influencing variables in the demographics. Additional factors were the agreement of the couple, cultural conventions, and the general economic advancement of the nation or area. The use of contraceptives is also influenced by the standard of services provided, women's education in particular, and religion [42].

7. Barriers to the Utilization of Contraceptive Methods

Constant obstacles prevent young women from using contraception. Several people have tried a variety of tactics to get around obstacles to effective contraception but without success, and some pregnant teenagers have blamed the inability to get contraceptives for their pregnancy [18]. Unintended pregnancy continues to be a significant social and public health problem despite rising efforts and accomplishments in expanding access to and availability of these contraceptives. There is still a sizable unmet demand for contraception on a global scale, and using contraceptives may be discouraged due to their complexity, potential risks to health, or access issues. Access to and proper use of contraception are frequently challenges for young women.

Lack of concern about the possibility of pregnancy, perceptions of invulnerability to pregnancy, institutional policies on contraceptives being forgotten, socio-cultural norms, poor access due to location, and low socioeconomic status are some of the barriers to effective contraceptives that have been identified [20,33,43]. Unless particular skills are gained, barriers including relationship reluctance, fear of partner rejection, and difficulty purchasing or carrying contraceptives are likely to continue over time despite constant exposure and experience. An obstacle to condom negotiation among female teenagers is the fear of losing a sexual partner for insisting on the use of a condom, particularly when communication and assertiveness skills are lacking [32]. The factors that prevent the effective use of contraceptive services are outlined below.

7.1 Socio-Cultural Barriers

Due to prevailing cultural or religious standards in the region where teenage females between the ages of 15 and 19 live, pressure from families and social shame may also be obstacles. Those surveyed in the Muramutsa research in Rwanda's Gasabo, Gatsibo, Nyagatare, Nyamagabe, Nyarugenge, and Rulindo districts in 2007 indicated adherence to a pro-birth culture, demonstrating how socio-cultural variables impede family planning practice in Rwanda [44]. Indian women with a certain family composition of two boys and one girl were 90% less likely to report having another pregnancy and 12 times more likely to be sterilized than mothers with only two daughters, according to a published study utilizing 2002 data [45].

7.2 Socio-Demographic Barriers

One of the obstacles to using contraceptive services is age. Contraceptive usage is less common among older women than among younger women. On the other hand, elderly women are more likely to employ sterilization or long-lasting techniques. There was a significant correlation between women's age and non-use, utilizing both long-term and short-term approaches, in research conducted by Murti in Indonesia in 2007. Education can influence the choice of contraceptive technique and has a favorable association with the use of contraceptives. Women with higher levels of education are more likely to utilize contraception and have a wider range of options. According to research done in Ethiopia, just 10% of women with no formal education utilize contraception, compared to 50% of women with secondary education [46].

Women without education had a 35 percent unmet need for contraception, compared to just 17 percent of those with secondary or higher education [47]. The use of contraceptives and method selection can both be influenced by the number of live children. Contraceptive use increases quickly as the number of children alive grows, according to the 2010 Rwanda Demographic and Health Surveys. The desire for contraceptive techniques among women of reproductive age was significantly influenced by the number of living children. This is demonstrated in the study conducted by Mussie et al. (2012), which found that moms who had two or more pregnancies were three times more likely to take contraceptives than women who had only one pregnancy [47].

7.3 Provider Attitude

Adolescent girls' desire to utilize contraceptive services may be significantly hindered by a negative attitude brought on by the aforementioned restrictions paired with apprehension about the repercussions of dissatisfied consumers [31]. Health professionals, including doctors, nurses, and technicians, may have personal prejudices that conflict with governmental regulations. According to research on physician influence done in the United States, 45 percent of doctors would advise against contraceptive sterilization for women who had had two pregnancies and one live birth, compared to only 29 percent for women who had had four pregnancies and three live births. According to a 2013 survey done in Egypt, more than 75 percent of the women who had been discontinued and over a third of non-users had been urged to come back later while they were menstruating [48].

7.4 Barriers from Side Effects

The IUD is the most widely used reversible contraceptive technique in northern Karnataka and south India, yet it has a poor continuation rate. To investigate the variables impacting the continued use of IUDs in south India, interviews with 713 IUD acceptors (461 in rural areas and 252 in urban areas) were conducted. By the time of follow-up, just 35% of respondents still had their initial IUD in place, and 57% had sought removal, mostly due to adverse effects. Numerous participants in a qualitative study conducted in India to evaluate factors affecting intrauterine devices among women in a minority community in Delhi revealed the same. Pain, bleeding issues, infection, pain from routine thread checks, and concerns about the validity of the approach were the most prevalent concerns [49].

7.5 The Barrier to Access

Insufficient access to and availability of contraceptive services may also be obstacles. Distance might be a barrier to accessing contraceptive services in rural locations. According to a study done in Pakistan, people are more likely to use contraceptives when services are improved. In three years, female contraceptive use increased from 14% to 22% as a result of new family planning clinics opening in metropolitan areas [50]. According to the findings of qualitative research carried out by Muramutsa in 2007 in the districts of Gasabo, Gatsibo, Nyagatare, Nyamagabe, Nyarugenge, and Rulindo, a shortage of qualified workers may make it more difficult to get contraceptives [44].

7.6 Barriers Associated with Religion

The degree to which religion acts as a deterrent to sterilization depends on the religion itself, how the Bible and the Koran are interpreted by religious authorities, and how uniformly the religion is practiced in a given area [23]. While non-Muslims in Bangladesh were twice as likely to have sterilization as Muslims, a sample of Indian women revealed that the incidence of sterilization among Muslim women (14%) was lower than among Hindu women (29%), and women from other religious groups (30–35%). Sterilization rates, however, can still be high in Muslim and Catholic nations, such as Turkey, and Brazil, respectively. This suggests that religious rules are not always (whether due to need or choice) rigidly understood, applied, or followed.

7.7 Misinformation Barriers

Knowledge of contraceptives and the utilization of contraceptive services were strongly correlated (Kokila, 2012). Results showing that women with moderate to high contraceptive awareness were six to eight times more likely to utilize contraceptive services than those with low knowledge provide evidence for this (Bulto, et al., 2014). Many researchers have used LACM to identify myths and misunderstandings as barriers. In the Ethiopian study, 33.2% of the women knew anything about LACMs, while 24.67% of the women knew about it and claimed that using Norplant would have a detrimental impact on their health.

They claimed that Norplant might result in high blood pressure, mental disease, anaemia, weight gain, uterine mass, headaches, and fever. Four women reported that implants might move freely in the body after insertion and could disappear the day they

were removed. Twenty-two percent of the women who heard myths and misunderstandings believed implants may result in permanent sterility, and roughly 15.6% believed IUDs might have the same effect. Of the majority of women, 20% were concerned about the health effects of IUDs; 11.2% had heard that they could make the vagina smell bad; and the rest had heard that they could make them uncomfortable or painful during sexual activity, give them headaches, and consume their uterus, making it thin. Also, they had heard that it may vanish inside the uterus.

Further research has been done on worldwide barriers to the use of contraceptive services in addition to the ones mentioned above. Few pregnant adolescent girls in New Zealand blamed their pregnancies on a lack of knowledge about contraception or a challenge getting access to contraceptive services; instead, researchers found that pregnancies were frequently linked to positive feelings about pregnancy. They concluded that these positive feelings interfere with effective contraception and that adolescents need motivation to avoid pregnancy rather than more information. Effective use of contraceptive techniques has been reported to be frequently hampered by a lack of worry over the risk of pregnancy.

As a result of their lack of concern for the risk of getting pregnant, many young moms have been unable to get contraception. They are less motivated to utilize contraceptives efficiently when they are accessible due to indifference, which also affects how they use them. Access to and usage of contraceptives have also been hampered by the perception of low pregnancy risk. Also, both young women who take contraceptives irregularly and those who have never used contraception share this common characteristic. The use of adult support, concrete sex education that is tailored to young women's experiences, and targeted contraceptive messages for young women will encourage a general understanding of preventing unintended pregnancies as the individual's responsibility. Barriers to accessing contraceptives have been overcome in some places.

Young women have barriers to getting contraceptives and family planning services due to their perception of a low chance of pregnancy, their lack of knowledge about the dangers of pregnancy (because they believe that it takes several sex acts before conception), and several other issues. Major obstacles to using contraceptives include fear of adverse effects, ignorance of alternative techniques, and personal religious beliefs. For instance, the south-eastern part of Nigeria, which is predominately Catholic, does not utilize contemporary contraceptives since the Catholic Church opposes their usage. Young women are at increased risk for sexually transmitted infections due to hurdles to family planning, such as not knowing where to get condoms and not talking about it with a partner.

In Ethiopia, the main factor contributing to unintended pregnancy and consequent unsafe abortions is a lack of access to contraception. Access to family planning methods was initially restricted to health facilities, under the strict supervision of medical professionals, with eligibility requirements and restrictions like the husband's written consent, proof of marital status, age, or parity, an arduous revisit schedule, and the requirement that only women who were menstruating be allowed to begin contraception. The removal of administrative and medical barriers that prevent quick, convenient, and appropriate access to methods has been linked to the success of family planning programs.

Static health facilities continue to be the dominant source of family planning, and geographical access is considered a possible major constraint on the uptake of services. In the majority of societies, women are shown to be willing to travel great distances for guidance and contraceptives, especially for methods that call for few or no further visits. A significant barrier to successful access to family planning services is poor service quality. Continuity of supply, personnel availability and competency, and treating patients with respect and appropriate privacy are a few factors (Board, 2014).

However, in Sri Lanka, the lack of reproductive health services, inadequate knowledge of those services, a lack of privacy and confidentiality, negative attitudes of society and parents, and public health facilities that are insensitive to young people's needs are the main obstacles that young people must overcome to access effective contraception. Adolescent-friendly services have been implemented, which have increased access and use of services among teenagers and decreased morbidity from STIs and unintended pregnancies. In a nutshell, it has been determined that using contraception is a successful strategy for addressing the issues of unintended pregnancy and unsafe abortion. Also, the barrier techniques help stop and manage STIs, including HIV/AIDS and other sexually transmitted illnesses (STIs). Although the number of young women using contraception has grown recently, the number of women regularly using an effective method of contraception has remained low. Because they are numerous and intricate, the causes of inconsistent contraceptive usage are difficult to categorize.

8. Conclusions

This study aimed to conduct a literature review of contraceptive usage among adolescent females. It revealed the empirical evidences in different countries based on already published works. Based on the stuly, the popular modern methods of contraception were explored; the kowledge and awareness of contraceptive services were reviewed; the factors affecting awareness of contraceptive services were identified; the approaches to utilizing contraceptives were revealed; the factors influencing the utilization of contraceptives were explored; and the barriers militating against its usage were reviewed. It is believed that this study will expose the reader to the better insight on the contraceptive usage among adolescent females.

Competing Interests

The author declares that there is no competing interest.

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