

**AN ASSESSMENT OF UPTAKE OF CONTRACEPTIVE INFORMATION  
AMONG YOUNG ADULT GIRLS IN KWARE SLUMS IN ONGATA RONGAI**

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**DECLARATION**

This research project is my original work and has not been presented for a degree in any other University.

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This research project has been submitted with my approval as the University Supervisor.

Signature... 

Date...19/11/2020.....

**Prof. Ndeti Ndati, PhD.**

## **DEDICATION**

This project is dedicated to my family for their incessant encouragement and reminder that I can achieve whatever I set my mind to and that focus is the premise of all success.

## **ACKNOWLEDGMENT**

I would like to express my gratitude to my supervisor Prof. Ndeti Ndati for his role as my supervisor in this research project and in the courses that he taught me. His guidance has been a sure blueprint that has provided the light necessary to complete this project.

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## ABSTRACT

This study sought to assess the contraceptive information uptake among young adult girls in *Kware*; a slum dwelling in Ongata Rongai, Kajiado North Sub-County. The objectives of the study were to; investigate the sources of information on sexuality among young adult girls in Kware, establish the factors contributing to contraceptive uptake among young adult girls in Kware Slums, explore the impact of contraceptive information the young girls in Kware access and investigate whether there are any information gaps on access and use of contraceptives among young adult girls in Kware. A mixed methods approach using both Qualitative and Quantitative strategies was used to collect data. The data collection tools were interviews guides and questionnaires. The interviews were administered orally to the young adult girls while the interview guides were used on the key informants who comprised of a nurse, pharmacist, a Community Health Volunteer, parent or guardian and an NGO or CBO staff member. Purposive sampling technique was used to select interviewees for qualitative data. while the systematic sampling technique was used to obtain quantitative data. The sample size for the quantitative data was 118 young adult girls between the ages of 18-21 years, while a total of 5 key informants were interviewed to get the qualitative data. The quantitative results were analyzed using the descriptive statistics and presented using tables and graphs while the qualitative results were analyzed using thematic content analysis and presented using narratives and verbatim quotes. Findings revealed that many of young girls got information concerning use of contraceptives from their parents. The results also showed that young girls, although in small quantity, access information from social media, TV/Radio, and medical personnel. Furthermore, results showed most of the respondents feared to be judged by people at the place of purchase of the contraceptives and lacked in-depth knowledge on the best method. The study concluded that the major source of information regarding the uptake of contraceptives was parents or guardians as the girls highly trust them. The study also concluded that the use of condoms is the main method young girls adopt as an alternative contraceptive method. Further, information relating to the uptake of contraceptives has resulted to many young adult girls making the right decision on the methods and types of contraceptive to use, staying away from sex, giving them the confidence to abstain and understanding whether contraceptives have side effects. The study recommends that the Ministry of Health should disseminate contraceptive information and regulate it as an authoritative voice on the subject in order to rule out myths and misconceptions as untrue information.

## ACRONYMS AND ABBREVIATIONS

|               |  |
|---------------|--|
| CBO.....      | Community Based Organization                       |
| CHV.....      | Community Health Volunteer                         |
| COVID-19..... | Corona Virus Disease of 2019                       |
| ECs.....      | Emergency Contraceptives                           |
| FP.....       | Family Planning                                    |
| GOK.....      | Government of Kenya                                |
| IBM.....      | Integrated Behavior Model                          |
| IRIN.....     | Integrated Regional Information Networks           |
| KDHS.....     | Kenya Demographic Health Survey                    |
| KNBS.....     | Kenya National Bureau of Statistics                |
| MLE.....      | Monitoring Learning & Evaluation                   |
| NCPD.....     | National Council for Population and Development    |
| NGO.....      | Non-Governmental Organization                      |
| PSI.....      | Population Services Kenya                          |
| SES.....      | Social Economic Status                             |
| SRH.....      | Sexual and Reproductive Health                     |
| SLC.....      | School Leaving Certificate                         |
| UNFPA.....    | United Nations Population Fund                     |
| UNICEF.....   | United Nations Children Fund                       |
| USAID.....    | United States Agency for International Development |
| WHO.....      | World Health Organization                          |

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## CHAPTER ONE: INTRODUCTION

### 1.0 Overview

This chapter covers background of the study, statement of the problem, research objectives, research questions, justification of the study and the significance of the study respectively.

### 1.1 Background of the study

As part of the Millennium Development Goal number 5 - to improve maternal health, governments committed to achieve, by 2015, universal access to reproductive health. However, universal access to contraceptives and information regarding the same has never been achieved as had been envisaged (WHO, 2015). In all matters relating to the reproductive system, good reproductive health means that a state of full emotional, physical and social well-being has been achieved. According to UNFPA's news on reproductive health, people need access to accurate information and the safe, affordable, effective and acceptable means of contraception as a means of safeguarding their sexual health. According to a fact sheet developed by Guttmacher institute in 2017 on the *contraceptive, maternal and healthcare needs of women in developing regions*, it was estimated that approximately 885 million women belonging to the reproductive age group want to avoid a pregnancy.

Of these, 214 million of them have an unfilled need for modern contraception (Bankole et al, 2016). A contraceptive is characterized as a method by devices or medications a person uses to prevent unwanted pregnancy; to distance children or to prevent pregnancy permanently and regulate high birth rates (Omondi, 1999; Awiti,

2013). Abortion is also used by both young and old women as a means of contraception despite its illegality (in some countries), insecurity and the unsafe nature of the process (WHO, 2012).

Scholars Hubacher and Trussell (2015), also state that contraception can be defined as modern or traditional. The most advanced methods for contraception include: sterilization, intra-uterine implants, oral contraceptive pills, injecting products, condoms, contraceptive emergency pills, contraceptive patches, spermicidal foams, contraceptive sponge and vaginal ring. Traditional contraceptive approaches include: rhythm and other forms of body fertility awareness, removal of penis from the pre-ejaculation cycle, lactational amenorrhea, and abstinence.

Globally, it is estimated that over 46,000 adolescent girls give birth each day (WHO, 2014). Although childbearing is a natural process for transition into adulthood, studies show that a significant portion of the experience especially for young mothers in particular is unintended, unwanted or mistimed. According to WHO, teenage pregnancy is defined as pregnancy in a woman between the ages of 10 and 19 years. WHO also reports that, 214 million women in their reproductive age who don't want children are not using a contraceptive method. In this particular age group, childbirth comes with its own set of social and health challenges; the worst-case being maternal and child morbidities.

In African countries, the situation is no different; young girls who do not use contraceptives as a means of birth control end up facing negative challenges associated with non-use including but not limited to unsafe abortion which leads to other complications like pre-eclampsia and obstetric fistula (Kabkayenga, 2011). Studies show that in Kenya, 45% of all sexually active unmarried adolescents have an unmet need for

contraception. (Hassan, 2012). Evidence shows that adolescents living in Kenyan slums engage in riskier sexual behavior than their peers in non-slum cities. Early sex debuts, transactional sex and multiple sexual partnerships are common occurrences. (Beguy. et al, 2002).

An elaborative study published by the *Alan Guttmacher Institute's Journal on Family Planning Perspectives*, asserts that if a teenager is given contraceptive information at an early age, the odds that come with lack of contraceptive information would be greatly reduced. Similarly, The *Mauldon* and *Luker* study clearly identifies two elements critical for success in this respect; credible education must come early, before a girl is sexually active for the first time, and it must include credible information about contraception. The study established that with these two elements present, odds improved by one third that a teenager would use protection from the start because they relied on the information. The sad reality that exists is that, worldwide, about 222 million women who do not want to get pregnant are not making use of the available contraceptive methods. These modern contraceptives are expected to prevent 308 million pregnancies of all reproductive ages women in developing regions per year. The report further elaborates that, if every woman who needed to use a contraceptive method in the developed world were to get access to it and use it correctly, then there would be approximately a three-quarters decline in unintended pregnancies (from the current 89 million to 22 million per year), unplanned births (from 30 million to seven million per year) and induced abortions (from 48 million to 12 million per year).

A study conducted by UNICEF established that adolescent pregnancies have become a global problem occurring in high, middle, and low-income countries. Every

year, an estimated 21 million girls aged 15–19 years in developing regions becomes pregnant and approximately 12 million of them give birth. Worse still, at least 777,000 births occur to adolescent girls younger than 15 years. A common indication is that these pregnancies are more likely to occur in slum environments where poverty, lack of education and employment opportunities are rife. There are different factors according to WHO, leading to the low intake in the slum environment of contraceptives such as side effects, the access to products and myths and misconceptions.

For correct contraceptive use to take place, there must be credible education about how to use these methods. Even though awareness of contraceptive methods is strong, poor knowledge and side effects of them are related to poor use (Obare, 2014) For young girls who tend to be naïve in most cases, this may be an uphill task to assimilate. For that reason, they suffer the greatest consequences. Unplanned pregnancy is one of the most common effects of lack of contraceptive use among young girls. Other negative outcomes of lack of contraceptive use include; exposure to sexually transmitted diseases such as HIV/AIDS and other Sexually Transmitted Infections (STI's). These consequences are mainly attributed to knowledge gaps on contraceptive usage. Misconceptions about how contraception works, socio-cultural and religious factors are frequently cited as reasons for not using a method among adolescent girls. In Kware Slums, statistics from the Kenya Demographic Health Survey shows rising figures of underage pregnancies over the years stressing the need to conduct this research in order to avoid future devastating realities.

Demographic wise, Kenya has a youthful rural population. The Kenya National Statistics Bureau (KNBS) has estimated that a total of 35.7 million (75.1 percent) Kenyans have less than 35 years of age. The data also shows that there was a stark rise in



population of 26% (37.7 million in 2009 to 47.6 million in 2019). This means that 9.9 million people were added to the population further revealing that only 36.4 Kenyan youth use contraceptives. This can directly be attributed to lack of contraceptive use as a result of knowledge or information gaps. Just 36.4 percent of Kenyan young people use contraceptives or any kind of contraceptives, from the information provided by KNBS (2014). Kenyan youth can be described as a versatile lot and in the Kenyan setting, majority of them move from the rural to the urban areas in search of employment opportunities. According to National Council for Population and Development (2015), The most popular areas in which they live are primarily slum environments in urban centers where knowledge of contraception and access to contraceptive methods is limited.

In addition, a study of sexual activity, HIV, STI and pregnancy prevention information and sources of information on sexual reproductive health, including sex education, was undertaken among very young adolescents from Burkina-Faso, Uganda, Malawi and Ghana. Findings to this particular study indicate that many of the target demographic population relied on information from their friends about sexuality and contraceptive use. They relied heavily on this information and used it to address their reproductive health concerns. Thus, this means that if their friend's level of information about contraceptives was inaccurate, then an entire population of peers would succumb to the negative effects of misinformation. The study established that the young adolescents had very high levels of awareness on the subject matter but also little credible knowledge about pregnancy and HIV prevention. Recommendations indicated that since majority of the study population were school-going, then sex education in schools would be the best avenue for reaching adolescents under age 15 (Bankole, 2007).

According to WHO's article on *Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*. Geneva: WHO 2011, Adolescents who may wish to prevent pregnancy may not be able to do so due to gaps and misunderstandings on where contraception can be accessed and how they can be used. Youth face obstacles to access to contraceptive drugs, such as limitation of contraceptive laws and policies based on characteristics such as age or marital status, dismissive attitude to acknowledge the sexual needs of adolescents (especially in Africa where it is assumed that it is not the right time for them to be engaging in pre-marital sex) and also their own financial challenges to access the contraceptives. In addition to these challenges, adolescents, due to their young age, the proper and consistent use of a contraceptive procedure may be lacking in autonomy. As a result, it was prudent to demonstrate that young girls in Kware slums also suffer from the same consequences associated with information gaps on contraceptive information. This study sheds light on what gaps exist and what ought to be done in order to ensure that information on contraceptive use is spread and understood.

Sexuality knowledge and information sources are a key contributor to the uptake of contraceptive information. Kofi Annan said aptly, "Wisdom is strength. Knowledge is liberating. In every society, in every family, education is the premise of development." This cannot be overstated enough especially with respect to protecting sexual and reproductive health for the very young adolescents, many of whom aren't sexually active, so that they make informed and responsible decisions when they start engaging in sexual activity. In this regard, this research provides valuable information as regards sexuality

knowledge and information sources that young adult girls have access to in Kware Slum Ongata Rongai, Kajiado North Sub- County.

## **1.2 Statement of the Problem**

Over time, the Kenyan government has espoused different strategies to highlight contraception as a step towards increasing the CPR and reducing the need for unmet Family Planning (GOK, 2019). This is a demonstration that the government has made available the information, but the uptake thereof is wanting. Overall, the sexually active Kenyan population consists of young people who may want to prevent pregnancies, but cannot do so because of perception about how to use contraceptive procedures (WHO, 2011).

In spite of the government's efforts towards reducing unplanned pregnancies, the rates continue to rise very fast. This study aimed to investigate the disconnect between the information that is available on contraceptives and the increase in figures of unwanted or mistimed pregnancies showing that the information available does not match the initiative. The situation is even worse for girls in slum dwellings. An analysis of high levels of poverty, low education and large households that affect access to basic health services, including family planning services in the slums of the Nairobi, Kisumu and Mombasa found that women with the lowest socio-economic status (SES), including slums are the less likely to use any modern method of contraceptives (USAID,2007).

The Kajiado County Integrated Development Plan 2018-2022 only indicates contraceptive and maternal health information from the Kenya Demographic Health Survey 2014. It does not give any contextual information on the contraceptive

information uptake in Kajiado North Sub-County among young adult girls in particular nor Kware Slums. This clearly demonstrates that the County does not have any direct-action plans about the situation, because it has not highlighted it as a problem. Furthermore, according to the Kajiado County Adolescents and Youth Survey NAYS 2015, the youth in all of Kajiado County have access and availability to health information and particularly contraceptives from the media (TV, radio newspapers), health facilities, schools, family, church, public forums, CHV's and social media yet despite of all these interventions the same report still states that teenage pregnancies is one of the leading problems facing the youth that has resulted in high rates of school drop-out in the region.

According to the KDHS 2, a total of 571, 891 and 1,009 young girls between the ages of 15-19 years have visited health centres in Kware Slums in Nkaimurunya Ward for ante-natal care in 2017, 2018 and 2019 respectively showing a rising trajectory of teenage pregnancies in the area. During the corona virus pandemic period alone, a total of 470 young girls in Kware accessed ante-natal services in a span of 5 months; by the end of this year this figure is feared to have run into thousands. This trend of steady rise in figures shows that the problem of contraceptive information uptake in the area is becoming more and more serious as the years' progress and it needs to be addressed. Suffice it to say that the problem doesn't exist in Kware alone medias have also published information on a government-managed health system citing that between January and May 2020, up to 4,000 teenage girls may have visited pre-natal health facilities alone in the county of Machakos. The number is projected to hit several thousand for the whole country by the time the year comes to a close (Plan, 2020). The

problem that has been investigated in this study is what is the disconnect that exists between the information that is already available for the young adult girls on matters contraceptives and the uptake of it. The problem is why are there still mistimed and unwanted pregnancies yet the information is available.

### **1.3 General Objective**

The general objective of this study was to: investigate the uptake of contraceptive information among young girls in Kware Slums, Ongata Rongai.

### **1.4 Specific Objectives**

The specific objectives of this study were to:

- i. Investigate the sources of information on sexuality among young girls in Kware.
- ii. Establish the factors contributing to uptake of contraceptives among young girls in Kware slums.
- iii. Explore the impact of the contraceptive information that the young girls in Kware access
- iv. Investigate whether there any information gaps on access and use of contraceptives among young girls in Kware, Kajiado County.

### **1.5 Research Questions**

- i. What are the sources of information on sexuality available among young adult girls in Kware Slums?
- ii. What are the factors that contribute to contraceptives uptake among young adult girls in Kware Slums?

- iii. What impact does contraceptive information have on the young adult girls in Kware?
- iv. What information gaps on contraceptive use and access do the young adult girls in Kware Slums?

### **1.6 Justification of the Study**

Kenya Demographic Health Survey 2014 indicates that at least 99.3 percent and 100 percent of men and women at the age of 15-49 have heard of a modern contraceptive method. This shows that the information is already out there and the target population of this study falls within the bracket. The begging question remains therefore, if the information is already in the public domain for their consumption and assimilation, why aren't they using it?

This study was therefore, worth pursuing because it generates scientific information and knowledge to help in formulating policies to address information gaps, improve access to information and to improve contraceptive use among the young girls especially in the slum areas. Similarly, the data is important in informing programs which are geared towards addressing information needs among the young girls ensuring that the communication strategies and channels used are well informed in promoting contraceptive uptake. Adolescents and future children's health and well-being are vital to Kenya 's economic fortune. Early and narrow pregnancies lead to a drop-out from school and reduce young people's economic opportunities. A necessary strategy to broaden these opportunities is to improve access to contraceptive drugs and to tackle the social and economic conditions leading to early childbirth.

Further, the study provides new data in the information access and contraceptive use among the young adult girls with the aim of filling the data between the past studies and the new studies. Further, by generating new data in this area of study, it will help policy makers and program designers address gaps which may arise from the study. Increased evidence indicates that the long-term financial and health benefits of increased access to contraceptives greatly outweigh the costs of inaction.

### **1.7 Limitation of the Study**

The study sought to investigate contraceptive information uptake among young adult girls in Kware slums in Ongata Rongai. The study focused on how information access affects choices made by the young adult girls on contraceptive use. One of the limitations of this study is that there didn't come across any document that disaggregates the population of Kware based on age hence the researcher wasn't able to get the total number of girls between the ages of 18-21 years specifically and used an estimation to arrive at the number of girls of this age bracket. The researcher thus used Mugenda and Mugenda formula to get the sample size population which is an estimation of the sample size.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.0 Overview**

This chapter probes into the review of the literature on the topic of study. It explores the empirical review and theoretical literature on aspects relating to contraceptive uptake among young adult girls.

### **2.1. Prevalence of Contraceptive**

Current reports on the global prevalence of contraceptives and unmet family planning requirements indicate total gains across countries. Despite overall improvements in some Sub-Saharan African countries (SSA), indicators are clear on the slow progress in contraceptive adoption and reduction in unmet needs or family planning (Nations, 2015). In conflict-afflicted areas in the SSA countries, family planning adoption and unmet needs for family planning represent a serious overview by humanitarian players. In these contexts, evidence shows low prevalence rates ranging from 4% to 16% and calls for more family planning investment both in the national and national action plans of the donor countries (McGinn, 2011).

Contraceptive coverage in eastern Africa is expected to increase to 40 % by 2030 and to 55% by 2050 (Nations, 2015). But only 6.8% of reproductive-aged women use family planning in South Sudan since 2015, 2.5% use modern family planning methods, and 4.1% use conventional family planning methods (Nations, 2015). South Sudan has been experiencing a long-standing national problem with low contraceptives, with no tangible intervention to counter it (Kane et al., 2016; Mugo et al.,2015). Two decades of civil war have disrupted Southern Sudan's health system, and therefore, even after the full



peace agreement was signed in 2005, a very small attempt has been made to plan for the family (Jones et al., 2015). And when the services were provided, family planning services remained underused (Kane et al., 2016). In South Sudan, low contraception intakes are likely to expose women to unforeseen pregnancies, an insufficient separation between children, and increased risks linked to the closed pregnancies and children's birth. In view of the crisis, the risk of malnutrition, disease, and higher mortality is greater for children in badly separated childbirths relative to those well separated (King, 2003).

Kenya's population continues to expand to an estimated 60 million by 2025, several years after modern family planning approaches have been put into practice (NCPD & UNFPA, 2013). While fertility decreased between 1978 and 1997, it has decreased in recent years (Ezeh et al., 2009). There are a variety of factors that cause this stall; a decline in the availability of modern contraceptive methods, the redistribution of funding for HIV / AIDS, and insufficient support for family planning programs (Ezeh et al., 2009; Ettarh & Kyobutungi, 2012). According to the 2008–09 Kenya Demographic Health Survey (DHS), the total fertility rate (TFR) was 4.6% and the current pregnancy was an unintentional rate of 42 percent for married women (KNBS & ICF Macro, 2009). Contraceptive prevalence was found to be 46 percent, which was not meeting Kenya's National Sustainable Development Policy's (NSDP) target of 62 percent in 2010 (Ettarh & Kyobutungi, 2012).

The fertility rate for young people has decreased by 7% over the last decade, but the total fertilities contribution (TFR) has risen from 32% at the end of the 1970s to 37% in 2008 (NCPD & UNFPA, 2013). The share of adolescents beginning children increased

from 2% by age 15 to 36% by 19 years (KNBS & ICF Macro, 2009). According to Kenya DHS 2008-2009, 12% of women aged 20-49 years had sex before 15 years of age, and about half had their first sex before 18 years of age (KNBS & ICF Macro, 2009). Analysis from the Adolescence Research Center found that four of 10 Kenyan girls had sex before the age of 19, many of whom had sex before the age of 12 (Integrated Regional Information Networks, (2008). The latest planning figures show that 97% of men and 85% of females between the ages of 15-19 are not married [(NCPD & UNFPA, 2013). This indicates that the early marriage age cannot be used for first-time marriage proxy (KNBS & ICF Macro, 2009) and that many youth have had sex before marriage.

The risks of mistimed and unwanted pregnancies in young women in Kenya are higher than in older women. Although all women (15-49 years of age) have high estimates of malnourished (26%) and unwanted (17%) pregnancies, the pregnancies among young (15-24 years) are even more mistimed (32% versus 30%) and undesirable (15% versus 10%) compared with other age groups. Some 13,000 girls in Kenya drop away each year as a result of unintended pregnancy (Integrated Regional Information Networks, 2008), and 103 out of 1000 births are born to girls between 15 and 19 years of age in Kenya. The leading cause of abortion is unintended pregnancy (Izugbara et al., 2011). Youth still use contraceptives little; 73% of the sexually active single women 15-19 years of age currently report using no system for the use of contraception (KNBS & ICF Macro, 2009).

## **2.2 Empirical review**

### ***2.2.1 The role of education***

Studies have shown that early pregnancy may limit girls' educational prospects and also their potential of fully participating in the community. From challenges in continuing their schooling right after a childbirth experience to getting good grades, furthering their education and in getting good jobs and income young mothers may find it difficult to cope and have dreams of a bright future. When a girl doesn't have all these challenges, then it is less unlikely that they will suffer from poverty. Education actually is a preventive factor that helps to postpone marriage and childbearing by developing your full potential as people and as economic actors. School is the only environment in which girls can be inspired to be what they want; they can take up jobs that seem to be masculine (Mensch & Bruce 1998).

Well-being is affected by poverty and gender disparity among a number of young girls in the developing world, as evidenced by inadequate education, violence and harassment, unfavorable working conditions, restricted access to treatment and early wedlock (Temin & Levine, 2009). There are also a host of adverse effects from early sexual intercourse, early pregnancy and early childbirth. On the other hand, analysis of data from the Longitudinal Health Survey demonstrated that improved education success has contributed to an early marriage decline (Mensch et al. 2005) in Sub-Saharan Africa and that young women registered in high school are less likely to participate in pre-marital sex than girls of the same age (Blanc et al. 2005). Probably one explanation for not rising pre-marital sex has been that schooling among girls has increased in more countries of the region.

Researchers Greene and Merrick, 2005 and 2010, have reported the connection between bad results in reproductive health, including early birth and household poverty demonstrating that education has a lot to do with the delay of early childbearing as knowledge about how to prevent pregnancies and desire personal advancement is taught in schools. This shows that education plays a crucial part in contraceptive information uptake or delay of sexual practices among young adult girls.

### ***2.2.2 Factors contributing to uptake of contraceptives***

Scholars Brown and Eisenberg observe that, among sexually experienced girls who do not want to become pregnant, approximately half of unintended pregnancies result from non-use of contraceptives, and the other half result from ineffective use. Although adolescent contraceptive use appears to be improving, young teenage girls remain inconsistent contraceptive users.

Kenya Demographic Health Survey 2014 indicates that at least 99.3 percent and 100 percent of currently married men and women at the age of 15-49 have at least heard of a modern contraceptive method and at least 45.2 percent of women aged 15-49 currently use one method of contraception. Despite them knowing about the contraceptives, 45.5 percent of women of the same age don't use any contraception. What is the reason behind the non-use of the contraceptive methods despite the knowledge available?

To find answers to this question, in April 2012, PSI Kenya conducted a qualitative study to improve the awareness of challenges to contraceptives among young

people. The research was carried out in the regions of Nyanza, Coast and Central. Urban regions of these areas were chosen on the basis of an almost regional average contraceptive prevalence and low socio-economic profile population. For a study, an interview of both users and non-users from randomly selected families was conducted and a sample was selected of sexually active women aged 15–24. Study results confirmed that contraceptive understanding and expertise do not actually translate into usage. Myths are the biggest obstacles to the modern usage of contraception by young people. Many respondents, particularly those from Kisumu reported hearing of or believing that the use of certain methods of contraception, in particular pills, resulted in cancer. Others claimed that the use of modern contraception contributed, among other false findings were low levels of libido.

This particular study also revealed the role that others play in determining contraceptive uptake among young teenage girls. Most of the respondents also used pronouns from the third person (he, she, she, she and others) to indicate that young people are discovering both real side effects and misconceptions from friends, family or partners who most often than not shared misconceptions and myths about family planning methods thus translating to non-use. PSI Kenya created a mass media initiative to counter young people's key misconceptions and misunderstandings as a result of this report. In general, the study focused on the following individual factors.

### ***2.2.3 General Knowledge***

Researches have shown that understanding or knowledge of contraception can help teenagers decide their use of contraception and prevent contraceptive

misconceptions (Ahmad et al., 2015). However, adolescents do not generally convert a high level of awareness into safer sexual activities and contraceptive use (Gubhaju, 2002), as described in the problem statement. A considerably large number of persons in the reproductive age group (15-49 years) are aware of at least one form, i.e., 99.8% of non-married women, 100% of married women, 99% of unmarried men, and 99.8% of married men. However, there is very little awareness of ECs, 28.8% in women, and 38.7% in men (Nepal, 2011; Ahmad et al., 2015). Although awareness among the youth has not been calculated individually, and since the adult population is included in the age group too, it is presumed to be at least one contraceptive form, primarily condoms or pills (Kathmandu, 2013), is known to nearly all youth(s). It also shows that married teenagers know marginally more than unmarried and that women are identified better than men, excluding ECs.

In a survey of married teenagers in Nepal, only a fourth of all married teenagers were aware of the four main methods: tablets, preservatives, injectables, and ECs (Aguilar Rivera & Cortez, 2015). Similarly, young people have no detailed knowledge of contraception methods such as effectiveness, side effects, source, and correct ways of using them. Only one in three married adolescents who do not use contraceptive medication know how to procure contraception from either a healthcare facility or the sub-health department. Surprisingly, the women who use contraception still have limited knowledge of the effectiveness of the procedure (Aguilar Rivera & Cortez, 2015). The married teenagers are fearful of contraception's side effects and have misunderstandings about the effects on fertility of hormonal contraceptives like pills (Aguilar Rivera & Cortez, 2015).

#### ***2.2.4 Education***

Education has a positive effect on the use of contraceptives in young people, as shown in the fact that, between 15-24 years old and older, condoms are 53.7% compared to 5.3% among young people without training in Kenya (Kabiru & Orpinas, 2009). According to Lindberg & Maddow-Zimet, (2012), youth aged 15-24 are six times more likely to encounter sex at the age of eighteen when having no education. The fertility rate is, in addition, inversely proportional to the levels of education, i.e., 3.7 births among women without education, whereas 1.7 births of SLC and above education (Simon et al., 2012). In Kenya, education is in short supply that contributes to early marriage, early childbirth, and low socioeconomic standing. Education gives young people the capacity to make choices in negotiations with partners about their sexual activity (Acharya et al., 2009), which helps to retard sex and increase the use of contraceptive methods.

#### ***2.2.5 Perception and Attitude***

The young people's view of contraceptives and attitudes to them are based on their values (McManus, & Dhar, 2008). A study carried across Nepal has found young people to feel that they are recognized and fearful that the service provider will share the details with friends and families if they go to pharmacies or health facilities to purchase contraceptives. It led adolescents to prevent the quest for methods of contraception (Regmi et al., 2010).

In teenagers too, there are many misunderstandings about contraceptives. A cross-sectional analysis by Mac Manus et al. (2008) among urban teenagers aged between 14

and 19 years in India suggested that 32% of adolescent girls agree that unmarried girls must not take contraceptive pills and that 21% of them believe married women can protect their body from HIV infection (McManus & Dhar, 2008). In Nepal, Stone et al., 57,8% of boys and 47,6% of girls said they could use the same condom more than once a high number of respondents (Regmi et al., 2010).

In the same way, youths do not want to use condoms on the basis of a physical appearance and social standing with their partner they consider "safe." They often interpret the request for a condom to be used as a sign of disease and the absence of condoms as a sign of confidence (Marston & King, 2006). More than half of teenagers in Nepal have had sex with sex workers. In a study conducted on Nepal's border regions, 69 percent married and 56 percent married young men between 18 and 24 years of age had not routinely used condoms with their causal partners, including sex workers, during their sexual intercourse. They think they should pick women who do not have the disease as partners (Tamang, 2001). These misunderstandings regarding contraception have a detrimental effect on the usage of contraception among teenagers.

### ***2.2.6 Wealth***

The family's wealth is positive for the use of contraceptives (Longwe, Huisman & Smits, 2012). The economic situation is one of the constraints of low-income countries such as Nepal to buy contraceptives or pursue facilities for sexual and reproductive health (Najafi-Sharjabad et al., 2013). Although contraceptives are issued without any expense from public institutions, almost half of adolescents rely mainly on private pharmacies from non-government sources (Kathmandu, 2013) because of different reasons, such as



very few rural public health facilities, health care provider's attitudes, fear of stigmatism, etc. (Regmi et al., 2010). As previously mentioned, early marriage and early childbearing are also associated with poverty. Poor girls are three times more likely than females in the highest income quintile to marry before the age of 18 and are half as likely to be mothers (Aguilar Rivera & Cortez, 2015).

### ***2.2.7 Substance Abuse***

The World Health Organization (2001) indicated that drug and alcohol use leads to risky sexual activity without the use of condoms and many sexual partners, including sexual intercourse. The chances for young men reporting alcohol use with casual sex are four times higher than for young men who do not use alcohol in their border towns in Kenya (World Health Organization, 2001). Likewise, according to Regmi et al., (2008, 2010) where in their qualitative survey with most respondents aged 10-25 among opioid injection users found that most men have encountered uncertain sexual behaviors, such as multiple sex partners, sex workers, and group sex without condoms. The interviewees indicated that during a sexual trip, they had more satisfaction. Many young people believe that the ability to offer and initiate alcohol gives them strength, and if they drink, the risk of rejection will decrease. The young people indicate that drinking alcohol decreases their concern about the preventive disease, safe sexual behaviors, and alcohol affects their decisions on sexual protection and contraceptive use even though they are aware of the incidence of unhealthy sexual activities.

### ***2.2.8 Sexual Pleasure***

According to Wong (2012), some of the major factors encouraging sexual activity and thereby affecting contraceptive use are sexual pleasure and curiosity. Teenage boys also believe that the use of anti-contraceptives, such as condoms, limits sexual gratification. Their option of contraception, in turn, is affected by this.

### ***2.2.8 Parental Communication and Beliefs***

In Kenya, reproductive and sexual health problems, including contraception, are seldom openly addressed in communities (Wegs et al., 2016). In Kenya, Parents feel that young people are too young to be able to learn about sexual problems and therefore view sex education as an opportunity for their children (Godia et al., 2014). A 15-19-year-old survey of teenagers in rural Uganda found only 50% of the adolescent population, 50.8% of males and 55% of females, had knowledge from their parents on their puberty and body changes (Amin et al., 2013). Literature indicates that if parents are more open about sex, contraceptives, and pregnancy with their children, particularly early on, then the teens would be more likely to postpone their sex debut by using contraceptives and have safer sex (Subedi, Jahan & Baatsen, 2018).

The good contact between mother/daughter is associated with an increase in effective contraceptive reliable means and also a reduction in option abortion (Subedi, Jahan & Baatsen, 2018) in a descriptive analysis in the cohort of women aged 15-24 in Israel. Kenyan parents also frequently think that contraception for married persons should

be restricted, and unmarried teenagers' contraceptive use should be avoided (Biddlecom et al., 2009).

### **2.3. Barriers to Effective Information on Contraceptives**

Sedgh & Hussain (2014) estimate that many women and couples in Sub-Saharan Africa have no modern contraception. For social, economic and health reasons they do not have enough knowledge about family planning benefits. Some do not know where to get a procedure or have an idea of the right method for them. Other women are discouraged from using family planning because they feel they are against abortion by their family members, their husbands, and religions (Kinaro et al., 2015).

Stereotypes and negative views of contemporary approaches are other important barriers to modern contraceptive use. These include false or exaggerated descriptions of the side effects, misunderstandings regarding long-term and short-term health consequences, and negative labeling of people using methods (Sedgh and Hussain, 2014). Researchers have found, for example, that women view pill use as more harmful than their pregnancy in developing and developed countries. Bradley, Fishel & Westoff (2012) estimated that approximately 70 % of women attributed high exposure to morbidity risks to the use of methods, such as the pill.

In numerous national surveys, mainly in rural areas, the prevalence of such myths and misunderstandings has been evident (Faye & Seck, 2013). More than one-half of the women in six cities in Senegal thought that contraceptive users would be faced with a health issue, like infertility, in MLE baseline surveys conducted between 2010 and 2012 (Corroon & Okigbo, 2015). Similar findings have been found in men. Kenya studies also

indicate that men see the use of contraceptives as negative for women. The use of contraception is restricted by a low level of awareness, according to these reports. Where the level of awareness is strong, the uses of modern contraception by prejudices and misconceptions are inhibited (Munene, 2015).

According to an Elias study, many women in Ghana feared in 2014 that pills and injections would be permanently infertile. On the other hand, in Kenya, sexually active women aged 19–24 indicate that young adult women misunderstand the side effects of modern contraceptives, including the hypothesis that modern contraceptives cause infertility or damage to women's uterus. Moreover, few individuals were met or heard about actual side effects such as weight gain (Bradley, Fishel & Westoff, 2012). A Kenyan reproductively active female study showed that women with modern contraception could build up and give birth to a life-threatening medical system, such as nasal and mouth bleeding. These negative attitudes are held and popularized in social media and peers (Paz Soldan, 2004).

Research into contraception found that an average of 20 to 50 percent of married women in 26 of the 51 countries surveyed cited side effects and health issues as significant reasons not to be employed with contraception. In sub-Saharan Africa, similar results have been published (Corroon & Okigbo, 2015). Misunderstandings and misconceptions are the key drivers of abortion in many other areas of the world, such as Mexico. Women prefer or discontinue other approaches in this regard (Cleland et al., 2012). As an unusable driver, myths differed considerably across Sub-Sahara, such as barriers to contraception in Kenya and Senegal. Contraceptive use is higher in married couples than in Senegal in Kenya (Corroon & Okigbo, 2015).

Research into the current beliefs and perceptions of the various contraceptive methods available is significant. For relevant intervention, it is important to recognize the barriers that lead to low contraceptive use. Such barrier knowledge would be critical to informing policymaking. This will help to remove the barrier to increased contraceptive usage in reproductive health and abortion policies (Cleland et al., 2012).

### ***2.3.1. Access to credible information on contraceptive use***

A study to reduce the prevalence of unintended pregnancy and unmet need for family planning (FP) among married adolescent girls aged 14 -19 years in urban slums of Dhaka, Bangladesh took place in 2014. From the findings, it was evident that the government should prioritize health education on family planning services to promote awareness and the consistent use of contraceptives among adolescent girls in urban slums in order to reduce the high levels of unintended pregnancy and other undesirable outcomes. The findings also point to the need to improve counselling on FP for adolescent girls and their spouses in order to alleviate some of the barriers in using family planning services, such as misconceptions and fear of side effects, and to ensure appropriate timing and consistent use of contraceptives.

Studies of the limits of contraceptive use by young women in developed countries was carried out by Williamson and Wight. The results show that multifaceted approaches at the community level and the combined provision of information, life skills, resources and access to youth-friendly services must be made accessible in order to improve modern contraceptive practices. These initiatives are intended to combat negative

assumptions regarding modern methods of contraception and the dual role of condoms in contraception and prevention of STI.

### ***2.3.2. Influences on decision making regarding contraceptive use***

Separate study in the Bangladeshi Rangpur district established that teen girls had little knowledge of the correct use of contraceptive methods and children's education in the decision making processes of teenage girls in Bangladesh. Bangladesh has the highest pregnancy rate in South Asia, and child marriage is one of the leading causes of teenage pregnancy. That said, the contraceptive prevalence rate in the country is very satisfactory, with contraceptive methods used by just 52 percent of married teenage girls. Qualitative data from Rangpur District study participants were collected in this particular study in 35 in-depth interviews, 4 primary informant interviews and one focus group discussions were also conducted with community health workers.

Based on the results, for cultural reasons, adolescent girls have shown very low level of making their decision on the use of contraceptive and childbearing practices. Decisions related to these vital lives were mostly made by either their husbands or by mothers-in-law. The most critical role for contraceptive uses and childbearing decisions was played by mothers-in-law when the husbands were unemployed and financially dependent on their parents. The lack of reproductive health awareness, the lack of negotiating skills and communication skills with husbands and relatives and the lack of confidence in contraceptive approaches have emerged as influence factors which have helped to prevent contraception by early childhood among married young adults. This means that the girls in question use only the contraceptive knowledge that comes directly

from the laws of their husbands and mothers and to the degree to which they are conscious. This results in the use of contraceptives being low or incorrect.

#### **2.4. Literature Gaps**

Efforts and services to support adolescent's (Sexual and Reproductive Health) SRH and the prevention of adolescent pregnancy have traditionally concentrated on women 21 years and above. Yet, the teenagers with the greatest vulnerabilities, of STD infections and who face the greatest risk of complications and death from pregnancy and child-birth are between age of 18 and 21. Earlier research has shown that expectations impact teenage contraception. Many research studies have explored the belief that contraceptive use induces consumers' infertility and promiscuity. This study aims to develop other current views of contraception in adolescents and to examine how these views impact their ability to take contraceptives.

Although there have also been comprehensive studies on adolescent contraception and teenage sexual behaviour, limited attempts have been made in order to link the sexual activity of teenagers with contraception. Most of the study concentrates on the youth's marital status and sexual activity level. There has been substantial research on adolescent contraceptive awareness. Many studies have operationalized "adolescent contraceptive awareness" as: what contraception strategies are understood by adolescents. The study further implements the variable by incorporating measures such as the awareness of successful / acceptable usage, benefits and drawbacks/side-effects of any three contraceptive methods.

## **2.5. Theoretical Framework**

This research study was guided by the Standpoint Theory and the Theory of planned behavior which is an extension of the Theory of reasoned action.

### ***2.5.1 Standpoint Theory***

The theory of standpoints is a theoretical view where its knowledge comes from a social role; a mental position from which life is viewed. Experiences of life and social groups shape people's view of life or their perspectives and ultimately their belief system which guides their decision-making process. Thus, for many young girls especially those living in slum environments, their perspectives have over the years been shaped by what people say, what they hear around them while growing up and what they are exposed to. The close-knit communities in which they live make them hear, see and believe what is going on around them and issues to do with contraceptives are no different.

American theorist Harding coined the term standpoint theory to categorize epistemologists that emphasize women's knowledge. In the book *The Daily World as Problematic: A Feminist Sociology* of 1989, Dorothy Smith, a sociologist in Canada, argued that sociology overlooked women and made them the 'Other.' That particular vision was shaped. She further confirmed that female experiences are fertile reasons for awareness and that sociologists will eventually start to ask new questions by basing sociological work on women's daily experiences. Standpoint theorists Harding and Wood, 1996 assert that the best way to discover how the world works is to start the inquiry from the standpoint of women and other groups of people who are on the margins of society.



In relation to this study, young girls especially in slum environments in Africa are not considered to be among the target group for family planning services and thus because they are considered the ‘other’, problems associated with them not being included in interventions will continue to escalate every day. Young girls are presumed to be school going and not engaging in under-age sex; this is far from the truth and their standpoint is important; it should be factored in and considered. In a report, Community and health systems obstacles are investigated and family planning and contraceptive services in the Kabwe District of Zambia are given and used, it was established that young girls are marginalized from getting information on contraceptive use with the rest of the married women, by health workers who are tasked with the responsibility of administering these health services wrongly assuming that they are underage and would not need to use contraceptives.

The synonyms for the word standpoint are telling. It may otherwise mean viewpoint, perspective, outlook and position. Harding and Wood think that the social groups within which we are located powerfully shape what we experience and know as well as how we understand and communicate with ourselves, others and the world. A young girl in Kware slum is essentially exposed to different social groups that shape what she perceives to be true about contraceptives. Her friends, parents or guardians may have told her that contraceptives are not a good way of preventing pregnancy because they may interfere with her libido or may make her infertile. A social group may also be the social media groups that the young girl subscribes to and what they say about contraceptives; this largely forms her belief system thereby exposing her to consequences of non-use. To stress this, the study carried out in Rangpur district in Bangladesh aptly

demonstrates that mothers-in-laws and husbands to newly married young girls, entirely make contraceptive decisions on behalf of the girl and determine when would be the right time to give birth (Shahabuddin et al. 2016). In this case, it is the standpoint of the mother-in-law or husband that is law rather than the standpoint of the young girl.

A research on contraceptives in young people in countries with low and middle income, findings indicated by and large that young girls had varied standpoints when it comes to contraceptive use. For instance, when one respondent was asked whether they would use a condom to prevent an unwanted pregnancy they responded by saying that the use of a condom and even carrying it would mean that they will be considered loose and therefore they wouldn't use it. (Castaneda, 2001). In addition, adolescents also have misunderstandings about how contraceptive strategies can impact their health and potential ability to carry children in the immediate and long term. Owing to the worries and concerns arising from this, young people also deem unsuccessful strategies such as elimination and conventional remedies more appropriate so they will not risk having children in the future (Wood, 2006).

Similarly, given the lack of an awareness of how and how contraceptives function, teenagers abuse them, as a young South African woman's statement revealed that she would often take a pill when she knows that her boyfriend is coming over to her house and they would most likely make love. This means that she would only take it on the material day of lovemaking and discontinue on other days posing a risk of incorrect use of contraceptives. Another young girl who was interviewed said that she sometimes forgets to take it before they make love and only does it after the act. Finally, young girls who would not want to be viewed as unfaithful said that they wouldn't really insist on

their boyfriends using a condom because they wouldn't want them to think that they were unfaithful and thus, unintended pregnancies would most always than not be the result. This study seeks to reveal that these misconceptions that exist in the South African slum where this research study was undertaken, still exists even in Kware Slum where the outcome of the misconceptions is evident.

In establishing the factors associated with contraceptive information uptake; the answer lies in what the young girls deem to be true which is most often than not what they hear or the kind of knowledge and information they are exposed to in the slum environment. Most often than not what they hear others speak, is what shapes their actions if at all no opposing truthful information is made available. In this same study, it was recommended that the awareness of the knowledge and contraceptive needs of youth by prominent leaders and the society at large and the threats to their well-being to not address these needs be strengthened (WHO, 2012).

Social and community expectations also impede discussion of contraception among couples. Furthermore, the use or proper use of contraception as young girls who are sexually active avoids information gaps and misunderstandings will only use the contraceptive information only to the extent to which they are aware of asserting that if limited information is available for their consumption, that is what they will use. In a research, contraceptive use among reproductive women in Kenya city slums was investigated, the use of family planning should be small, relative to the national level estimated at 46 per cent, compared to the low educational levels among women of slums with high school dropouts, and inadequate familial planning services (Republic of Kenya, 2008).

### ***2.5.2 Theory of Planned Behavior***

The theory of planned behaviour was proposed by Icek Ajzen (1985) through his article "From intentions to actions: A theory of planned behaviour." (Ajzen, 1991) The theory was developed from the theory of reasoned action, which was proposed by Martin Fishbein together with Icek Ajzen in 1980. The theory of reasoned action was in turn grounded in various theories of attitude such as learning theories, expectancy-value theories, consistency theories (such as Heider's balance theory, Osgood and Tannenbaum's congruity theory, and Festinger's dissonance theory) and attribution theory (Fishbein, 1975). According to the theory of reasoned action, if people evaluate the suggested behavior as positive (attitude), and if they think their significant others want them to perform the behavior (subjective norm), this results in a higher intention (motivations) and they are more likely to do so.

Many research confirmed a high association between attitudes and subjective expectations with behavioral intent and actions. It is built around several constructs such as attitude, subjective norm (social network, perceived behavioral control). These are the best social predictors of behavior and in turn influences people to act the way they do. In other words, if a young adult girl in Kware thinks that using contraceptives is a good idea and think that her social network comprising of her friends think that it's a good idea and believes that she can handle using them, then she will definitely use them. If one of these constructs is unfavorable then the girl is most unlikely to use the contraceptives. The

theory was intended to explain all behaviors over which people have the ability to exert self-control.

### ***2.5.3 Synthesis of Theories***

The theory of standpoints argues that through power relationships that build and divide social groups into dominant and non-dominant categories, people generate information. Within these categories, interactions create distinct, unequal opportunities that foster different ways of understanding and being. Members of the non-dominant party can have more complete knowledge of truth than dominant ones because from both viewpoints they view the universe. Therefore, the theory indicates that social and group norms hinder discussion between couples about contraception.

The Theory of Planned Behaviour was chosen because it offers simple descriptions of constructs and a full body of association evidence supports it. The Theory of Planned Behaviour offers a clear and efficient mechanism that can be used to examine the purpose of a person to take contextual action. The Theory of Planned Behaviour believes that the majority of human activity is target-oriented, socially motivated and that people take logical and rational decisions. Therefore, usage of contraceptives is seen by this theory as a motivation from social groups.

## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **3.0 Overview**

This chapter describes the methods used in conducting the research. It entails the research design, research method, study area, sample size, target population, data collection procedures, ethical considerations and analysis procedure.

### **3.1 Research Design**

Research design provides a means of planning and executing a particular research. It provides a framework for finding answers to the research questions (Punch, K 1998). This study was based on an explanatory; sometimes referred to as causal research. This particular design is used in order to help us find answers to the research questions presented. Its purpose is to increase the understanding of a researcher on a certain subject determining why and how things happen the way that they do (CSC, 2018). Through this design, information was obtained using questionnaires and interview guides.

### **3.2 Research Method**

Methods for study are the strategies, procedures or techniques used in data collection or analysis to detect new knowledge or to better understand the subject in question. This research study used a mixed methods approach in collecting data integrating both qualitative and quantitative strategies. Mixed research methods are the type of research in which an investigator or research team puts together elements of qualitative and quantitative approaches of research, for a wide scope for interpretation or corroboration purposes, such as the use of qualitative and quantitative viewpoints, data collecting, review and inference techniques (Johnson et al. 2007).

### **3.4 Target Population**

The target population for this particular study was young girls in Kware Slums between the ages of 18-21 years. State Adolescent Health Resource Centre defines this age group as late adolescent or young adulthood. This population was selected because family planning ought to not only be administered on mothers but also to young girls because of their early sex debuts. The Kenya Demographic Health Survey and the Performance Monitoring and Accountability, have shown that the majority of rural women begin their sexual debuts at the age of 14, 6 years prior to using contraceptives and 4 years before marriage in urban centres (KNBS,2014). Community Health Volunteers (CHV's), NGO/CBO Officials, pharmacists, parents or guardians and nurses will be interviewed as key informants for this particular study after using an inclusion or exclusion criteria to establish who to interview. One person was interviewed from each category.

### **3.5 Study Site**

Our location of study is known as *Kware* Slum, located in Kajiado North Sub-County. According to the 2019 National Census, Kware slum has a population of 26,355 (13,174 males; 13,181 females) (KNBS Vol 2, 2019). In southern Kenya, Kajiado County is situated. It bordered the counties of Nairobi on the northeast, Narok on the west, Nakuru and Kiambu on the north, Taita Taveta on the southeast, Machakos and Makueni on the northwest and east, and the Republic of Tanzania on the south. It bordered the county on the northwest. It is located from 360 5' to 370 5' East and from Latitude 10 0' to 30 0' South.

The land covered in the County is 21,900.9 km<sup>2</sup>. Kajiado County is one of the 47 counties with its headquarters in Kajiado town. It enjoys the benefits of being within the Nairobi Metropolis which consists of 4 counties; Nairobi, Kiambu, Machakos and Kajiado. The county's projected population for 2018 stands at 1,112,823, with male constituting 50.2 percent and female 49.8 percent. With almost every ethnic population in Kenya in major urban areas the county is strongly cosmopolitan.

The county continues to experience rapid urbanization and urban growth as a result of high migration from other parts of the country and within the borders. The county boasts of a rich *Maasai* culture that is recognized worldwide. Wildlife is a predominant feature in the county with Amboseli National park being one of the major tourist attraction sites among other sites like Olorgesailie pre-historic site and the Ngong Hills. Ngong Hills provides a beautiful scenery for picnics and hiking, it is also useful as a site for wind power generation and also useful in providing bearing for aircrafts landing at the Jomo Kenyatta International Airport (KCDP, 2018-2022).

### **3.6 Sample Size and Sampling Procedures**

#### ***3.6.1 Sample Size***

The target population is the young girls (18 to 21 years). The population of young girls in Kware slums is not known. However, according to the Kenya Population Housing Census 2019 Vol 3, the total number of females in Kajiado County is 155,908. The population of women in Kware was 13,181. Therefore, the proportion of women in Kware compared to Kajiado North was approximately 8.4%. Further, the total population of girls between the ages of 18 and 21 years in Kajiado North was 13964. Assuming the same distribution of



women applies to Kware, the population of girls (18-21 years) was calculated. Thus, the population of girls between 18 and 21 years in Kware slums was estimated to be

$$0.084 * 13,964 = 1172.9$$

An equivalent of 1173 young adult girls.

In order to determine the sample size for this particular study Mugenda and Mugenda sample determination formula for homogenous populations was used. for homogenous populations, a sample equivalent to 10% - 30% is adequate for a study. Mugenda & Mugenda (1999) state that a sample is a smaller group or sub-group obtained from the accessible population. This subgroup is carefully selected so as to be representative of the whole population with the relevant characteristics. Each member or case in the sample is referred to as subject, respondent or interviewees. Therefore, the study selected 10% of the girls aged between 18 and 21 years in Kware slums..

$$= 0.1 * 1173 = 117.3$$

Equivalent to 118 girls.

The assumption of homogeneity was arrived at because the target population share certain characteristics. These include; at this age, most of the girls are perceived to have entered adulthood, most of them live under their parents' care, it is at this age they are perceived to have completed basic education and gaining their freedom to make their own decisions. A total of 5 key informants were interviewed for this study. These were; a nurse, a pharmacist, a Community Health Volunteer, a parent or guardian and an

NGO/CBO staff member and conveniently interviewed at their base locations within Kware Slums.

### **3.6.2 Sampling Techniques**

In his report, Reid (1993) defined a population as all units with particular characteristics of research interest. A research sampling technique is defined as a method that involves respondents being chosen by chance with an equal probability of being chosen. This study used both purposive and systematic sampling techniques. Purposive sampling technique was used to select the key informants in this case the nurses who administer the contraceptives, pharmacists who sell the contraceptives, CHV's who work with local NGO's to provide these contraceptives, NGO/CBO staff who are aware of the prevailing problem in the slum in respect to contraceptive information uptake among young girls and parents or guardians to the young girls who are in close contact with them and would confide in them about their sex life. The researcher looked for the nurses, CHVs, pharmacists, NGO/CBO staff, parents or guardians at their base locations at the time of carrying out the study.

Systematic sampling method was used to obtain the quantitative data from the young girls. Systematic sampling procedure is defined as a sort of probability sampling system in which samples are chosen by a random starting point from a wider population but with a daily interval. It is determined by dividing the population size by the target sample size, called the sampling interval. According to the KPHC 2019 Vol 2, Kware has a total of 431 households this means that the periodic interval used was 3 since the desired sample size is 118 young adult girls. For instance, the first house was the starting

point and a young adult girl from every third house from that one was interviewed. In case there isn't a young adult girl of the age 18-21 years in the targeted house, then skipped that house and moved to the next one and from there apply the interval formula. This particular sampling method is time and cost efficient making it ideal for this study.

### **3.8 Pilot Study**

Data collection tools were pre-tested on 10 recruited participants in Kware Slums to rule out any cases of ambiguity in the actual study. The data from pilot study was not used in the main study.

### **3.9 Data Collection Methods**

A survey method is used to collect quantitative data. Questionnaires were the tools used to collect the quantitative data in this study. A questionnaire is given the definition as a data collection instrument that involves asking a particular subject to answer a set of written and oral questions. The use of structured questionnaires, and interview question guides were used to capture information from the study population. The questionnaires were used to collect information from the young girls because they allow one to gather information from large audiences and are economical (Robson,2002). In addition, the questionnaires most likely produce more accurate results.

The use of interview question guides was used to guide face to face interviews from key informants like the medics who either sell or administer the contraceptives to the young girls, and their parents or guardians. A trained research assistant was present to conduct face to face interviews for key informants. A mixed methodology approach

consisting of both Quantitative and Qualitative data collection strategies was employed in this study. Data was collected by the principal investigator and a research assistant. Pretested structured questionnaires were used to interview the participants. A total of 118 young adult girls were selected using a systematic sampling technique and interviewed by way of questionnaires to obtain the quantitative data. In the case of qualitative data, a total of 5 key informants were identified purposively and interview guides were used to obtain the information.

### **3.9.1 Data Analysis and Presentation**

The data was quantitatively analyzed using descriptive statistics and presented in graphs and tables while the Qualitative data was analyzed using thematic content analysis where respondent responses were grouped according to the objectives of the research study and presented using narratives and verbatim quotes. The thematic mapping approach was used to analyze all transcripts from interviews seeking trends and correlations on emerging topics, focusing on drivers and barriers to the use of knowledge on contraceptives.

### **3.9.2 Validity**

A triangulation method which entails getting information from different sources was used to affirm the goal of the study. This ensured that the findings are valid and can be relied upon.

### **3.9.3 Ethical Considerations**

Approval for research was sought from respondents and the principal investigator and assistant as well as the researcher introduced themselves and explain the purpose of the study and assure respondents of the safety of their identities. An oral informed consent was sought from the interviewees prior to the interviews.

## **CHAPTER FOUR: FINDINGS AND DISCUSSIONS**

### **4.1 Overview**

This chapter presents findings of the study based on research objectives. The semi-structured questionnaire collected primary information, while the document review collected secondary data. Data collected from respondents for the four study objectives were analyzed using descriptive statistics of frequencies and percentages.

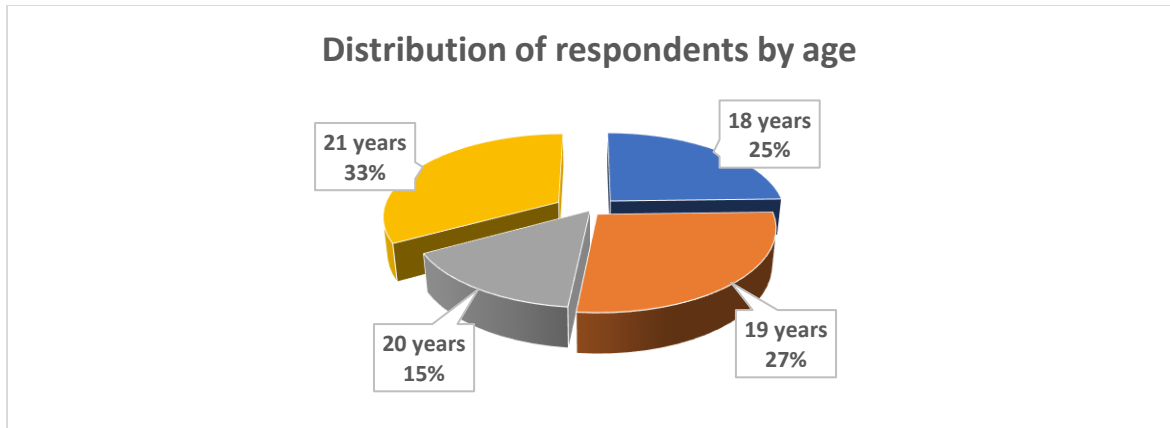
### **4.2 Response Rate**

A total of 118 dully filled and usable questionnaires out of a proposed sample of 118 questionnaires were obtained from respondents for the study. This represented 100% response rate which was sufficient for doing the analysis. Therefore, all the tables and graphs presented in this chapter have a sample size of 118 unless stated otherwise. In this regard, some tables have a total response of more than 118 and this represents multiple response (where respondents were required to give more than one response).

### **4.3 Demographic Information**

This respondents' demographic information is presented in this section and include age, level of education attained and whether the respondents were sexually active.

#### ***4.3.1 Age of respondents***



**Figure 4.1: Distribution of respondents by age**

Research findings revealed that of the 118 respondents, a majority of 33% were 21 years of age, followed by 27% of 19 years of age, and 25% were 18 years of age. 15% of the respondents were 20 years of age. The results showed a fair distribution of age of respondents.

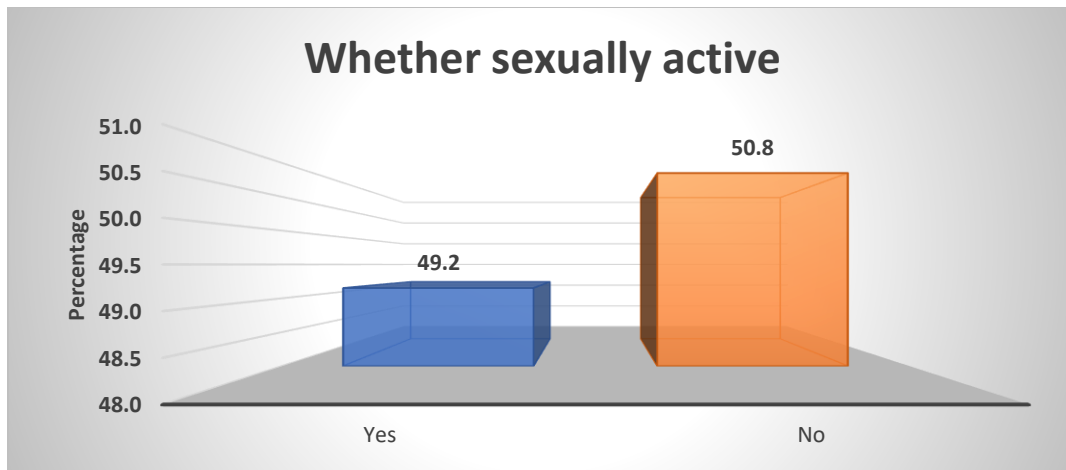
#### **4.3.2 Level of education**

The research attempted to assess the degree of the respondents' education level. This was critical because it allowed the researcher to assess the study's level of understanding and to understand the issues.

**Table 4. 1 Level of education of respondents**

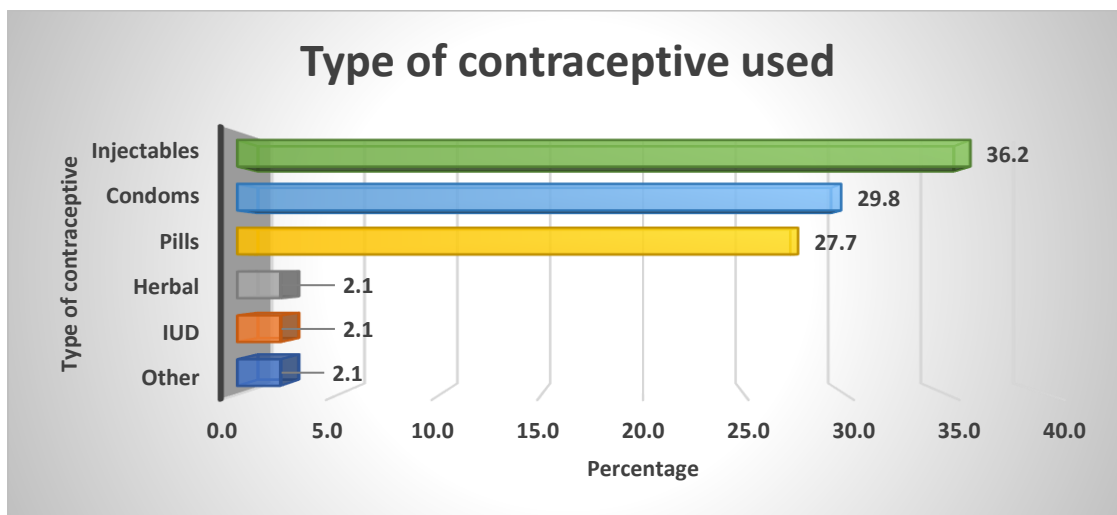
| <b>Education Level</b> | <b>Frequency</b> | <b>Percent</b> |
|------------------------|------------------|----------------|
| Primary School Level   | 5                | 4.2            |
| Secondary School level | 105              | 89.0           |
| Dropout                | 8                | 6.8            |
| Total                  | 118              | 100.0          |

Many respondents had reached a high school level of schooling, with a level of 89.0% (n=105) and a dropout level of 6.8% (n=8) respectively. Five (5) of the respondents had a primary school level making 4.2% of them.



**Figure 4.2: Whether respondents were sexually active**

Out of 58 girls who reported to be sexually active, 80% (n=47) reported to be using contraceptives while the rest did not. This implies that sexual activity was directly related to use of contraceptives among young adult girls. The girls mainly did this to prevent unplanned pregnancies which would lead to shame amongst their peers and other major setbacks in life.



**Figure 4.3: Type of contraceptive used by respondents**

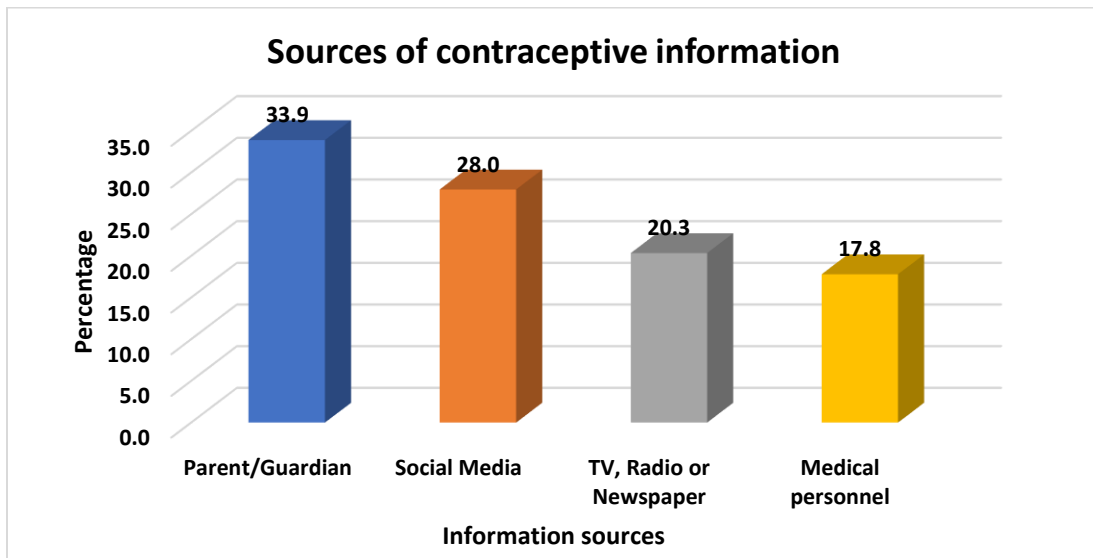
Research findings revealed that of the 118 respondents, a majority of 36.2% used injectables, followed by 29.8%, of those used condoms, and 27.7% who used pills. Herbal, IUD, and other methods shared a proportion of 2.1% each. The results showed



young girls adopt injectables, use of condoms, and pills as effective methods of contraception. The choice of injectables was because the girls may not have to worry about the cost of contraceptives since in most of the government facilities, the 3 months injectable (Depo) is given free of charge. Also, it would give the girls freedom to enjoy sex without worries of ‘forgetting to use condoms or everyday pills or even buy after morning-after pills.

#### 4.4 Sources of information on sexuality among young girls

The initial research objective sought to determine the various sources of information about contraceptives that were available to the young girls of between 18 to 21 years in Kware. There were various sources of information available to the respondents as shown in Figure 4.4.



**Figure 4.4: Sources of contraceptive information**

In the figure above, results indicated majority of young girls got information concerning use of contraceptives from their parents as was reported by 33.9% of the

respondents. 28.0% indicated social media was their main source of information, while 20.3% said they got information from TV, Radio or Newspaper, and finally, 17.8 indicated the information is from medical personnel. This confirms the standpoint theory where it is argued that knowledge stems from a social position as well as a mental position from which life is viewed. Experiences of life and social groups shape people's view of life or their perspectives and ultimately their belief system which guides their decision-making process. It implies that parents play a big role in the growth of their children thus take it upon themselves to talk about sexuality and contraception with the young girls as a way to caution them and prevent them from straying.

One parent said:

I believe it is the duty of every parent to educate their children about sex education so that they can make the right choices in life. It is not like in the past where parents used to fear talking about sex to their children. The thing is, if as a parent you don't do it, then the wrong person will. Like me, I believe that a majority of parents do this.

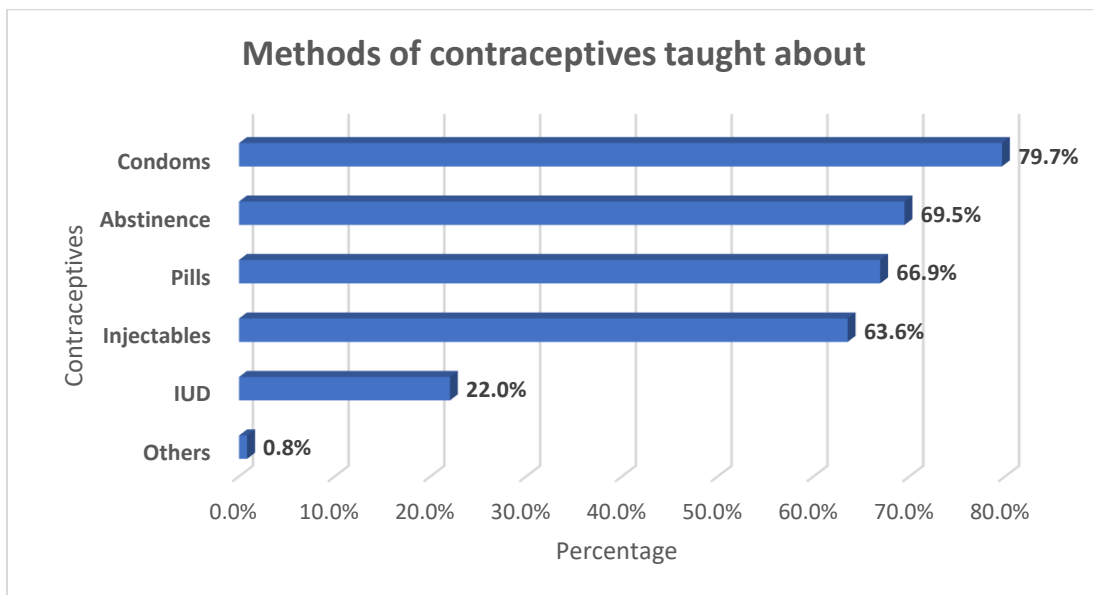
#### ***4.4.1 Level of trust of information sources***

The respondents were asked to rate how much they trusted contraceptive information from various sources. The rating was based on a likert scale of 1-5 where 1 was very low extent while 5 was very high extent.

***Table 4. 2 Level of trust of information sources***

| <b>Indicators</b> | <b>Very low extent</b> | <b>Low extent</b> | <b>Moderate extent</b> | <b>High extent</b> | <b>Very high extent</b> | <b>Mean</b> | <b>Std. Deviation</b> |
|-------------------|------------------------|-------------------|------------------------|--------------------|-------------------------|-------------|-----------------------|
| Medical personnel | 2.5                    | 0.0               | 10.2                   | 11.0               | 76.3                    | 4.58        | 0.870                 |
| Parents/ Guardian | 7.6                    | 5.9               | 5.1                    | 11.9               | 69.5                    | 4.30        | 1.263                 |
| TV/Radio          | 16.9                   | 10.2              | 34.7                   | 15.3               | 22.9                    | 3.17        | 1.354                 |
| Social Media      | 20.3                   | 12.7              | 34.7                   | 18.6               | 13.6                    | 2.92        | 1.295                 |
| Peers             | 49.2                   | 9.3               | 24.6                   | 8.5                | 8.5                     | 2.18        | 1.350                 |

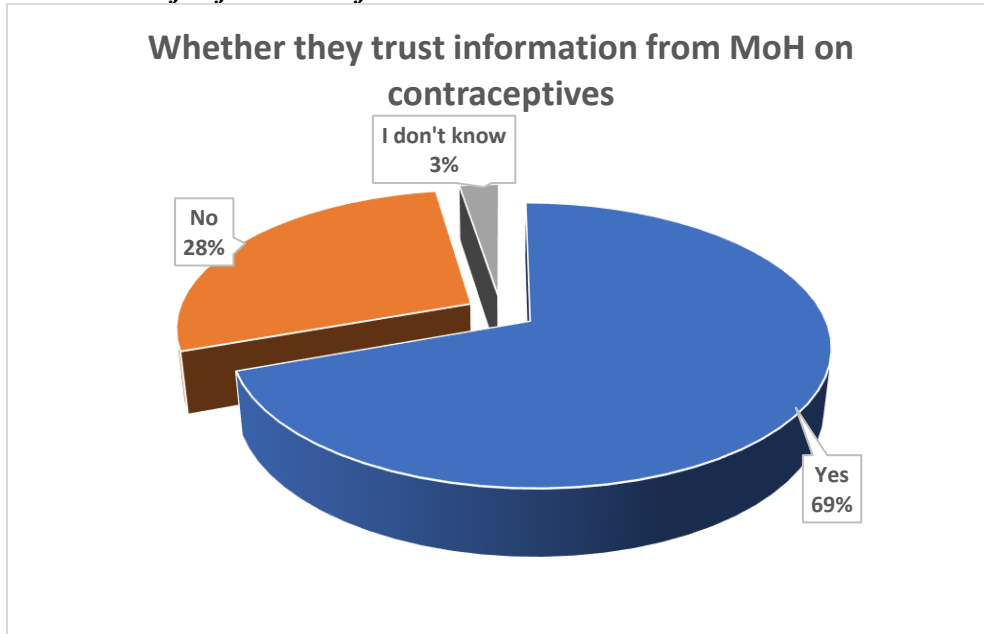
The results in the table above showed that the level of trust in information provided by medical personnel was higher compared to other sources of contraceptive information. This was evidenced by the high mean score of 4.58 with standard deviation of 0.870. this was closely followed by information from Parents/guardians where 69.5% trusted it to a very high extent. In TV/Radio, respondent level was found to of moderate extent with majority of 34.7% indicating so, on overall the level of trust for TV/Radio had a mean of 3.17 with standard deviation of 1.354. Social media was moderately trusted with majority of 34.7 agreeing to this count. This shows that young girls tend to trust information given by either the medical practitioners or the parents. It therefore implies that increasingly parents play a major role in their children’s sexual behavior thus they ought to be well equipped with the correct information regarding contraceptives that they can pass across to the children. The finding concurs with those of PSI Kenya who developed a qualitative study to better understand barriers to contraceptive uptake among young women in April 2012.



***Figure 4.5: Methods of contraceptive respondents were taught about***

Results showed the respondent were majorly taught on the use of condoms with 79.7%, while abstinence had 69.5%, use of pills was third with 66.9%, injectable came fourth with 63.6, while IUD and Others scored 22.0% and 0.8%, respectively. The results showed uses of condom, assistance and injectables are the major methods of contraception taught to young adult girls. This basically shows that most respondents are aware of contraceptives and knowledge of modern contraceptive methods was high. It was also evident that majority of respondents knew at least one method of contraception. This is in line with findings from the Kenya DHS (2009) that demonstrated knowledge of contraceptives is almost universal. Further, the results support that of Kenya Demographic Health Survey 2014 which indicated that at least 99.3 percent and 100 percent of currently married men and women at the age of 15-49 have at least heard of a modern contraceptive method and at least 45.2% of women aged 15-49 currently use one method of contraception.

#### 4.4.2 Trust of information from Government's MoH



**Figure 4.6: Whether they trust information from MoH on contraceptives**

Most of the respondents trusted the information from MoH which was represented by 69%, while those disagreed had accounted for 28% and those who didn't know shared the rest percentage as illustrated in Figure above.

#### 4.4.3 Best source of contraceptive information

**Table 4. 3 Best source of contraceptive information**

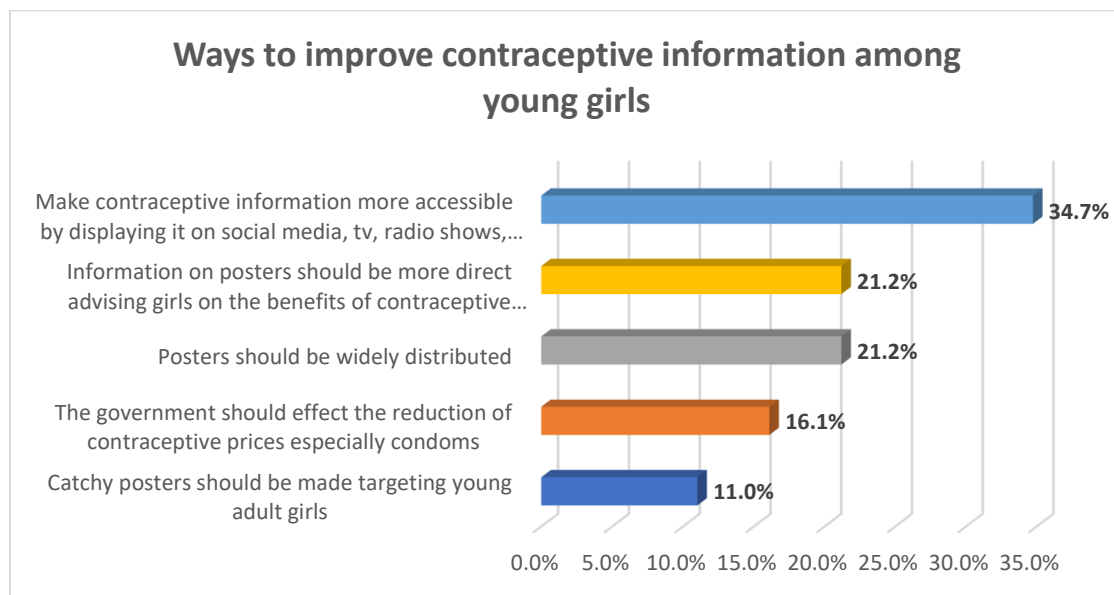
|                   | Frequency  | Percent      |
|-------------------|------------|--------------|
| Medics            | 65         | 55.1         |
| Social Media      | 21         | 17.8         |
| Family members    | 21         | 17.8         |
| Posters           | 4          | 3.4          |
| TV/Radio          | 3          | 2.5          |
| Peers             | 3          | 2.5          |
| None of the above | 1          | 0.8          |
| <b>Total</b>      | <b>118</b> | <b>100.0</b> |

In the question concerning the best source of contraceptive information, results in the table above indicated the medics are the best source of information with majority of

respondents of 55.1 agreeing to the count. Social media and family members followed with 17.8% each, while other information sources shared the rest proportion of agreement.

#### ***4.4.4 Ways to improve contraceptive information among young girls***

The respondents were asked to suggest ways in which contraceptive information would be improved to enhance its access.



***Figure 4.7: Ways to improve contraceptive information among young girls***

The figure above shows the main ways to improve contraceptive information among young girls and the result indicate, making the contraceptive information more accessible by displaying it on the mainstream media as well as the social media (34.7%), ensuring that information on is widely distributed (21.2%), the government should effect the reduction of contraceptive prices especially condoms, and catchy posters should be made targeting young adult girls as reported by 16.1% and 11.0% of the respondents respectively. This means that there is need to use various platforms to provide

information on contraceptives in order to reach as many girls as possible. This is because in modern era of technology, many young people are able to access social media and other information channels. Some of them would not like to get such information in the presence of their parents especially from TV but would be comfortable to access it from social media where they interact with peers.

One Key Informant said:

The Ministry of Health should take centre stage in centralizing contraceptive information to one source and it should be made clear that this is the only credible source of information that young adult girls should trust. That way, all the other myths and misconceptions will slowly fade away and will not be considered or taken into account. This will greatly reduce the implication that comes with lack of or incorrect contraceptive use.

#### **4.5 Factors contributing to uptake of contraceptives among young girls**

The second objective of the study sought to determine are factors that contribute to or hinder the uptake of contraceptives among young girls of between 18 and 21 years. The girls who reported to have used contraceptives were asked how they felt the first time they used them.

***Table 4. 4 Feeling after first time use of contraceptives***

| <b>Indicators</b>           | <b>Frequency</b> | <b>Percent</b> |
|-----------------------------|------------------|----------------|
| I feared that it might fail | 20               | 45.5           |
| Worried                     | 16               | 36.4           |
| Confident                   | 8                | 18.2           |
| <b>Total</b>                | <b>44</b>        | <b>100.0</b>   |

Based on the results in Table 4.4, most respondents (45.5%) feared that the contraceptive might fail, another 36.4% were worried, while only 18.2% were confident.

#### ***4.5.1 Source of information on contraceptives***

The source of information on contraceptives may either promote or hinder the uptake. It is in this view that the respondents were asked about their main sources of information concerning contraceptives.

***Table 4. 5 Main sources of information on contraceptives***

| <b>Sources</b>                 | <b>Frequency</b> | <b>Percent</b> |
|--------------------------------|------------------|----------------|
| Parent/Guardian                | 54               | 45.8%          |
| Friends                        | 22               | 18.6%          |
| Church youth group pastor      | 5                | 4.2%           |
| Social media                   | 24               | 20.3%          |
| TV, Radio, Newspapers, Posters | 15               | 12.7%          |
| None of the above              | 2                | 1.7%           |

As evidenced in Table 4.5, majority of the respondents (45.8%) indicated parents or guardians were the main source of information, followed by Social media (20.3%), Friends (18.6%), and TV, Radio, Newspapers, Posters (12.7%). Church youth group pastor represented the smallest proportion of 4.2% while those who didn't get any information from the outlined sources accounted for 1.7%. These findings support that of Oindo (2002) who noted his study, that health providers and other educational sources were rarely mentioned as the source of information on contraception. Instead, peers and other community members acted as the main sources, and their perceptions also heavily influenced the decision to use or not. However, these sources often propagated myths (infertility, birth defects) and exaggerated rare side effects (uncontrollable bleeding, enormous weight gain/loss). The standpoint theory plays a major role in understanding this finding where many young girls especially those living in slum environments, their perspectives have over the years been shaped by what people say, what they hear around them while growing up and what they are exposed to.



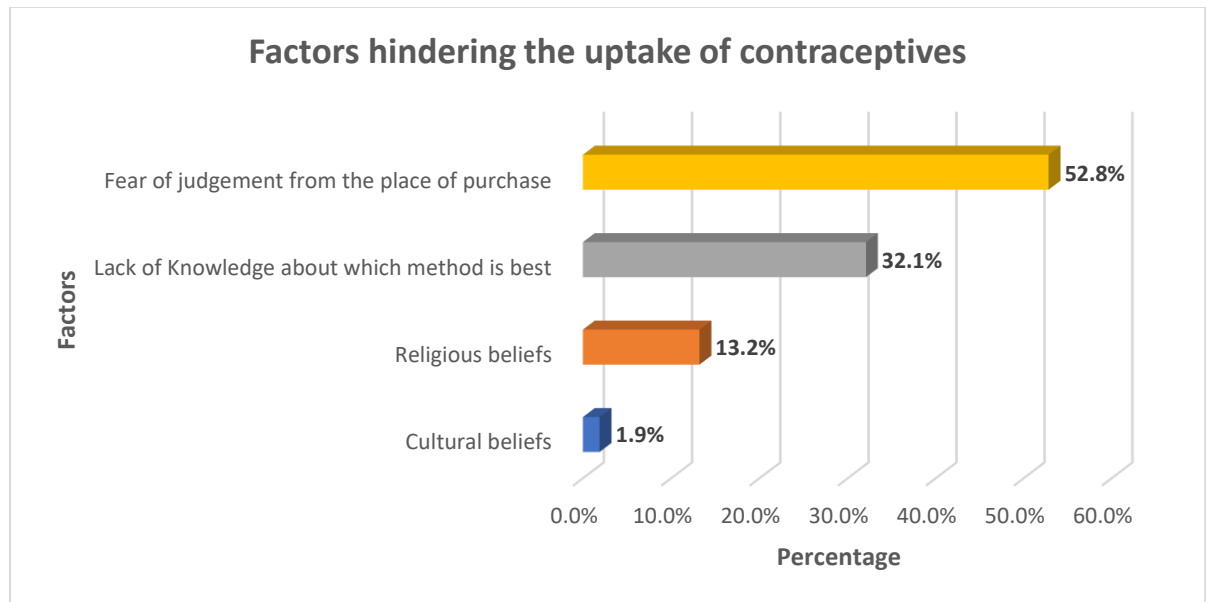
#### 4.5.2 Sources they believe and can take information from

**Table 4. 6 Sources they believe and can take information from**

| Sources                        | Frequency  | Percent      |
|--------------------------------|------------|--------------|
| Parent/Guardian                | 62         | 52.5         |
| Social media                   | 18         | 15.3         |
| Friends                        | 16         | 13.6         |
| TV, Radio, Newspapers, Posters | 12         | 10.2         |
| Church youth group pastor      | 6          | 5.1          |
| None of the above              | 4          | 3.4          |
| <b>Total</b>                   | <b>118</b> | <b>100.0</b> |

When respondents were asked on sources they believe and can take information from, results indicated 52.5% of the respondents agreed with Parent/Guardian, 15.3% believe can take information from social media, while 13.6% believed can take information from friends, TV, Radio, Newspapers, Posters represented a proportion of 10.2%, and 5.1% believed on the information of Church youth group pastor.

#### 4.5.3 Factors hindering the uptake of contraceptives



**Figure 4.8: Factors hindering the uptake of contraceptives**

In the question of the factors hindering the uptake of contraceptives, most of the respondents representing 52.8% feared to be judged on the place of purchase while

32.1% lacked knowledge the best method for them to use. The results indicated 13.2% were hindered by religious beliefs to take contraceptives. For instance, the Roman Catholic Church prohibits the use of contraceptive products since it believes, it is a sin against nature. Some denomination of Protestants has approved contraception. Furthermore, Islamic law says that children are Gifts from Allah, so some Muslims think they have many children, but Allah and the Prophet say that children have the right to education and protection in future. In Kware slum, young adult girls who strongly subscribe to certain religious affiliations believe that contraceptives should not be used at all even in the confines of the marriage set up. One girl believed a man ejaculating outside of a woman's body is murder. These kinds of beliefs when taken into account will result in the young adult girl giving birth to too many children that she cannot take care of just because she believes she is sinning against God.

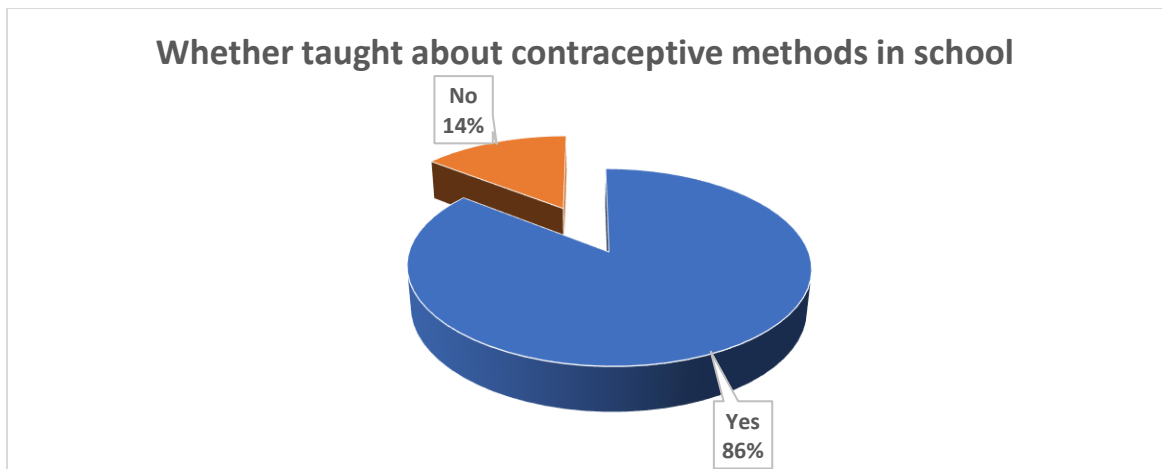
One key informant stated:

Some girls here come from extreme religious backgrounds that have the wrong information as far as contraception is concerned and it is very hard for them to change from that and use contraceptives when they finally become sexually active thus risking their lives and the lives of the innocent unborn children.

Besides, a paltry 1.9% of the respondents reported the influence of cultural beliefs that inhibit the uptake of contraceptive information. This was pointed out during Key Informant Interviews where it was said that;

In Kware, girls who subscribe to particular cultures chose herbal contraceptive methods to prevent pregnancy because they believe that other contraceptives contain harmful chemicals that may prevent them from getting pregnant in the future when they are ready to or may destroy their reproductive health in one way or the other.

The results support those of Ahmad et al. (2015) where authors have shown that understanding or knowledge of contraception can help teenagers decide their use of contraception and prevent contraceptive misconceptions. Similarly, according to Aguilar Rivera & Cortez. (2015), young people have no detailed knowledge of contraception methods such as effectiveness, side effects, source, and correct ways of using them. Only one in three married adolescents who do not use contraceptive medication know how to procure contraception from either a healthcare facility or the sub-health department. In terms of cultural beliefs, the results support those of Wegs *et al.* (2016) who said that in Kenya, reproductive and sexual health problems, including contraception, are seldom openly addressed in communities.



**Figure 4.9: Whether taught about contraceptive methods in school**

The research also sought to determine whether the respondents were taught about contraceptives methods in school and results as shown in the figure above showed that 86% were in agreement while 14% were never taught. Basically, at this age, most of the young girls are expected to have been in school and with the introduction of sex education in learning institutions, especially secondary schools, most of the girls were expected to have been taught about sexuality and contraception.

#### *4.5.4 Perception of information from school and other sources*

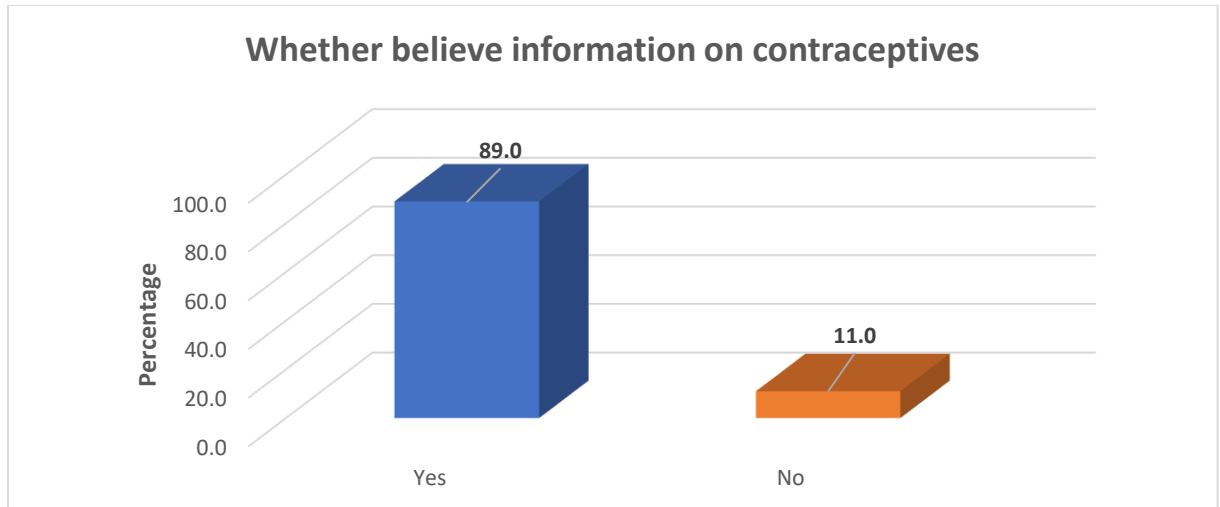
***Table 4. 7 Perception of information from school and other sources***

|  |              | <b>Frequency</b> | <b>Percent</b> |
|--|--------------|------------------|----------------|
| Information from school is accurate          | Yes          | 81               | 80.2           |
|  | No           | 20               | 19.8           |
|  | <b>Total</b> | <b>101</b>       | <b>100.0</b>   |
| Information from other sources is misleading | Yes          | 60               | 59.4           |
|  | No           | 41               | 40.6           |
|  | <b>Total</b> | <b>101</b>       | <b>100.0</b>   |

In the perception of information from school and other sources, results in the table above showed that 80.2% agreed that information from school is accurate while 59.4% agreed that information from other sources is misleading. The high number of respondents confirming that information from school was accurate is cue to the fact that information given in school is based on facts. The notion that information from other sources might be misleading was because there were varied sources of information some of which one cannot authenticate the information given. For instance, information from peers may be based from hearsay or what they have heard other people say about contraceptives, which may necessarily not be true.

#### **4.6 Impact of the contraceptive information on the young girls**

The third objective of the study sought to determine the impact of contraceptive information on the young girls between 18 and 21 years.



**Figure 4.10: Whether believe information on contraceptives**

On the question of whether the respondents believed on the information on contraceptive, majority 89.0% indicated they believed while only 11.0% were in disagreement.

#### **4.6.1 Reasons for believing the information**

**Table 4. 8 Reasons for believing the information**

| <b>Reasons</b>                       | <b>Frequency</b> | <b>Percent</b> |
|--------------------------------------|------------------|----------------|
| They work well for others and myself | 38               | 41.3           |
| It is from a credible source         | 29               | 31.5           |
| I have proven it's true/ correct     | 18               | 19.6           |
| Research                             | 4                | 4.3            |
| Made me understand the effects       | 3                | 3.3            |

The study's results showed that the main reason for believing the information concerning contraceptives was because they work well for others and themselves which represented 41.3%, while reason of a credible source represented 19.6%. This was then followed by research and the notion that the information made the respondents

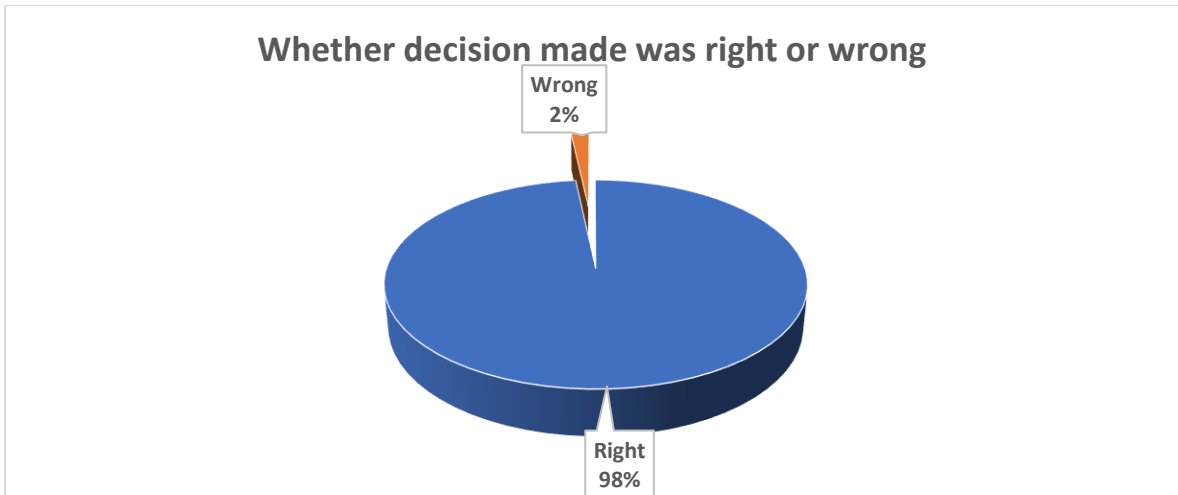
understand the effects of contraceptives as reported by 4.3% and 3.3 %, respectively. This implies that many girls believe information after they get evidence on their (contraceptives) performance. Some go to an extent of trying out the methods and proving that indeed the information given is true. Therefore, it was not easy just to receive information and believe it until one has evidence that the method works either for them or their friends. This gives credence to the standpoint theory where it is perceived that for many young girls especially those living in slum environments, their perspectives have over the years been shaped by what people say, what they hear around them while growing up and what they are exposed to.

#### ***4.6.2 Decision made after receiving information***

*Table 4. 9 Decision made after receiving information*

| <b>Decisions made</b>                                     | <b>Frequency</b> | <b>Percent</b> |
|---|------------------|----------------|
| Made the right decision                                   | 38               | 38.4           |
| Made me choose my contraceptive type                      | 30               | 30.3           |
| Made me stay away from sex/ Gave me confidence to abstain | 21               | 21.2           |
| Negative/ made wrong decision                             | 5                | 5.1            |
| Staying confident   | 4                | 4.0            |
| Realized it does not have side effects                    | 1                | 1.0            |

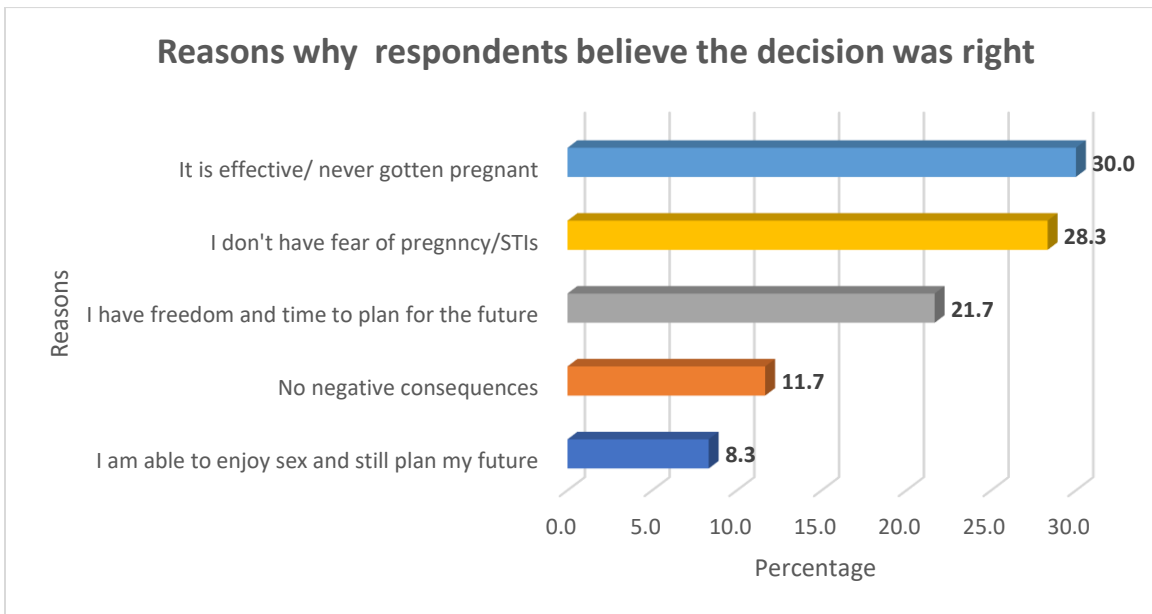
On the decision made after receiving information, results showed most of the respondents representing 38.4%, made the right decision concerning uptake of contraceptive, while 30.3% of respondents made them choose their contraceptive type, 21.2% indicated that information made them stay away from sex and gave them confidence to abstain. Moreover, as a result of the information, 5.1% of the respondents were able to stay confident, 1% realized that the contraceptives do not have side effects while the information led to some respondents making wrong decisions (4.0%).



**Figure 4.11: Whether decision made was right or wrong**

The results showed that the respondents made the right decision with 98% agreeing on this count while the rest made the wrong decision.

**4.6.3 Reasons the decision was right**



**Figure 4.12: Reasons why respondents believe the decision was right**

On the testing why the reasons were right, results showed that the main reason was that it is an effective method because the girls have never gotten pregnant with a

proportion of 30.0%, while the fear of pregnancy/STI's was represented with 28.3%. 21.7% of the respondents indicated that they have freedom and time to plan for the future, while no negative consequences and able to enjoy sex and still plan for future represented 11.7% and 8.3%, respectively. This shows that information on contraceptives came as a big reprieve to majority of young girls as it gave them freedom to engage in sexuality and still plan for their future without worrying about unintended pregnancies.

#### **4.7 Information gaps on access and use of contraceptives among young girls**

The fourth objective of the study sought to determine the information gaps on access and use of contraceptives among young girls of between 18 and 21 years. The objectives were splinted into five sub-objectives which included; myths about contraceptives, best contraceptive method for 18-21-year-old adult, what people say about contraceptive methods, whether there is something important about contraceptives that you don't know, and gaps in contraceptives information.

##### **4.7.1 Myths about contraceptives**

In this regard, the study sought to know what information is available to the young girls about use of contraceptives. In most cases, there are different things that people say about contraceptives, some which is not true. The respondents were therefore asked to highlight the information they hear from different people about contraceptives that they think it is not true. Results were as presented in Table 4.10.

**Table 4. 10 Myths about contraceptives**

| <b>Myths</b> | <b>Frequency</b> | <b>Percent</b> |
|--------------|------------------|----------------|
|--------------|------------------|----------------|



|  |    |      |
|--|----|------|
| Leads to loss of fertility/ barrenness/ can't conceive in future                   | 24 | 22.4 |
| Contraceptives are not effective/ can fail   | 23 | 21.5 |
| All contraceptives work  | 11 | 10.3 |
| Contraceptives are a sin   | 8  | 7.5  |
| Leads to weight loss/gain  | 8  | 7.5  |
| Have negative effects on health/ destroy your hormones                             | 7  | 6.5  |
| Sex before marriage is ok/ young girls can have sex and be safe avoiding pregnancy | 7  | 6.5  |
| Contraceptives have no side effects  | 6  | 5.6  |
| Make one have low sex drive  | 2  | 1.9  |
| Condoms burst or are fake  | 2  | 1.9  |
| Condoms don't allow people to enjoy sex  | 2  | 1.9  |
| Contraceptives are not for unmarried people  | 2  | 1.9  |
| Causes cancer  | 1  | 0.9  |
| Make one old   | 1  | 0.9  |
| Easy to be used  | 1  | 0.9  |
| Contraceptives are cheap   | 1  | 0.9  |
| Leads to bad morals  | 1  | 0.9  |

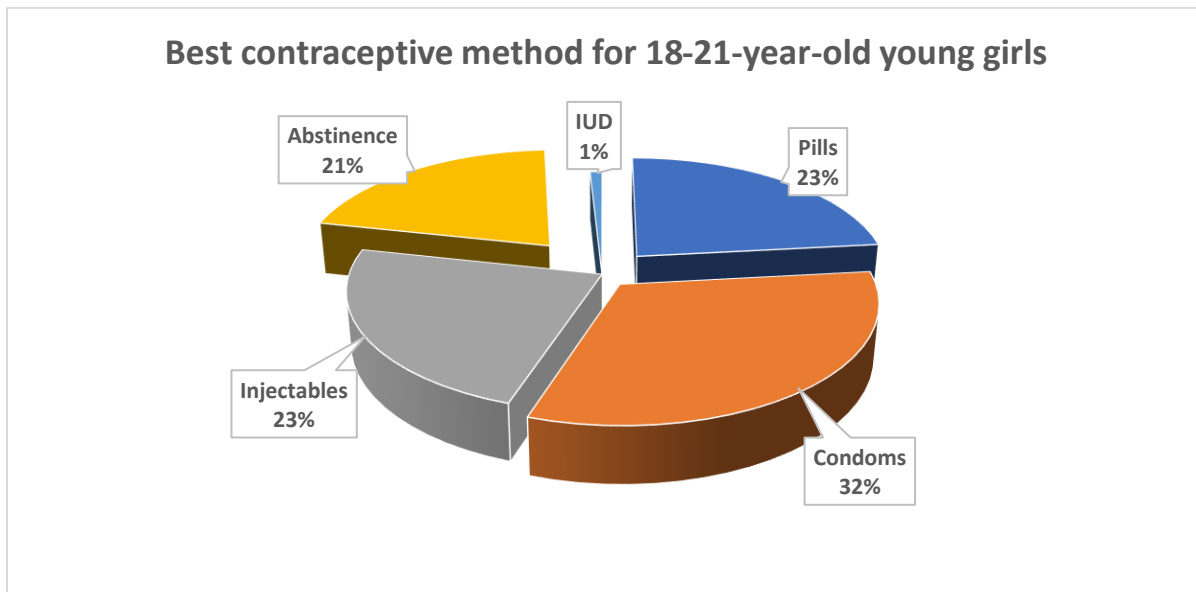
The study to determine the myths about contraceptives and the results that the most prevalent myths about contraceptives was that they lead to loss of fertility/ barrenness/can't conceive in future as reported by 22.4%, while contraceptives are not effective/ can fail represented a value of 21.5%, followed by the notion that all contraceptives work (10.3%), while contraceptives are a sin and leads to weight gain had a proportion of 7.5% each. The myths that contraceptives cause cancer, make one old, easy to be used, are cheap, leads to bad morals had the minimum proportion of 0.9% each. Therefore, it was believed that it was possible that modern contraception methods could cause temporary infertility or reduce one's childbearing capacity, limiting the number of children they were able to conceive in their lifetime.

Other side effects of contraceptives were weight gain, lack of sexual desire, headaches and blood pressure. These results are supported by the Kenya DHS that found, overall, 36% of women report discontinuation within the first 12 months of using a method due to side effects; and 16% of married women not currently using were not

doing so due to fear of side effects (KDHS, 2009). Further, PSI (2012) observed that a large number of respondents in their study, especially those from Kisumu reported having heard or believed that the use of certain contraceptive methods, especially pills, led to cancer.

However, some of this information was said to be false during the key informant interviews. The notion that contraceptives lead to loss of fertility/ barrenness/ can't conceive in future was refuted by the medical personnel interviewed during the study. It was indicated that contraceptives, especially the hormonal, may lead to delayed conception but not barrenness. This perception is usually as a result of continued search for children without factoring the aspect of the amount of sperm required to fertilize the ovum.

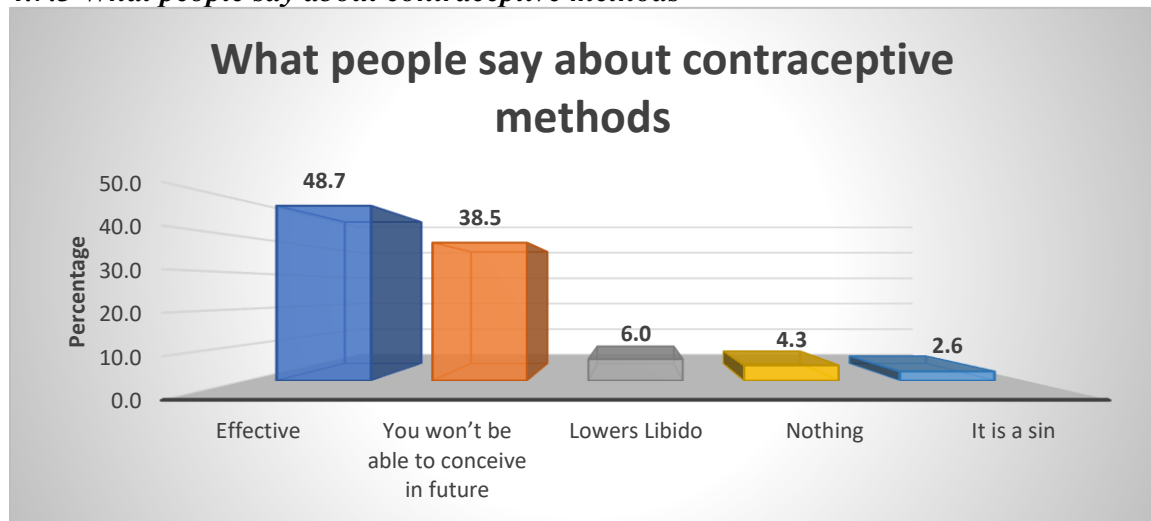
#### ***4.7.2 Best contraceptive method for 18-21-year-old adult***



***Figure 4.13: Best contraceptive method for 18-21-year-old young girls***

On the best contraceptive method for 18-21-year-old adult, results in the figure above showed that use of condom was the best method of contraceptive with 32%, followed by injectable and use of pills with 23% each, abstinence was represented by 21%, and finally IUD was represented by 1%. Generally, knowledge of use and potential side effects varied between respondents, and between methods. For instance, although the majority of respondents correctly understand that condoms offered dual protection, some felt that condoms were not reliable for pregnancy prevention.

#### 4.7.3 What people say about contraceptive methods

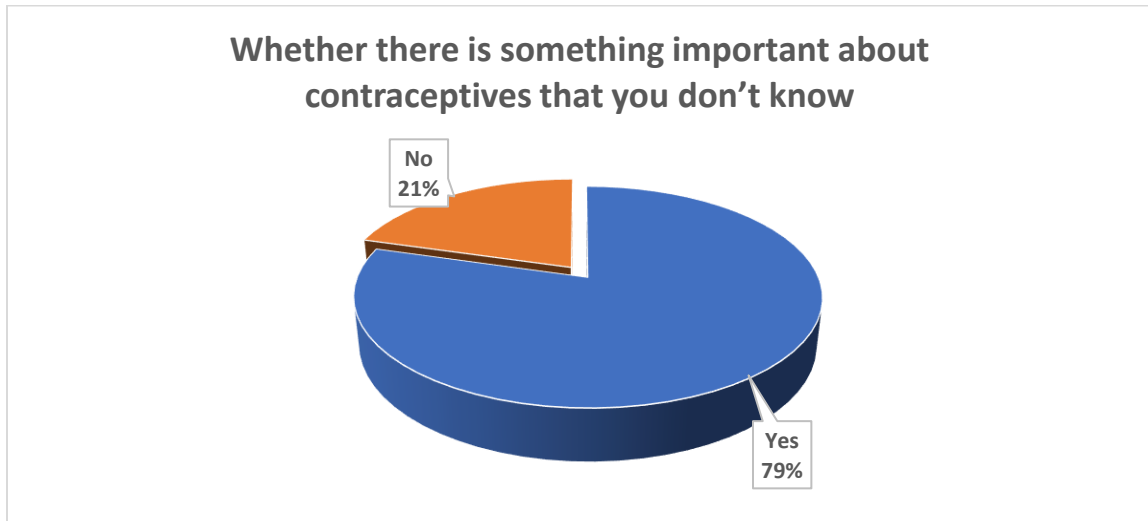


**Figure 4.14: What people say about contraceptive methods**

Results showed that majority of majority of respondents indicated that many people said contraceptive methods are effective with a proportion of 48.7%, followed by

a person can't be able to conceive in future with a proportion of 38.5%, while lowers libido, nothing and it is a sin showed a value of 6.0%, 4.3%, and 2.6%, respectively.

#### ***4.7.4 Whether there is something important about contraceptives that you don't know***

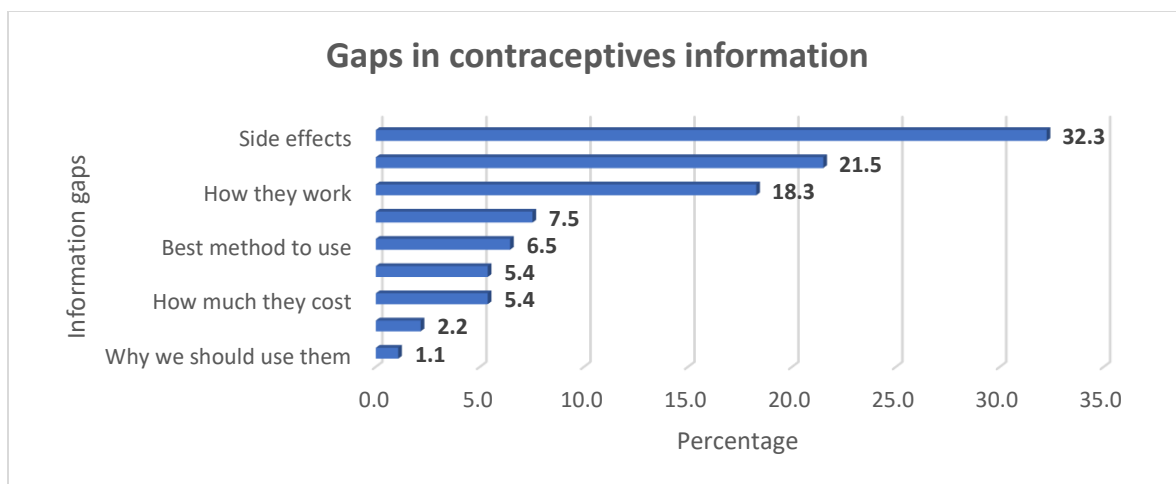


***Figure 4.15: Whether there is something important about contraceptives that you don't know***

As shown in the figure above, results showed that the respondent had something important about contraceptives that you don't know which was represented by a proportion of 79%, while the rest did know everything about contraceptives.

#### ***4.7.5 Gaps in contraceptives information***

Another intention of this study was to establish the information gaps regarding contraceptives. In this case, the respondents were asked to highlight what kind information regarding contraceptives they require. Results were as presented in Figure 4.16.



**Figure 4.16: Gaps in contraceptives information**

The study also sought to determine the gaps in contraceptive information and results as shown on the table above, majority indicated there was a gap on the side effects represented by proportion of 32.3%, details about all methods of contraceptives with 21.5%, while the gap of how they work with 18.3%, while in appropriate way to use, best method to use, how to get them, how much they cost, when to use, and why they should use them was represented by 7.5%, 6.5%, 5.4%, 5.4%, 2.2%, and 1.1%, respectively. This finding concurs with that of Wegs *et al.* (2016) who noted that the women who use contraception still have limited knowledge of the effectiveness of the procedure.

Further, the respondents were asked who they thought had enough information about correct contraceptive use. This was to determine the sources that respondents thought had authentic and trustworthy information on contraceptives. The findings were as presented in Table 4.11.

**Table 4.1: Source of enough information about correct contraceptive use**

| Sources                        | Frequency | Percent |
|--------------------------------|-----------|---------|
| Medics                         | 79        | 66.9    |
| Parent/Guardian                | 18        | 15.3    |
| Social media                   | 13        | 11.0    |
| TV, Radio, Newspapers, Posters | 3         | 2.5     |

|              |            |              |
|--------------|------------|--------------|
| Don't know   | 5          | 4.2          |
| <b>Total</b> | <b>118</b> | <b>100.0</b> |

Based on the results in Table 4.11, most of the respondents perceived that medical personnel had enough information about correct contraceptive use (66.9%), followed by parents/guardians (15.3%), and social media (11.0 %) while TV/Radio/Newspapers/Posters represented a proportion of 2.5%. Only few respondents didn't know who got enough information about correct contraceptive use.

#### **4.8 Discussion of Findings**

This section presents the study findings and compares them with other studies. The section is organized in terms of the study objectives.

##### ***4.8.1 Sources of Information on Contraceptives***

The first objective of this study sought to establish the various sources of information about contraceptives that were available to the young girls of between 18 to 21 years in Kware. Results showed that a large number of young girls got information concerning use of contraceptives from their parents with 33.9% agreeing to the count. The results concur with those of PSI Kenya who developed a qualitative study to better understand barriers to contraceptive uptake among young women in April 2012. The study was conducted in Nyanza, Coast, and Central regions.

Urban regions of these areas were purposively selected based on having contraceptive prevalence rate close to the regional average and having a population with low socio-economic profiles. This particular study also revealed the role that others play in determining contraceptive uptake among young teenage girls. Most respondents often used third person pronouns ('he', 'she', 'they', 'others') showing that young women learn about both true side effects and myths from friends, family or partners who most often

than not shared misconceptions and myths about family planning methods thus translating to non-use.

In addition, the study found out that besides trusting information from medical personnel, a large proportion of young girls trust information given by their parents/guardians. This was evidenced where 69.5% of the girls trusted information from parents to a very high extent. In this way, if parents are more open about sex, contraceptives, and pregnancy with their children, particularly early on, then the teens would be more likely to postpone their sex debut by using contraceptives and have safer sex. The finding supports Subedi, Jahan and Baatsen (2018), who observed that good contact between mother/daughter is associated with an increase in effective contraceptive reliable means and also a reduction in option abortion.

#### ***4.8.2. Factors contributing to low uptake of contraceptives***

The second objective of the study sought to determine the factors that contribute to or hinder the uptake of contraceptives among young girls of between 18 and 21 years. The finding of the current study showed most of the respondent representing 52.8 feared to be judged in the place of purchase while 32.1% lacked knowledge of which is the method. The results indicated 13.2% were hindered to take contraceptives by religious beliefs, while only 1.9% were controlled by cultural beliefs. The results support those of Ahmad et al. (2015) where authors have shown that understanding or knowledge of contraception can help teenagers decide their use of contraception and prevent contraceptive misconceptions.

Similarly, according to Aguilar Rivera & Cortez. (2015), young people have no detailed knowledge of contraception methods such as effectiveness, side effects, source,

and correct ways of using them. Only one in three married adolescents who do not use contraceptive medication know how to procure contraception from either a healthcare facility or the sub-health department. Surprisingly, the women who use contraception still have limited knowledge of the effectiveness of the procedure. In terms of cultural beliefs, the results support those of Wegs *et al.* (2016) who said that in Kenya, reproductive and sexual health problems, including contraception, are seldom openly addressed in communities. Furthermore, according to Godia *et al.* (2014), the results showed that in Kenya Parents feel that young people are too young to be able to learn about sexual problems and therefore view sex education as an opportunity for their children.

#### ***4.8.3 Impact of the contraceptive information on the young girls***

The third objective was designed to explore the impact of the contraceptive information that the young girls in Kware access. This objective was synthesized in five different form which include the believe about contraception, Reasons for believing the information, Decision made after receiving information, whether was right or wrong, and Reasons the decision was right. Results showed that majority (89.0%) of the respondents believed the information on contraceptive. Furthermore, the study's results showed that the main reason for believing the information concerning contraceptives was because they work well for others and myself which represented 41.3%.

In addition, On the decision made after receiving information, results showed most of the respondents representing 38.4%, made the right decision concerning uptake of contraceptive as they considered the information helpful in deciding on how to protect themselves. Furthermore, On the testing why the reasons for taking contraceptives were rights, results showed that the main reason was that it is an effective method was never



gotten pregnant with a proportion of 30.0%. The results support that of Kenya Demographic Health Survey 2014 which indicated that at least 99.3 percent and 100 percent of currently married men and women at the age of 15-49 have at least heard of a modern contraceptive method and at least 45.2 percent of women aged 15-49 currently use one method of contraception. Others reported that the use of modern contraceptives led to low libido levels among other untrue observations.

#### ***4.8.4. Information gaps on access and use of contraceptives among young girls***

The fourth objective of the study sought to determine the information gaps on access and use of contraceptives among young girls of between 18 and 21 years. Information gaps are the unknown facts about the methods, manufacturer, side effects and usage of contraceptives. Results showed that side effects there was a major gap which was represented by proportion of 32.3%, followed by the details about all methods of contraceptives (21.5%), information on how the various contraceptive methods work (18.3%), the information on appropriate way to use the contraceptives, best contraceptive method to use, how to get the contraceptives, how much they cost, when to use, and why girls should use the contraceptives.

PSI Kenya produced a qualitative study in April 2012 to give a better understanding of the obstacles to young women's contraceptives usage. The study was carried out in Nyanza, coastal and central regions, where the results of this research showed the myths and misconceptions constitute the key obstacles to contraceptives among young women. In addition, several respondents, in particular those from Kisumu, indicated that the respondents have learned or believed that using certain contraceptive methods, in particular pills, caused cancer.

## **CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Overview**

This chapter looks into the summary of the study, conclusions based on the findings and recommendations.

### **5.2 Summary**

The broad objective of this study was to investigate the uptake of contraceptive information among young adult girls in Kware Slums, Ongata Rongai. The study also sought to investigate the sources of information on sexuality among young girls in Kware, establish the factors contributing to uptake of contraceptives among young girls in Kware slums, explore the impact of the contraceptive information that the young girls in Kware access, to investigate whether there any information gaps on access and use of contraceptives among young adult girls in Kware, Kajiado County. Despite providing the Kenyan government with information to promote the use of contraceptive use as a step towards increasing the CPR and reduce unfulfilled family planning concerns over the years, the study was inspired by the fact that the use of information was lacking. This study aims to investigate the disconnect between the information that is available on contraceptives and the increase in figures of unwanted or mistimed pregnancies showing that the information available does not match the initiative.

The research used an explanatory research design. A qualitative research approach and a quantitative research strategy were also used as they yield logical and unbiased results. Purposive sampling was used to collect data using questionnaires from 118 respondents. In addition, other key Informants were selected for interview were represented as follows: a nurse who administers the contraceptives, a pharmacist who

sells the contraceptives, a CHV who works with local NGO's to provide these contraceptives, an NGO/CBO staff who are aware of the prevailing problem in the slum in respect to contraceptive information uptake among young girls and parents or guardians to the young girls who are in close contact with them and would confide in them about their sex life.

Findings revealed that many of young girls got information concerning use of contraceptives from their parents. The results also showed that young girls, although in small quantity, access information from social media, TV/Radio, and medical personnel. Results also showed that many young girls have a higher trust to their parent/guardians and friends in the decision of up taking contraceptives. Furthermore, results showed that there were various methods of contraceptives that are considered by young girls these include use of condoms, abstinence, use of pills, injectable, and IUD. Most young girls consider use of condom as effective method of contraceptive.

In the case of factors that lead to or hinder the uptake of contraceptives, results showed most of the respondent feared to be judged in the place of purchase, lacked knowledge of which is the best method. While other methods that hindered to take contraceptives were religious beliefs and cultural beliefs. Furthermore, on Impact of the contraceptive information on the young girls, results show that the main impact is that it has enabled them to make the right decision. These decisions included choice of the right their contraceptive type, staying away from sex/ gave them confidence to abstain, staying confident and realization that contraceptives do not have side effects. However, the information made some of the girls make wrong decisions.

Finally, on finding out the information gaps on access and use of contraceptives among young girls, results showed there are many gaps that needs to be looked upon so that the young can have credible knowledge on the subject. Some of the gaps from the study findings include; side effects, details about all methods of contraceptives, how they work, appropriate way to use, best method to use, how to get them, how much they cost, when to use, and why they should use them. These gaps are prone to reduce the uptake of contraceptives by the young girl in Kware.

### **5.3 Conclusion**

This section covers the conclusions of this study based on research findings. The conclusions are divided into two categories, namely: theoretical and empirical conclusions.

#### ***5.3.1 Theoretical Conclusion***

This study was guided by two theories; Standpoint Theory and the Theory of Planned Behavior.

In the standpoint theory, knowledge is seen to stem from a social position; a mental position from which life is viewed. Experiences of life and social groups shape people's view of life or their perspectives and ultimately their belief system which guides their decision-making process. Thus, for many young girls especially those living in slum environments, their perspectives have over the years been shaped by what people say, what they hear around them while growing up and what they are exposed to. The theory

is useful in this study since young girls especially in slum environments in Africa are not considered to be among the target group for family planning services and thus because they are considered the 'other', problems associated with them not being included in interventions will continue to escalate every day.

The theory also utters that young girls are presumed to be school going and not engaging in under-age sex despite this being far from the truth and their standpoint is important thus the argument should be factored in and considered. Therefore, the standpoint theory concludes that girls perceive different knowledge concerning contraceptives usage from friends, family, and community. There were also many factors that hinder them from considering contraceptives such as poor understanding of how contraceptives methods work and how they should be used.

On the other hand, theory of planned behavior was developed from the theory of reasoned action which states that if people evaluate the suggested behavior as positive (attitude), and if they think their significant others want them to perform the behavior (subjective norm), this results in a higher intention (motivations) and they are more likely to do so. It is built around several constructs such as attitude, subjective norm (social network, perceived behavioral control). These are the best social predictors of behavior and in turn influences people to act the way they do. Therefore, the theory concludes that if a young adult girl in Kware thinks that using contraceptives is a good idea and thinks that her social network comprising of her friends think that it's a good idea and believes that she can handle using them, then she will definitely use them. If one of these constructs is unfavorable then the girl is most unlikely to use the contraceptives.

### ***5.3.2 Empirical conclusion***

The findings of this study revealed that indeed there was a relatively high uptake of contraceptive information among young girls in Kware Slums, Ongata Rongai. The first objective was to Investigate the sources of information on sexuality among young girls in Kware. Sources of information are media through the young girls received and learn on the uptake of contraceptives. The study categorized this objective according to the Sources of information on sexuality among young girls, level of trust of information sources, methods of contraceptives taught, as well as ways to improve contraceptive information among young girls. Based on the results on this objective, the study concluded that the major source of information concerning the uptake of contraceptives was from parents/guardian as the girls could show high trust in them. The study also concluded that use of condoms is the main method young girls adopt as an alternative method. Furthermore, the study concluded that making the contraceptive information more accessible was the main way to improve contraceptive information among young girls.

The second objective of the study sought to determine the factors that contribute to or hinder the uptake of contraceptives among young girls of between 18 and 21 years in Kware slums. In this objective, the study concluded that fear to be judged in the place of purchase, lacked knowledge of which is the best method, religious beliefs, and cultural beliefs are the major factors that lead to or hinder the uptake of contraceptives.

The third objective of the study sought to determine the impacts of contraceptive information on the young girls between 18 and 21 years in Kware slums. The results of this objective derived the conclusion that information concerning the uptake of

contraception have resulted to many people making the right on the methods and types of contraceptive to use, staying away from sex/ giving them confidence to abstain, and understanding whether contraceptives have side effects.

The fourth objective of the study sought to determine the information gaps on access and use of contraceptives among young girls of between 18 and 21 years in Kware slums. The study made conclusion that many young girls face many gaps in regards to the side effects of contraceptive details about all methods of contraceptives, how they work, appropriate way to use them, best method to use them, how to get them, how much they cost, when to use them, and why they should use them.

#### **5.4 Limitations of Current Study**

Various shortcomings in good research are possible. These limitations include factors which can restrict the precision of the results of the study. In the current research, sampling is a deep limitation because the collection of a sample cannot reach the whole population, and hypotheses for the whole population can change. The study also includes 118 interviewees who cannot justify the investigation of the uptake of contraceptive information among young girls in Kware Slums, Ongata Rongai, as a significant number of the population cannot be included in the survey. A small sample may also avoid the research results being generalized.

#### **5.5 Recommendations**

In order to address the uptake of contraceptive information among young girls in Kware Slums, Ongata Rongai, this study makes the following recommendations in respective areas:

- i. Contraceptive information should be streamlined to specific credible sources and posters and other IEC materials should be printed and displayed in public places in the slum like schools, hospitals, outside pharmacy walls, youth centres and church youth group spaces highlighting that the girls should only believe contraceptive information from these particular sources. Contraceptive information sources should be documented.
- ii. IEC materials about contraceptives for young adults should be catchy and very easily accessible to them.
- iii. The County government should focus more on this issue and conduct serious civic education in the slum about contraceptives, their use and consequences of non-use. It should also highlight the importance of abstinence and the severity of HIV and AIDS and other STD's. The researcher observed that the girls only feared pregnancy as a negative consequence and were not conscious about STD's.
- iv. The study also recommends that medics should be empowered to deliberately provide contraceptive information as majority of the girls interviewed said that they would trust information provided to them by medics. A strong observation is that the medics should be commissioned to go into the slum to provide the information as opposed to the girls seeking them for information when it's too late. This is to say that their authority as trusted sources of information should be optimized by the government to give civic education on this subject.

## **5.6 Suggestions for Future Research**

The current study focuses on the uptake of contraceptive information among young girls in Kware Slums, Ongata Rongai. Hence researchers can conduct the same



study in other major slums in Kenya, e.g. Kibera, Mukuru kwa Njenga and compare their results with current results and see if the finding concur or differ. The research was carried out during hard times of COVID-19 where many people are living in difficult circumstances. The same study can be conducted in Kajiado County after the pandemic has been controlled and compare. Researchers can adapt this methodology and increase the sample size and cover a wider area and compare results.

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## APPENDICES

### Appendix I: Introduction Letter

School of Journalism and Mass Communication,

University of Nairobi.

Dear Respondent,

**Re: Research Study**

I am a student of the University of Nairobi, pursuing a Master of Arts Degree in Communication Studies. I am currently in the process of undertaking a study on the Assessment of Contraceptive Information Uptake among young girls in Kware Slums aged between 18-21 years in, Kajiado North Sub-County.

Please find attached a questionnaire and an interview guide to facilitate data collection for this study. Note that the information you provide will only be used for academic purposes while maintaining strict confidentiality.

Your co-operation towards the achievement of this endeavor will be highly appreciated.

Thank you,

Carol Njeri Meja.



## Appendix II: Research Questionnaire

Please fill in the blanks or tick (✓) where appropriate to provide the information requested.

### Section 1: Personal Information

- a) Name (Optional).....
- b) Age.....
- c) What is your level of education?

Primary School Level [ ] Secondary School level [ ] Dropout [ ]

#### d) Sexually active?

YES [ ] NO [ ]

If you answered yes above. Please answer the following:

e) Contraceptive method used .....

f) Year of First Sexual Encounter.....

g) Year of First Contraceptive use.....

### Section 2: Sources of Information

1. How did you first learn about contraceptives?

- a) Parent/Guardian
- b) TV, Radio or Newspaper
- c) Social Media
- d) Medical personnel

2. To what extent do you trust the following sources of information on sexuality? Where 1= very low extent, 2= Low extent, 3= Moderate extent, 4= High extent and 5= very high extent (**Tick the appropriate box**)

|                      | 1 | 2 | 3 | 4 | 5 |
|----------------------|---|---|---|---|---|
| a) Social Media      |   |   |   |   |   |
| b) TV/Radio          |   |   |   |   |   |
| c) Peers             |   |   |   |   |   |
| d) Medical personnel |   |   |   |   |   |
| d) Parents/ Guardian |   |   |   |   |   |

2. What other methods of contraception have you been taught about?

Pills [ ] Condoms [ ] Injectables [ ] Abstinence [ ] IUD [ ] None [ ] Others [ ]

3. Would you trust information from the Government's Ministry of Health about contraceptives?

Yes [ ] No [ ] I don't know [ ]

4. In your opinion which is the best source of contraceptive information for you that you would use?

- a) Social Media
- b) TV/Radio
- c)Peers
- d)Posters
- e) Family members
- d)Medics
- d)None of the above

5. How do you think contraceptive information can be improved for young adult girls in Kware Slum?

- a) Catchy posters should be made targeting young adult girls
- b) Posters should be widely distributed
- c) The government should effect the reduction of contraceptive prices especially condoms
- d) The government and other partners should make contraceptive information more accessible by displaying it on social media, tv, radio shows, more campaigns.
- e) Information on posters should be more direct advising girls on the benefits of condoms as the best contraceptive method for our age group

6. What information were you given about contraceptives?

**Section 3: Factors that contribute to contraceptive information uptake**

1. What was your feeling concerning the contraceptive method you first used?

Confident [ ] Worried[ ] I feared that it might fail[ ] Wont use it again[ ]

2. Who advised you on contraceptives and their use?

- a) Parent/Guardian
- b) Friends
- c) Church youth group pastor
- d) Social media
- e) TV, Radio, Newspapers, Posters
- f) None of the above

3. Which of the sources above did you believe and take into account?

- a) Parent/Guardian
- b) Friends
- c) Church youth group pastor
- d) Social media
- e) TV, Radio, Newspapers, Posters
- f) None of the above

4. What challenge did you face after you first had sex and needed to use a contraceptive?

- a) Lack of Knowledge about which method is best
- b) Fear of judgement from the place of purchase
- c) Religious beliefs
- d) Cultural beliefs
- e) Others, Specify.....

4. Have you been taught about contraceptive methods in school?

YES[ ] NO[ ]

5. What do you think about the information taught in school *vis a vis* the information you have heard in relation to contraceptives?

Information from school is accurate YES [ ] NO [ ]

Information from other sources is misleading YES [ ] NO [ ]

**Section 4: Impact of contraceptive information young girls in Kware access**

1. Do you believe the information you have come across?

YES [ ] NO [ ]

Explain your reason for the answer given

above.....

2. How did the information influence your decision making?

Explain your reason for the answer given

above.....

3. Do you think the decision you made was right or wrong and why?

4. What information have you come across that you feel is untrue?

Explain your reason for the answer given

above.....

**Section 5: Information gaps**

1. In your opinion what would be the best contraceptive method for 18-21-year-old adult girls?

2. Why did you feel that contraceptives are good?

3. What do people around you say about contraceptive methods?

Effective [ ] Lowers Libido [ ] You won't be able to conceive in future [ ] It is a sin [ ] Nothing [ ]

4. Do you feel that there is something important about contraceptives that you don't know.

Yes [ ] No [ ]

What is it that you feel you do not know? .....

5. Who do you think you have enough information about correct contraceptive use?

## Appendix III: Research Interview Guide

Name (Optional).....

Age.....

Level of Education.....

Key informant category:

CHV, NURSE, PARENT/GUARDIAN, PHARMACIST, CBO

STAFF.....

### **Section 1: Sources of Information**

1. What would you think is the percentage of sexual activity among young adult girls in Kware?
2. Are these girls using contraceptives and what is the percentage of the same?
3. What sources of contraceptive information are young adult girls in Kware exposed to?
4. What in your opinion would make a girl choose one source of information over another?

### **Section 2: Factors that contribute to contraceptive uptake**

1. What do you think are some of the factors that contribute to information uptake of contraceptives in Kware?
2. Based on your answer above give reasons for each statement

### **Section 3: Impact of contraceptive information the young adult girls in Kware access.**

1. What impact do you think the contraceptive information available to the girls has on their decisions?
2. Do you think that they trust the information and would want to assimilate it?
3. Give reasons to 2 above

### **Section 4: Information gaps**

1. What are the sources of contraceptive information among young girls in Kware?
2. Which of the sources are credible from 1 above and which ones are not and why?
3. Why do you think they would choose one source of information over another?
4. Do you think that there is sufficient credible information on contraceptive use available for young girls in Kware?
5. How would you propose information on contraceptive use among young girls in Kware be designed?