AN ASSESSMENT OF THE UPTAKE OF MODERN CONTRACEPTIVES AMONG WOMEN IN NAIROBI COUNTY: A STUDY OF THE C-WORD CAMPAIGN

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DECLARATION

DECLARATION

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

Signature……. Date……

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DECLARATION BY SUPERVISOR

This project has been submitted for examination with my approval as a university supervisor.

Signature…… Date……..

DR. NDETI NDATI

DEDICATION

To my loving parents Dennis and Margaret and my siblings for always encouraging me to rise above excellence.

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ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

CDC: Centers for Disease Control and Prevention

FHO: Family Health Option

FP: Family Planning

HIV: Human Immunodeficiency Virus

KDHS: Kenya Demographic Health Survey

LAPMs: Long-acting and permanent methods (LAPMs)

LVCT: Liverpool Care and Treatment

MNH: Maternal, Neonatal and Child Health

NCAPD: National Coordinating Agency for Population and Development

PSI: Population Services International

RH: Reproductive Health

SBCC: Social and Behaviour Change Communication

SRH: Sexual Reproductive Health

STDs: Sexually Transmitted Diseases

VCT: Voluntary Counselling and Testing

WHO: World Health Organisation

ABSTRACT

The study assessed the uptake of modern contraceptives among women in Nairobi County: A study of the C-Word Campaign.

The objectives of the study were: (i) to establish the knowledge levels of contraceptive use among women aged between 15 – 24 years in Nairobi; (ii) to find out the type of modern contraceptive methods targeted by the C-Word Campaign; (iii) to find out the challenges faced by women towards accessing modern contraceptives and information and (iv) to establish the role of communication on influencing contraceptive uptake as an intervention on increasing contraceptive prevalence and social behaviour change.

The study used the descriptive research design. It utilised two theories of behaviour change communication. These were: the theory of planned behaviour (TPB) and the process of behaviour change (PBC). Qualitative data was collected using the interview method. Key informant interviews and focus group discussion methods were used to collect data. The tools used were interview schedules and interview guides respectively. The data were interpreted using thematic analysis.

The study found out that the youth had a basic knowledge and understanding of contraceptives and the C-word campaign. The campaign helped them to know of other methods they can use to protect pregnancies and where to access them. They learnt about the campaign from media, Lvct clinic and their friends.

The study concluded that the campaign should also be broadcasted through other platforms which are more appealing to the youth like road shows all over the country, actual visits to schools especially during cultural days, sports days or when there is an activity at school and focus group discussions. The study recommends that Lvct health and its partners should ensure that they give enough information about the types of contraceptives they offer and even give out booklets to help the youth make rational decisions on their contraceptive choice and where to buy from.

CHAPTER ONE
INTRODUCTION

1.0 Background of the Study

Effective communication processes lie in a background of every company that wants to be successful in a long term (Purves, 2005). Usually with the word communication people understand the interaction with others on everyday basis with the aim of exchanging information. Communication is recognized as an important input in various programs which use different terms to describe the approaches in use – information, education, and communication (IEC), behaviour change communication (BCC) and others,(Reproductive Health Strategy,2010 – 2015). Communication plays a key role in ensuring people know about the modern contraceptive methods available, benefits of using contraceptives, where they can access them and be advised on which methods best suites them depending on their situation and persuaded to make a decision.

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57% in 2012. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67%. There is with significant variation among countries in these regions (WHO, 2013). In Kenya use of modern contraceptive methods among women of ages 15-49 account for 39% while for youth ages 15–19 is 4.9% and those of age 20 -24 is 23.6%. As a result information access on contraceptives by the youth is essential for increasing their knowledge and awareness of the modern methods available. This eventually will affect their perceptions and behaviour and lead to increase in uptake of contraceptives and reduce unwanted pregnancies. It is important for contraceptive providers to know the types of persons who are more or less likely to be reached by the media for purposes of planning programmes intended to spread information about health and family planning.

Kenya's population has grown rapidly since 1948, increasing from 5.4 million to the current estimate of 40 million. It is projected to increase to 65 million by 2030 (NCAPD

2008). High population growth has resulted in a youthful population and built-in momentum for future growth. Even with declining fertility, the youth bulge means that there will still be a large number of women of childbearing age in the future. Kenya's Reproductive Health/Family Planning (RH/FP) programs have evolved over time, reflecting a range of Government of Kenya (GOK) policy frameworks, strategies, and service guidelines for providers. Despite these milestones, many issues continue to be a challenge to the youth who are the future leaders of the country. These include teenage pregnancies and sexually transmitted diseases (Kenya Demographic Health Survey, 2008/9). According to Kiragu et al. (1998), adolescent reproductive health has now become an even greater priority at a policy level, as attested to by the recent sessional papers on AIDS as well as the national Information, Education, Communication, and Advocacy Strategy. A better understanding of teenage fertility can result in improved services to this very vulnerable special group. In an attempt to address the reproductive health needs and to reduce fertility of this special group, the government, through the National Coordinating Agency for Population and Development, put in place an Adolescent Reproductive Health Policy to ensure youth are exposed to and can access reproductive health services. Therefore issues on the youth's reproductive health and family planning critically affect the health and development of the country and need to be given utmost consideration.

Family planning (FP), maternal, neonatal, and child health (MNH), and sexual and reproductive health (RH) for adolescents and youth are fundamental elements of the RH Communication Strategy for Kenya (2010–2012). These are key areas to address for Kenya to make progress on Millennium Development Goals (MDGs) and Vision 2030.

Recently, the Government of Kenya (GOK) and donors agreed to bolster RH/FP programs and services to ensure the country meets the goals ahead, including the 2015 target set by the Ministry of Public Health and Sanitation (MOPHS) of increasing contraceptive prevalence from 46% to 56%. Social and behaviour change communication (SBCC), which includes advocacy, social mobilization, and individual behaviour change, is vital to Kenya's achievement of the MDGs and Vision 2030. SBCC is a crucial component in changing social norms; addressing myths and misconceptions; and improving knowledge, attitudes, and practices of Kenyans with regard to RH/FP and

MNH. Without normative changes, increased uptake of available RH services cannot be achieved (Ministry of Public Health and Sanitation, 2010).

In Kenya, less than half of married couples use modern family planning methods - condoms, pills, injections, implants and intrauterine contraceptive devices (IUCDs). The unmet need for family planning is high; one in four married women either do not have access to family planning services or lack information or motivation to use services (PSI Kenya, 2010). This clearly indicates the need for making contraceptive literature widely and easily accessible especially using modes of communication that most people can afford, understand and relate to. Since still many people fear talking about their sexuality, modes of communication that offer confidentiality should be employed. There is also need of bringing family planning services closer to the people for instance establishing preventive sites near workplaces and residential places.

Effective contraception is healthy and socially beneficial for mothers and their children and households (Kaunizt, 2008). Contraceptive use is a dynamic process; women initiate and stop contraceptive practice in response to changes in their own circumstances and in their social and health environment and they choose different methods at different points in their lives. Thus, the contraceptive prevalence and method mix at any given point in time is the result of a whole series of decisions made by individual women to start contraceptive use, stop use, restart use, and to choose one method over another one, (KDHS, 1998). Unmet need for FP remains high. In Africa, 53% of women of reproductive age have an unmet need for modern contraception, in Asia, Latin America and the Caribbean regions with relatively high contraceptive prevalence the levels of unmet need are 21% and 22%, respectively (WHO, 2013). In Kenya the unmet need for FP among youth ages 15–24 is 30 % (KDHS 2008/9). Of the 63% of Kenyans with unmet FP needs 60% are in rural areas and 74% are in urban areas. This because of high rural to urban migration and so the people at the village are few as compared to urban areas and a number of women agreeing to participate in unprotected sexual activity to earn a living. The unmet need for FP among youth ages 15–24 is 30%, and there is a large unmet need for FP among people living with HIV (PLHIV). Approximately 55% of currently married couples who do not use FP say they intend to use it in the future, and another 27% want to wait at least two years before the birth of their next child (KDHS

2008/2009). It is therefore the responsibility of modern contraceptive providers to effectively communicate to the public on their services using widely accessible channels in order to reduce the unmet need for family planning services among different age groups.

According to the 2008/9 KDHS, while use of any FP method is 46%, modern methods account for 39%. Injectables and pills are the most popular modern methods, and account for 22% and 7% respectively. Traditional methods (rhythm and withdrawal) account for 6%. This shows that most people have now resolved to modern methods because they offer more security and reliability as compared to traditional methods. A lot of publicity has been carried out to inform the people about the available modern methods but the challenge is on increasing demand and utilization among women aged years 15 – 24 and that's why the purpose of this study is to assess how the C-Word Campaign contributes towards their uptake of modern contraceptives.

Some of the major modern contraceptive providers in Kenya include Marie Stopes Kenya that exists to bring quality family planning and reproductive healthcare to the world's poorest and most vulnerable people. They have been delivering family planning, safe abortion, and maternal health services for over 35 years (http://mariestopes.org). Family Health Options Kenya (FHOK) is a local Non-Governmental organization, which has been a leading service provider of sexual and reproductive health services in the country for the last five decades. It has presence in seven of the eight provinces with a strong grassroots network. FHOK has played a leading role in providing sustainable, innovative and comprehensive services in response to health and socio-economic needs of all Kenyans (FHOK. (2014, 10 20). FHOK. Retrieved from FHOK: http://www.fhok.org).

PSI/Kenya has been implementing social marketing programs to address HIV and AIDS, reproductive health, malaria and child health promotion. PSI/Kenya promotes products, services and healthy behaviour that enable low-income and vulnerable people to lead healthier lives, (PSI Kenya. (2010, 10 20). PSI Kenya. Retrieved from PSI Kenya: http://psikenya.org).

We also have Liverpool, Care and Treatment (LVCT) Health which empowers health communities by offering HIV testing and counselling using research results, capacity

improvement and policy reform action to promote universal access to equitable HIV and SRH services reaching the most vulnerable populations (LVCT Health, 2014) http://www.lvct.org).LVCT Health which currently rolled out the C-Word Campaign will be used as the study site.

The Ministry of Health is mandated to support the attainment of the health goals of the people of Kenya .It has come up with various programmes and initiatives in order to promote health practices among the people. Out of the situation analysis that was carried out before the Reproductive health communication strategy guidelines were implemented, there was need to integrate communication as a core component in reproductive health programmes and in contraceptive awareness communication programming should emphasize dual protection, including use of dual contraceptive methods for greater security. The RH communication strategy outlines the components that any healthy communication campaign should have in order to ensure its effectiveness. Some of the components include being results oriented, evidence based, client centered, participation, benefit oriented, service linked, multi-channelled, technical quality, advocacy related, expanded to scale, programmatically sustainable and cost effective.

The RH Communication Strategy was implemented in accordance with the National Reproductive Health Policy and the National Reproductive Health Strategy (2009–2015). The strategy is managed and coordinated by the Division of Reproductive Health (DRH) of the Ministry of Public Health and Sanitation (MOPHS) at the national level, and by provincial and district health management teams at their respective levels. The overall purpose of this implementation guide is to ensure coordination and synergy of RH/FP Social and Behaviour Change Communication (SBCC) programming. It also ensures consistent SBCC on RH/FP by setting the stage for scale and impact. This guideline also defines a common measurement for success. The implementation guide thus outlines the roles and activities of the GOK and partners at national, regional, and county levels. Developed through a consultative process with the RH Communication Technical Working Group (TWG) and partners, the guide will assist stakeholders working in RH/FP to develop SBCC programs and activities that are aligned with the RH Communication Strategy.

While contraceptive use has grown in Kenya over the years, both unmet need for family planning and unintended pregnancies remain very high suggesting important barriers to effective contraception (APHRC Policy Brief No.26, 2011). Contraception use allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility (WHO 2013). Contraception (birth control) prevents pregnancy by interfering with the normal process of ovulation, fertilization, and implantation. There are different kinds of birth control that act at different points in the process (Whitney, 2003).

The study site was LVCT Health Nairobi. It was formerly know by the name Liverpool VCT Care and Treatment. Its Vision is to empower health communities and its mission is to excel in HIV testing and counselling and use research results, capacity improvement and policy reform action to promote universal access to equitable HIV and SRH services reaching the most vulnerable populations.

The head office is in Hurlingham in Nairobi. It also has a training institute at Kilimani business centre in Nairobi and other branches in Kisumu and Embu. LVCT Health has partnered with Population Services International Kenya (PSI/Kenya), Ministry of Health, Trocare, Centers for Disease Control and Prevention (CDC), Population Council, USAID and many others to create awareness on its reproductive health products and services.

LVCT Health rolled out their contraceptive department in 2010.The main responsibilities include distributing quality family planning products at highly subsidised prices, educating the public and improving the knowledge, skills, attitude and performance of health care providers in the provision of quality family planning services. One of the interventions to increase awareness on contraceptive use is the C-word campaign. CDC is funding this campaign and Population Services International Kenya (PSI) is in charge of its advertisement in electronic and print media.

The study was exclusively on the C-word campaign that was picked purposively because it is the only contraceptive intervention LVCT health is conducting for the youth at the moment. This campaign was developed in collaboration with the Ministry of Health - Division of Reproductive Health, and launched in October 2010, in order to address the low awareness and uptake of contraception among sexually active women aged 15-24 years. The campaign’s objectives are to demystify the topic of contraceptives among

young women and men aged 15-24 years as well as educate young women on the modern contraceptive choices available to them. Evidence showed that among all sexually active women of reproductive age, the unmet need and non-use of family planning (FP) is highest among women aged 15-24 years, and the total demand for FP services is at 71.1% among married women compared to only 16.4% among unmarried women. Furthermore in the last 20 years, active and consistent national communications to create awareness and demand for family planning, (FP) has been insufficient; therefore there is a large cohort of young women who have never been exposed to FP messaging (PSI Kenya. (2010, 10 20). PSI Kenya. Retrieved from PSI Kenya: http://psikenya.org).

LVCT Health receives feedback on the C-Word Campaign through the hotline 1190 which is free. The one2one youth hotline is a toll free helpline that offers, sexual reproductive information, confidential information and counselling services to young people in Kenya 12hours a day (8am-8pm)/ 7days a week. The hotline receives over 10,000 calls monthly. In 2012, 151,184 people accessed our hotline services. The high call volumes were as a result of a private public partnership between LVCT and Safaricom Limited, Kenya's largest Telecommunication firm (LVCT. (2014, 10 20). *LVCT*. Retrieved from LVCT: http://www.lvct.org).

This study derived from the concern over the low levels of contraception use among the youth in Kenya and the increase in population and teenage pregnancies despite efforts to create awareness on the various modern contraceptive methods. The study was an assessment of the uptake of contraceptives among women in Nairobi based on the C-Word Campaign and its role towards increasing modern contraceptive uptake.

1.1 Problem Statement

Demand for and awareness on contraception remains a major concern in Kenya. This is clearly attested to by the low levels of contraception of modern methods in Kenya, which currently stands at 39 per cent (KDHS 2008-2009). These levels are far below the 2015 government prevalence targets of 56 per cent. It is partly because of the low levels of contraception that the fertility levels in the country have remained high, at 4.6 per woman against the desired levels of 2.1 per woman (NCPD 2014). In addition, the discussion and dissemination of information about contraceptives remains low in Kenya (PSI Kenya,

2010). There is a large potential for further increases in contraceptive use among the youth (APHRC, 2001).

Various efforts are being made to help boost contraception levels in the country since effective contraception use is healthy and socially beneficial for mothers and their children and households (Kaunizt, 2008). One of the efforts being made to boost the contraceptive prevalence is led by LVCT Health through the C-Word Campaign that is being advertised on electronic and print media. However, although this programme of contraception and the campaign have been rolled out, there has not been an effort to assess the extent to which messages on contraception are being packaged and communicated to beneficiaries (women) to ensure they are well understood and lead to social behaviour change. This study therefore sought to assess the uptake of contraceptives among women in Nairobi basing on the C-Word Campaign adopted by LVCT Health to convey messages on contraception.

1.2 Study Objective

1.2.1 General Objective

The general objective of this study was to assess the uptake of modern contraceptives among women in Nairobi by studying the C-Word Campaign.

1.2.2 Specific Objectives

i. To establish the knowledge levels of contraceptive use among women aged between 15 – 24 years in Nairobi County
ii. To find out the type of modern contraceptive methods targeted by the C-Word campaign.
iii. To find out the challenges faced by women towards accessing modern contraceptives and information.
iv. To establish the role of communication in influencing contraception uptake as an intervention on increasing contraceptive prevalence and social behaviour change.

1.3 Research Questions

i. What are the knowledge levels of contraceptive use among women in Nairobi aged between 15 – 24 years?

ii. Which types of contraceptive methods are being targeted by the C-Word campaign?
iii. What are the challenges faced by women towards accessing modern contraceptives and information?
iv. Does the C-Word Campaign adopted by LVCT Health contribute to increase in contraceptive prevalence and social behaviour change?

1.4 Justification of the Study

Various research findings have indicated that the low contraceptive prevalence rates are evidence of the failure of preventive interventions. Among the youth, it appears evident that providing contraceptive information is not enough to change their behaviour and unsafe practices. Other unexplored psychosocial factors seem to contribute to the efficacy of contraceptive knowledge and information. This study sought to establish how to bridge the gap between knowledge on contraceptives and increase in demand and utilization.
The findings of this research are useful to LVCT health, health partners, donors and the Ministry of Health to identify the young women's thoughts, perceptions, challenges and knowledge on contraceptive use and their recommendations on what can be done in order to increase the demand for and utilization of RH/FP services.

The findings will also help the government of Kenya to know the key areas to address in regard to social norms, myths and misconceptions, improving knowledge and practices of Kenyans with regard to reproductive health and family planning this is in order to make progress towards achieving Millennium Development Goals (MDGs) and Vision 2030.

LVCT Health, PSI Kenya and Ministry of Health will benefit from the findings of the research because they will get feedback on what aspects of the C-Word campaign are working, what needs to be changed and what can be added to make it more effective.

The findings will provide information base that will help Ministry of Health and the Government of Kenya for future family planning programming in Kenya.

The research findings may also help in determining the communication needs of the youth and therefore provide ways in which contraceptive communication interventions can be effectively packaged with the knowledge, consultation and participation of young people.

The findings presented in this study may also help in the identification of areas for further research in the field of health communication. It is worth noting that this study was limited to students from Kenyatta University and Kahawa Christian Secondary School which are both located in Nairobi region. There is room to study other students in rural areas.

1.5 Scope of the Study

Among the many interventions targeting population reduction in Kenya, contraception use has been identified as a gateway to a health and developed country. The Ministry of Health whose mandate is to come up with interventions towards achieving its health goals has partnered with various donors and NGOs to implement campaigns to increase contraceptive prevalence in the country. This study will focus on only one intervention that is the C-Word Campaign adopted by LVCT Health. This campaign targets young people of ages 15 – 24.

The findings of this study will then be used as a representation of the overall effectiveness of behaviour change communication campaigns adopted by modern contraceptive providers.

1.6 Operational Definition of Terms

- **Communication**: According to Griffin (2009), communication refers to a process of transmission of information in order to create awareness and change people's thinking, feeling and behaviour towards a certain direction. In this study communication's important goal is to inform people about contraceptives, to change their behaviour and persuade them to use them
- **Modern Contraceptives**: According to World Health Organization (WHO), modern contraception refers to birth control by prevention of conception or impregnation by use of pills, condoms, Intrauterine Devices (IUD), Tubal ligation, vasectomy, Lactational amenorrhea method (LAM) and injectable. This is the definition that will be employed in this study.
- **Employee**: According to the Oxford English dictionary an employee is any person under employment, contract of service or apprenticeship with a company. In this study an employee refers to health care staff in LVCT Health.

- **Employer**: According to the Oxford English dictionary an employer is a person that engages others to perform certain tasks for payment of wages or salary. This study adopts this definition.
- **Woman**: World Health Organization (WHO) defines a woman as an adult female human. In this study it refers to a female aged 15 -24 years. The word young woman was used interchangeably to refer to youth and student.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This section basically singled out various literature materials relevant to the study, it covered both primary and secondary literature. Various publications in the books, journals and Internet sources were used to gather relevant information about the study. The section also looked at the theoretical frame works. The theoretical framework provided the theories upon which the study was grounded.

2.1 Role of Communication towards Contraceptive Uptake and Social Behaviour Change

According to Griffin (2009), communication refers to a process of transmission of information in order to create awareness and change people's thinking, feeling and behaviour towards a certain direction. In this study communication's important goal is to inform people about contraceptives, increase their demand for and utilization of contraceptives, to change their behaviour and persuade them to use them. Communication plays a key role in ensuring people know about the modern contraceptive methods available, where they can access them and be advised on which methods best suites them depending on their situation and persuaded to make a decision.

Strategic communication is increasingly being recognized as an essential element of any successful health, social or development programme. When properly implemented, communication results in sustained change in policy, social norms and behaviours. Communication is also essential in overcoming barriers to access to services or generating demand for such services. Within the context of reproductive health, communication has been seen as an important input into tackling sexual and reproductive health issues including deteriorating indicators, unmet need for reproductive health, poor utilization of available services as well as weak dissemination of existing policies and guidelines on reproductive health to the lower levels (Ministry of Public Health and Sanitation, 2010).However, in this study of the C-Word Campaign, communication can be more effective if the characteristics of the women being targeted can be well understood in terms of their belief systems, religion, level of education, background,

principles and socialization. This will help the health and communication practitioners design messages that best suit their needs and easy for conceptualization in order to achieve the intended results. Recent study by the Agency for Health Care Policy and Research revealed that communications leads to the improvement of interpersonal and group interactions in clinical situations (for example, provider-patient, provider - provider, and among members of a health care team) through the training of health professionals and patients in effective communication skills. Collaborative relationships are enhanced when all parties are capable of good communication.

Communication is recognized as an important input in various programs, which use different terms to describe the approaches in use – information, education, and communication (IEC), behaviour change communication (BCC) and others (KDHS 2008/2009). Therefore in the C-word campaign effective communication can achieve the desired social behaviour change which is the increase in demand, uptake and utilization of modern contraceptive methods.

The Ministry of Health recognizes communication as a vital tool for effective implementation of the Country's RH policies. In a setting beset with numerous challenges ranging from social and cultural factors to system and implementation challenges, effective communication is critical to facilitate shifts in attitudes, beliefs, perceptions and behaviour which ultimately bring about social change. Also communication initiatives have a chance of succeeding only when situated within the cultural context of the target audience (UNAIDS, 1999). Kunda and Tomaselli 2009 reiterate that "Effective health communication interventions depend on understanding the knowledge, attitudes and practices of people from given cultural vistas". Therefore, any intervention focusing on behaviour change has to design communication messages that can easily be understood and that are not biased. It is important to understand the target audience's characteristics.

According to the Ministry of Public Health and Sanitation, Social and behaviour change communication (SBCC) is an interactive, researched, and planned process aimed at changing social conditions and individual behaviours. This process includes five steps

which include understanding the situation, focusing & designing your strategy, creating interventions and materials, implementing and monitoring and evaluating and replanning.

Social and behaviour change communication (SBCC), which includes advocacy, social mobilization, and individual behaviour change, is vital to Kenya's achievement of the MDGs and Vision 2030. SBCC is a crucial component in changing social norms; addressing myths and misconceptions; and improving knowledge, attitudes, and practices of Kenyans with regard to RH/FP and MNH. Without normative changes, increased uptake of available RH services cannot be achieved (KDHS 2008/2009).This argument has contributed to healthy practitioners carrying out a situation analysis and background study before rolling out any contraceptive campaign based on behaviour change. Change can only take place when the targeted population can understand the messages being conveyed and able to offer feedback.

The Ministry of Health further observes that developing appropriate SBCC programming and more targeted communication messages requires an understanding of the underlying determinants for positive RH/FP behaviours for each audience, as well as the perceived benefits of changed behaviours. Knowing this information contributes to more targeted communication messages and programs. It is also essential to collect information on barriers to uptake of RH services and to conduct further qualitative formative research, using key informant interviews and focus group discussions with carefully segmented audiences. Barriers should be addressed in the corresponding communication objectives.

Behaviour change communication (BCC) involves the development of tailored messages and approaches to develop promote and sustain individual, community and societal behaviour change. Cognizance is given to cultural diversity and audience reception and a multi-channel approach is employed. BCC can improve and promote dialogue at community and national level on a range of health issues (PSI Kenya 2010).

2.2 The Role of C-Word Campaign towards increasing contraceptive uptake

This is one of the interventions to increase awareness and uptake on modern contraceptive use adopted by LVCT Health. This campaign is being funded by Centers for Disease Control and Prevention (CDC) and Population Services International Kenya

(PSI) is in charge of its advertisement in electronic and print media. There have been other campaigns advocating for abstinence for example the campaign that was named ”Tumechill” that targeted young people, however, evidence shows that not many youth can abstain therefore C-Word campaign comes to offer the youth options available for them.

The C-Word (C for Contraceptives) BCC (Behaviour Change Communication) campaign was developed in collaboration with the Ministry of Health - Division of Reproductive Health, and launched in October 2010, in order to address the low awareness and uptake of contraception among sexually active women aged 15-24 years. This was after they carried a situation analysis and finding revealed that the 15-24-age bracket had low percentages in uptake of contraceptives and high rates of unwanted pregnancies. The campaign’s objectives are to demystify the topic of contraceptives among young women and men aged 15-24 years as well as educate young women on the modern contraceptive choices available to them. Evidence showed that among all sexually active women of reproductive age, the unmet need and non-use of family planning (FP) is highest among women aged 15-24 years, and the total demand for FP services is at 71.1% among married women compared to only 16.4% among unmarried women. Furthermore in the last 20 years, active and consistent national communications to create awareness and demand for family planning, (FP) has been insufficient; therefore there is a large cohort of young women who have never been exposed to FP messaging (PSI Kenya. (2010, 10 20). PSI Kenya. Retrieved from PSI Kenya: http://psikenya.org).Albright (2007) suggest that researchers must take into consideration the characteristics of their target populations including demographics as well as the specific social and cultural context, in order to advance their understanding. Further, she adds that circumstances of the particular set of individuals or target audiences must be clearly understood in order to design an information strategy. Contraceptive messages need to be targeted to smaller groups or individuals because of the range of individual information needs and processes through which individuals make sense of their worlds and their realities. A mass media approach designed to change behaviour is inadequate to provide incentive for all members of the society.

LVCT Health receives feedback on the C-Word Campaign through the hotline 1190 which is free. The hotline 1190 is advertised below contraceptives messages that are aired on Citizen Television, Nation Television, Kiss Television, Q television and Radio Jambo before and after prime time news. It is also advertised once monthly in the Insyder Magazine. The one2one youth hotline is a toll free helpline that offers, sexual reproductive information, confidential information and counselling services to young people in Kenya 12 hours a day (8am-8pm)/ 7days a week. The hotline receives over 10,000 calls monthly. In 2012, 151,184 people accessed the hotline services. The high call volumes were as a result of a private public partnership between LVCT and Safaricom Limited, Kenya's largest Telecommunication firm (LVCT Health, 2014)http://www.lvct.org).

Kenya has experienced dramatic demographic evolution since 1960.The key features of this evolution have been rapid increase in fertility especially during the 1960 – 1980 period and substantial declines in mortality; particularly childhood mortality (NCPD, 1989) which have accelerated population growth rate which reached its peak at 3.8% in 1979.The high population growth rate has contributed to diverse, social, economic, political and environmental problems which necessitated Government's aggressive programs particularly family planning to arrest it. Some of the programs include implementing the RH communication strategy guidelines and communication campaigns towards increasing the uptake of modern contraceptives.

To attain a balance between resources and population, Kenyan population policy promotes family planning as an entitlement that is based on informed and voluntary choice. Therefore, it is the responsibility of LVCT health to ensure its reproductive health services are easily accessible to the youth to help them decide on which method to use.

The Ministry of Health previously had designed campaigns to address contraceptive use. Communication programming emphasizes dual protection, including use of dual contraceptive methods. One of the campaign called "Jipangie Maisha Poa" (Plan for yourself a good life) targeted women and men aged 25-35 years. Some of the themes and key messages of these campaign included: Spacing your children at least two years apart is key for a healthy and prosperous family, modern family planning methods are safe and

reliable, use a modern family planning method to delay pregnancy or space births, talk to your partner about a modern family planning method of your choice and visit a health facility for more information and family planning services. The other campaign was targeting the youths and was called “Don’t take chances, take control”. The campaign targeted the youths aged 18-24.Some of the themes and key messages included: It is okay to learn about various modern methods of contraception to take control of your life and prevent unwanted pregnancies, several modern methods of contraception exist and each has its own benefits and limitations, It is important to visit a health provider for counselling on appropriate methods, only condoms can protect you from sexually transmitted diseases, it is important to delay child bearing and it is important to delay sexual debut (MOHPS,2010).

2.3 Types of Modern Contraceptive Methods

Contraception (birth control) prevents pregnancy by interfering with the normal process of ovulation, fertilization and implantation. Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility (WHO, 2013). There are different kinds of birth control that act at different points in the process (Whitney, 2003). Not all contraceptive methods are appropriate for all situations and the most appropriate method of birth control depends on a woman's overall health, age, frequency of sexual activity, number of sexual partners, desire to have children in the future and family history of certain diseases. Individuals should consult their health care providers to determine which method of birth control is best for them. Some types carry serious risks, although those risks are elevated with pregnancy and may be higher than the risks associated with the various methods (KDHS 2008/9).

According to World Health Organization (WHO), modern contraception refers to birth control by prevention of conception or impregnation by use of pills, condoms (female and male), Intrauterine Devices (IUD), Tubal ligation, vasectomy, Caps, Lactational amenorrhea method (LAM) and injectable. This is the definition that was employed in this study. There are two permanent methods of contraception: female sterilization/tubal ligation and vasectomy (male sterilization).This is why this study seeks to find out they

type of modern contraceptives targeted by LVCT Health together with its partners in the C-Word Campaign.

Table 2.1 Types of Contraception and Family Planning

<table>
<tr><td colspan="3">Male condom
The male condom is made of very thin latex rubber. You use a condom once and then throw it away. It should be fitted over the man’s erect penis before it touches your vagina or genital area. This stops sperm from reaching the egg.</td></tr>
<tr><td>Advantages</td><td>Disadvantages</td><td>Effectiveness</td></tr>
<tr><td>1. It is straightforward to use.
2. It can protect you against some sexually transmitted infections (STIs).
3. You only need to use one when you have sex.</td><td>1. Sex has to be interrupted to put the condom on.
2. The condom can be split, or can slip off if it is not put on carefully.
3. Some people can develop an allergy to latex rubber or to the spermicide in the lubricant.</td><td>If you use them carefully and consistently, male condoms are highly effective in preventing both pregnancy and STIs, including HIV. Their general effectiveness ranges from about 85% - 98% (Family Planning Association).</td></tr>
<tr><td colspan="3">Female condom

The female condom is made of very thin polyurethane. You use a female condom once and then throw it away. You put it into your vagina to form a lining before you start having sex. This stops sperm from reaching the egg.</td></tr>
<tr><td>1. It is straightforward to use.
2. It can protect you against some sexually transmitted infections.
3. You only need to use one when you have sex.</td><td>1. Female condoms not as widely available as male condoms, and can be expensive.
2. They’re not as effective as male condoms.
3. A female condom can move around when you are having sex, so it’s important to make sure your partner’s penis stays inside it.</td><td>The female condom can be up to 95% effective if you use it according to the instructions (Family Planning Association).</td></tr>
<tr><td colspan="3">Diaphragm and cap
A diaphragm is a dome of thin rubber. A cap is very similar, but smaller. Diaphragms and caps must be used with a spermicide (a gel or cream that kills sperm). You put the diaphragm or cap inside your vagina to cover your cervix (the entrance to your womb). This stops sperm from reaching the egg.</td></tr>
<tr><td>1. They are straightforward to use
2. You only need to use one when you have sex.
3. You can put your diaphragm or cap in at any time before sex, when it is convenient.</td><td>1. Putting a cap or diaphragm in can interrupt spontaneous sex.
2. The spermicide can be messy and may cause irritation for you or your partner.</td><td>Diaphragms and caps are 92%-96% effective if you use them according to the instructions (Family Planning Association).</td></tr>
</table>

	3. Caps and diaphragms need to be fitted by a healthcare professional to make sure they are the right size.	
Intrauterine devices (IUD) Intrauterine devices (IUDs) are small plastic and copper devices of varying shapes and sizes that are put in the womb (uterus). IUDs prevent fertilization by an effect both on sperm and eggs. They also make the womb lining unreceptive to a fertilized egg.		
1. Once you have had an IUD fitted, you don't have to think about contraception for as long as it is in place, which can be anything from 3 to 12 years. 2. The IUD doesn't interfere with sex.	1. IUDs can cause your periods to be heavier, longer and more painful than normal. 2. Immediately after you have an IUD fitted, there is a chance that you may get an infection. 3. IUDs can come out of your womb, so you have to be taught how to check if your IUD is still in place. 4. IUDs are not suitable for everyone.	It doesn't protect you from sexually transmitted infections. IUDs are 98-99% effective (Family Planning Association).
Intrauterine system (IUS) The intrauterine system (IUS) is a 'T' shaped device that is put in your womb and slowly releases progestogen. This makes the womb lining very thin and unreceptive to a fertilized egg, and affects your cervical mucus to make it very hard for sperm to get through.		
1. Once you have had an IUS fitted, you don't have to think about contraception for as long as it is in place, which can be up to 5 years. 2. The IUS doesn't interfere with sex. 3. Within 3 to 6 months of using an IUS, most women find that their periods become lighter and less painful.	1. An IUS can cause irregular bleeding for the first few months after it is fitted. 2. The IUS can come out of your womb, so you have to be taught how to check that the IUS is still in place. 3. It can cause side effects such as breast tenderness, headaches and acne for the first three months or so after the IUS is fitted. 4. The IUS is not suitable for everyone.	It doesn't protect you from sexually transmitted infections. The IUS is more than 99% effective (Family Planning Association).
The combined pill The combined pill (often just called 'the pill') contains two synthetic versions of hormones that women have naturally in their bodies: estrogen and progestogen (the man-made form of the hormone progesterone). The pill keeps your hormones steady so you don't ovulate. It also affects your cervical mucus (makes it harder for sperm to get through it) and stops the lining of your womb from thickening and preparing itself to host a fertilized egg. Most types of combined pill are taken once a day for 21 days and then you have a seven-day break. During this break, you'll have a bleed, but this is not the same as a period, it's actually a 'withdrawal bleed' – your body's response to the hormones being stopped.		
1. The pill doesn't interrupt sex at all.	1. The pill can have side	The combined pill is over

2. Most women find that the withdrawal bleed is much lighter and shorter than a 'real' period, and have fewer PMT symptoms. 3. The withdrawal bleed is very regular and predictable, because you know when you stop taking the pills for your break.	effects including mood swings, weight changes, breast tenderness, headaches and nausea. 2. In rare cases, the pill can cause serious side effects, such as blood clots (thrombosis). 3. If you are over 35, if you smoke or are breastfeeding, you may not be able to take the combined pill. 4. It doesn't protect you against sexually transmitted infections.	99% effective if you use it according to the instructions (Family Planning Association).
The mini pill The mini pill is also called the progestogen-only pill. Progestogen is the man-made form of progesterone. The mini pill affects your cervical mucus (makes it harder for sperm to get through it) and stops the lining of your womb from thickening and preparing itself to host a fertilized egg. In some cases it also stops ovulation. You take a mini pill each day for 28 or 35 days (depending on the brand) and then immediately start the next pack.		
1. The pill doesn't interrupt sex at all. 2. It can also reduce PMT symptoms.	1. The mini-pill can have side effects including acne and breast tenderness. 2. Your periods may stop altogether or be irregular, light, or more frequent while you are taking the mini pill. 3. It doesn't protect you against sexually transmitted infections. 4. The mini-pill should be taken at same time of each day, every day, otherwise its effectiveness is reduced	The mini pill is 99% effective if you use it according to the instructions (Family Planning Association).
Calendar Rhythm Method The calendar rhythm method is a natural contraception method that involves learning about your fertility and working out when you are fertile and infertile each cycle, so you can avoid sex during the fertile phase of your cycle. It requires that you track your cycle for a few months to identify when you ovulate and therefore should avoid having sex. The method is based on the following facts: ▪ Sperm can survive in your uterus for several days and you can therefore get pregnant if you have sex on the days leading up to ovulation. ▪ The female egg is fertile for about 24 hours following its release from your ovary. ▪ You cannot get pregnant between the 2 days after ovulation and your next period.		
1. It has no side effects. 2. You can use this method to plan or avoid pregnancy.	1. It can take up to 6 cycles to build an accurate picture of your cycle. 2. You and your partner need to be committed to the method 3. It doesn't protect you from	Can be up to 98% effective (Family Planning Association) if taught well and instructions are followed closely.

	sexually transmitted infections.	
Contraceptive injections and implants (small plastic tubes implanted in the inner side of your upper arm) are long-term hormonal contraceptives. Injections and implants release progestogen into your body to prevent (or inhibit) ovulation. They also make the womb lining unreceptive to a fertilized egg, and affect your cervical mucus to make it very hard for sperm to get through.		
1. You don't need to remember to do anything regularly for these methods other than repeating them 2. They don't interfere with sex	1. Most women who have injections or implants find that their periods change or become irregular. 2. Other side effects include mood swings, weight changes, headaches, bloating, acne and breast tenderness. 3. Implants can be difficult to remove. 4. Once you have had a contraceptive injection, its effects cannot be reversed until the injection 'runs out', which can be up to 12 weeks. 5. They don't protect you from sexually transmitted infections.	Contraceptive injections and implants are over 99% effective (Family Planning Association).
Sterilization is a surgical procedure that is usually permanent, so it's only appropriate if you're absolutely sure you don't want more children or any at all.		
Male sterilization (vasectomy) A vasectomy is a minor operation that stops sperm travelling from the testicles (where sperm is made) to the penis. You can rely on it when a doctor has given the all clear after two sperm tests.		
1. A vasectomy doesn't interfere with sex and has no effect on sex drive or the pleasure felt at orgasm.	1. A vasectomy can't easily be reversed. 2. It doesn't protect you against sexually transmitted infections.	Around 1 in 2000 vasectomies fail (Family Planning Association).
Female sterilisation (tubal occlusion) Tubal occlusion is an operation that stops the egg from travelling down the fallopian tubes. It is effective from the time of the period after the operation.		
1. Female sterilisation doesn't interfere with sex and has no effect on sex drive or the pleasure felt at orgasm.	1. You will need to be admitted to hospital for the operation and you will usually need a general anaesthetic. 2. A tuba occlusion can't easily be reversed. 3. It doesn't protect you against sexually transmitted infections.	Around 1 in 200 female sterilisations fail (Family Planning Association).

Source: WHO Modern Contraceptives 2013

2.3.1 Benefits of Modern Contraceptive Methods

Promotion of family planning and ensuring access to preferred contraceptive methods for the youth is essential to securing the well-being and autonomy of women, while supporting the health and development of the country. When the youth are empowered with adequate information on types of modern contraceptives available they can make informed choices on what method to use in case they are sexually active. This will help them delay pregnancies and other risks of health problems and death from early childbearing. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion (WHO, 2013).

The use of contraception among sexually active youth can prevent unwanted pregnancies, which contribute to the world's highest infant mortality rates. Research has shown that infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

Modern contraception reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV. Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. However, if the youth are empowered on the benefits of modern contraceptives then they can overcome these risks. Modern contraceptives offer the key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts (WHO, 2013).

2.4 Modern Contraceptive Uptake in Kenya

Contraceptives play a critical role in family planning and thereby controlling population growth, which remains a key pillar in the pursuit of economic and social development as well as in the achievement of Millennium Goals 4 and 5 (Kenya Ministry of Health, 2010). Further, contraceptives have been instrumental in the fight against sexually

transmitted diseases (STIs), not least HIV/Aids. Many developing economies are characterized by rapid population growth that is partly attributed to high fertility rate, high birth rates accompanied by steady declines in death rates, low contraceptive prevalence rate and high but declining mortality rate (Oyedokun, 2007). Therefore the government has a critical role to play to ensure that they are nurturing a population that is empowered with information on contraceptive use and access hence leading to a healthy people who can contribute towards the country's development. However, this can be made possible if women can be persuaded to change their lifestyles, beliefs, habits and perceptions regarding modern contraceptives uptake. This will in turn increase demand and utilization of family planning services. Therefore this study will assess the contribution of the C-Word campaign towards uptake of modern contraceptives among women.

According to the United Nations Population Fund (UNPF, 1998) one of the goals of family planning and reproductive health programs is to ensure that women have the freedom to decide whether they want children, when and how many. Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care (Kenya Constitution, 2010).

Although the government has made some exciting advancements, more needs to be done to prevent unintended pregnancies. Empowering people, including youth, with knowledge about family planning and access to services will improve health and well-being and pave the way for a more prosperous Kenya.

In Kenya, less than half of married couples use modern family planning methods - condoms, pills, injections, implants and intrauterine contraceptive devices (IUCDs). The unmet need for family planning is high; one in four married women either do not have access to family planning services or lack information or motivation to use services (PSI Kenya, 2010). This clearly indicates the need for making contraceptive literature widely and easily accessible especially using modes of communication that most people can afford, understand and relate to. Since still many people fear talking about their sexuality, modes of communication that offer confidentiality should be employed. There is also

need of bringing family planning services closer to the people for instance establishing preventive sites near workplaces and residential places.

Although the use of modern contraceptive methods has risen steadily in Kenya, trends show a general increase in the use of short-acting methods and a decline in the use of long-acting and permanent methods (LAPMs). According to the 1993, 1998, and 2003 KDHS, use of Depo-Provera increased from 7% in 1993 to 15% in 2003. Injectables remain the most widely used LAPM and are the future method preferred by 47% of married women. During the same period among currently married women ages 15–49, female sterilization (bilateral tubal ligation) decreased from 5.5% to 4.5%, and IUD use declined from 4.2% to 2.5% (KDHS, 2003). This shows that a large number of people use short term modern methods as compared to permanent methods and that's why this study seeks to find out they type of modern contraceptives targeted by LVCT Health together with its partners in the C-Word Campaign.

According to the 2008/9 KDHS, while use of any FP method is 46%, modern methods account for 39%. Injectables and pills are the most popular modern methods, and account for 22% and 7% respectively. Traditional methods (rhythm and withdrawal) account for 6%. This shows that most people have now resolved to modern methods because they offer more security as compared to traditional methods. A lot of publicity has been carried out to inform the people about the available modern methods but the challenge is on increasing demand and utilization among women aged years 15 – 24 and that's why the purpose of this study was to assess how the C-Word Campaign contributes towards the uptake of modern contraceptives.

According to the Ministry of Health, high awareness and knowledge of FP methods has not translated into high contraceptive prevalence rates. Though 95% of the population reported knowledge of at least one method of FP, the contraceptive prevalence rate across the country is only 46% (KDHS, 2008/9). This rate is below the national target and there are huge regional variations. As a result information access on contraceptives by the people is essential for increasing their knowledge and awareness of the modern methods available. This eventually will affect their perceptions and behaviour and lead to increase in uptake of contraceptives and reduce unwanted pregnancies. It is important for

contraceptive providers to know the types of persons who are more or less likely to be reached by the media for purposes of planning programmes intended to spread information about health and family planning.

The Ministry of Health has a responsibility of improving the health of the citizens by narrowing the gap between service provision and demand for services. The ultimate goal is to reduce ill health by increasing the population's knowledge on preventable health measures and bringing quality services closer and more accessible to the beneficiaries by strengthening the current public health policies and interventions, while embracing new communication technologies to foster sustained economic growth. However, the Ministry has not done assessments on the communications campaign adopted by various modern contraceptive providers in the country on how they contribute towards high uptake of modern contraceptives and that's why this study seeks to find out how the C-Word campaign contributes towards demand and utilization of modern contraceptives among women in Nairobi.

Despite substantial declines in fertility and increases in contraceptive adoption over the past two decades, unmet need for family planning remains high in Kenya with about one in four married women having an unmet need for family planning. This represents a major reproductive health challenge given the government's commitment to "make available quality and sustainable family planning services to all who need them, in order to reduce the unmet needs for family planning". It also suggests a large potential for further increases in contraceptive use (KDHS 2008/9). This clearly indicates that there is need to use communication campaigns that appeal to change in lifestyles, persuade women to use contraceptives and that have a benefit attached to them. That's why this study is assessing the uptake of modern contraceptives among women based on the C-Word Campaign. The study seeks to find out how the campaign increases the demand and utilization of reproductive health services among the youth.

Unmet need for FP remains high. Of the 63% of Kenyans with unmet FP needs, 60% are in rural areas and 74% are in urban areas. The unmet need for FP among youth ages 15–24 is 30%, and there is a large unmet need for FP among people living with HIV (PLHIV). Approximately 55% of currently married couples who do not use FP say they

intend to use it in the future, and another 27% want to wait at least two years before the birth of their next child. As a result the youth need to be empowered with the right information on contraception use and where they can access them. Currently there is inadequate access to services by adolescents and youths and only 12% of health facilities provide youth-friendly services (Kenya Service Provision Assessment Survey-2004). This has contributed to the large unmet need for services compounded by a growing young population. Securing adequate, reliable supplies of essential contraceptives is important and this why this study focuses on the C-Word campaign whose study population are the youths.

2.5 Challenges towards Modern Contraceptive Uptake

While contraceptive use has grown in Kenya over the years, both unmet need for family planning and unintended pregnancies remain very high suggesting important barriers to effective contraception (APHRC Policy Brief No.26, 2011). In Africa, 53% of women of reproductive age have an unmet need for modern contraception. In Kenya the unmet need for FP among youth ages 15–24 is 30% (KDHS 2008/9), in Asia and Latin America and the Caribbean regions with relatively high contraceptive prevalence the levels of unmet need are 21% and 22%, respectively (WHO, 2013).In order to curb this problem contraceptive providers should make contraception information accessible to increase people's knowledge and awareness of the available modern contraceptive methods, which may eventually affect their perceptions and behaviour. It is also important to spread information about health and family planning using multiple channels to reach intended target group. The C-Word campaign targets the youth and as a result electronic, print and social media are most appropriate. Some of the contributing factors towards the high unmet need are fast growing population and shortage of family planning services (WHO, 2013).

An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include: limited choice of methods; limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people; fear or experience of side-

effects; cultural or religious opposition; poor quality of available services; gender-based barriers (WHO, 2013).

Socio-cultural beliefs and practices, gender dynamics, poor male engagement, and weak health management systems continue to impede the demand for and utilization of RH/FP services (KDHS 2008/9). Another barrier to effective communication intervention includes lack of Youth friendly services and facilities not available in most regions of the country (MOH 2012).This study intends to find out some of the challenges encountered by the youth towards accessing modern contraceptives and how they can be overcome.

2.6 Importance of Reproductive Health Communication Strategy

The RH Communication Strategy was implemented in accordance with the National Reproductive Health Policy and the National Reproductive Health Strategy (2009–2015). The strategy is managed and coordinated by the Division of Reproductive Health (DRH) of the Ministry of Public Health and Sanitation (MOPHS) at the national level, and by provincial and district health management teams at their respective levels. The overall purpose of this implementation guide is to ensure coordination and synergy of RH/FP Social and Behaviour Change Communication (SBCC) programming. It also ensures consistent SBCC on RH/FP by setting the stage for scale and impact. This guideline also defines a common measurement for success. The implementation guide thus outlines the roles and activities of the GOK and partners at national, regional, and county levels. Developed through a consultative process with the RH Communication Technical Working Group (TWG) and partners, the guide will assist stakeholders working in RH/FP to develop SBCC programs and activities that are aligned with the RH Communication Strategy (MOHPS 2010-2012).

The RH communication strategy outlines the components that any healthy communication campaign should have in order to ensure its effectiveness. Some of the components include being results oriented, evidence based, client centred, participation, benefit oriented, service linked, multi-channelled, technical quality, advocacy related, expanded to scale, programmatically sustainable and cost effective.

A number of GOK policy documents place a strong emphasis on the important role of SBCC in improving RH/FP behaviours and health outcomes. The list includes the National Reproductive Health Policy for Kenya, National Reproductive Health Strategy (2009–2015), RH Communication Strategy (2010-2012), Youth Reproductive Health Policy, FP guidelines for service providers, and Roadmap for Maternal and New-born Health.

This implementation guide is based on current implementation and coordination structures of the MOPHS, though these will change when Kenya's new constitution, with its focus on counties, is operationalized. The target populations for the guide are: provincial health management teams, district health management teams, APHIA Plus partners implementing RH/FP activities, coordinating agencies civil society organizations, including NGOs, CBOs, and faith-based organizations (FBOs), community networks and private providers.

2.7 Theoretical Framework

The section covered the specific theories upon which the study was based; the theories guided the actual study.

2.7.1 Theories

The UK government Choosing health: making healthy choices easier white paper (DOH 2004) identifies one fundamental and important problem with health messages: that it is not a lack of information in health, but that it is 'inconsistent, uncoordinated and out of step' (DOH 2004: 21) with the way the population live their lives. This suggests perhaps that despite efforts from health practitioners, some messages are not as effective as they could be. The Population Reference Bureau (2007) in the US suggests that human behaviour is the central factor in most leading causes of mortality and morbidity. They advocate that behaviour change strategies should be at the forefront of any attempts to reduce mortality and morbidity. Being able to predict behaviour makes it easier to plan an intervention (Naidoo and Wills 2000). Therefore the first stage of any communication campaign is to analyse the behavioural aspects of the health problem (Rice &Atkin, 2001).

In addition it is proposed that if we can understand factors that influence behaviour 'we will be in a better position to devise strategies and formulate methods that will achieve our health education goals no matter what our philosophy or what model we choose to follow' (Tones and Green 2004). Theory enables the practitioner to predict the outcomes of interventions and the relationships between internal and external variables. Underpinning communication in health promotion should be an understanding of how and why people change their behaviours and at what point of intervention it is best to target a message. This allows identification of the actions needed to change that behaviour and highlights the pathways of influence that hinder (or promote) that behaviour.

This study selected two types of theories. The cognitive and stage step theories. Cognitive theories provide "continuum accounts of behaviour", (Rutter & Quine, 2002).They propose that a certain set of perceptions or beliefs will predict a behaviour. The theory of planned behaviour (TPB) will be discussed and applied to the adoption of contraceptive use and awareness among the youth. Stage step theories assume that the individual is not on a continuum but at a "step or stage". Each stage on the model is a step ahead towards attaining the desired behaviour. The individual goes through a process of change which involves a series of stages (a cyclic or literal series of steps). This study embraced the theory of process of behaviour change (PBC) and its application to the context of contraceptive use and awareness. These two theories were selected because of their suitability and clear link towards communication of health messages based on understanding people's beliefs, attitudes, knowledge levels, religion and cultural orientation.

2.7.2 The Theory of Planned Behaviour (TPB)

This theory is a modified version of Theory of Reasoned Action (TRA) by Ajzen and Fishbein (1980). What was added is the variable of "perceived behavioural control". TRA explains that any intervention attempting to change behaviour should focus on beliefs .As a result for C-Word campaign to successfully influence youth to adopt the use of contraceptives it should focus on their beliefs. However, later there were arguments that

behaviours are not under “violational control” leading to the revision of the model and expansion to include “perceived behaviour control” (Rutter and Quinne, 2002).

TRA was revised to the Theory of Planned Behaviour (TPB) (Ajzen, 1991). TPB focuses on beliefs of the individuals and behavioural control which is a determinant of behavioural intention and behavioural change. According to TPB the closest determinant of behaviour is the intention to perform or not perform that behaviour.The main determinant of behaviour is based on the person’s intention to perform that behaviour. Intention is determined by three factors which include the attitude to the behaviour. This involves the balancing of the pros/cons of performing the behaviour or the risks/rewards they associate with that choice. The youths weighing the risks of not using contraceptives and the rewards for using then they make a choice.

Subjective norm involves social pressure from significant others, for example peers, media or family. Other youths who are already using contraceptives share the experience with others, messages from the advertisements on electronic media of the C-Word campaign.

Under perceived behavioural control the perception that the person has about their ability to perform the behaviour. Through information empowerment from the messages on electronic media concerning the C-Word the youths feel they could use contraceptives in order to take charge of their sexuality.

The more positive the attitude, supportive the subjective norm and higher the perceived behavioural control and the stronger the intention the more likely it is that a person will perform that behaviour. This theory has been widely applied in the context of understanding and predicting behaviour. Hence it can be used to design contraceptive messages that promote usage, demand for and utilization of family planning services.

2.7.3 Process of Behaviour Change (PBC)

The Population Communication Services/Centre described this theory for Communication Programmes (2003, U.S.A). It explains that communication is a process where people move between stages of the process of behaviour change framework.

In the PBC people move through a number of steps. In pre-knowledge the person is unaware of any risks or problems associated with their behaviour. At this stage the youth is not aware of any modern contraceptive method and of any need to use contraceptive because they have not been exposed to contraceptive information. The next step is knowledgeable when a person is aware of the problem and of the risks attached to their behaviour. At this step the youth is aware that by using contraceptives they may reduce chances of contracting sexually transmitted diseases and unwanted pregnancies. They now know the various methods available and their effectiveness. Then the person approves and becomes in favour of changing their behaviour. This step is when the youth is in favour of using modern contraceptives.

The other step involves intention when a person is intending to take action to change their behaviour. This step is when the youths want to change their behaviours and intends to start using a certain modern contraceptive method, which they are comfortable with. They then start practicing the intended behaviour is being practiced. At this point the person starts using a particular contraceptive method. Lastly they start advocating. The new behaviour is being implemented and the youth advocates that behaviour to another. The youth has been using a certain contraceptive method over a period and is advocating the behaviour to her friends.

Depending on what stage the youth is at on the PBC framework different messages are designed for them for communication. A person moves upwards towards the final goal of using contraceptives.

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the procedures that were used in conducting the study. The chapter offers the research site, target population, research design, sample size and sampling procedures for the study. It also discusses the data collection procedures, data analysis and presentation, validity and reliability of research instruments and ethical considerations.

3.1 Research Site

The study site was LVCT Health which is located at Hurlingham in Nairobi County. Purposive sampling was used to select Nairobi region as the study site since it's where LVCT Health's headquarters is located. The region has an estimated 80 employees. It was formerly known by the name Liverpool VCT Care and Treatment. It also has a training institute at Kilimani business centre in Nairobi and other branches in Kisumu and Embu. It has five sites in Nairobi where they offer family planning, HIV counselling and other reproductive health services. The sites include Nairobi deaf which is located at Commerce House in Nairobi CBD, Githurai VCT located in Githurai; KU-shewa 4 located inside Kenyatta University, Sokoni in Sokoni Arcade and at Hurlingham inside the LVCT Health premises.

3.2 Target Population

Orodho (2005) defines population as all the items or people under consideration. For this study, the target population are women of ages 15 -24. Evidence showed that among all sexually active women of reproductive age, the unmet need and non-use of family planning (FP) is highest among women aged 15-24 years, and the total demand for FP services is at 71.1% among married women compared to only 16.4% among unmarried women (PSI Kenya, 2010). Also the C- Word Campaign targets women of this age bracket to change their behaviour and demand levels for contraceptives use in order to prevent unwanted pregnancies and diseases. The unmet need for FP among youth ages 15–24 is 30% (KDHS 2008/2009). Contraceptive use is a dynamic process; women initiate and stop contraceptive practice in response to changes in their own circumstances

and in their social and health environment and they choose different methods at different points in their lives. Thus, the contraceptive prevalence and method mix at any given point in time is the result of a whole series of decisions made by individual women to start contraceptive use, stop use, restart use, and to choose one method over another one (KDHS, 1998).

3.3 Research Design

The study used descriptive design to assess the impact of the C-Word Campaign on the targeted population. It will help collect information on the women's knowledge levels on contraceptive use, behaviours, challenges they face in accessing contraceptives and their opinions. Descriptive design is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals (Orodho,2003).It can be used when collecting information about people's attitudes, opinions, habits or any of the variety of education or social issues (Orodho and Kombo,2002).Therefore a descriptive design provided an accurate target population characterisation and analysis.

3.4 Sample Size and Sampling Procedures

3.4.1 Sample Size

The study used 45 participants to obtain required data for the study.

3.4.2 Sampling Procedures

Sampling is a process of selecting a number of individuals or objects from a population such that the selected group contains elements representative of the characteristics found in the entire group, (Orodho and Kombo 2002). Sampling is important because one can learn something about a large group by studying a few of its members thus saving time and money. In this study the sample size consisted of 45 participants who were obtained using purposive sampling. In purposive sampling the researcher purposely targeted a group of people believed to be reliable for the study. The researcher selected select 20 girls from Kenyatta University in Kahawa, Kasarani District and another 20 from Kahawa Christian Secondary School which is also in Kasarani District. These girls visit the LVCT Health preventive site within Kenyatta University that offers free counselling and reproductive health services to the University students and Secondary schools nearby. Also in the site the nurses were promoting the C-Word campaign. The 40 girls

were aged between years 15-24 and the other 5 respondents represent LVCT nurses in charge of administering family planning services in Nairobi region. Thus, provided a rich case for in-depth analysis related to the research questions.

3.5 Data Collection Procedures

The study utilized both primary and secondary data. These data were both numerical and textual data. The study used qualitative data collection techniques, where the researcher applied interview schedules to collect data from key informants and interview guides to collect data from the study population.

3.5.1 Key Informants Interview

In-depth interviews were employed in data collection using an interview schedule. Key informant interviews were of a conversational style rather than a formal question answer format (Campbell *et al*., 1999). Interview method, as stated by Strauss & Corbin (1990), enables striking of rapport with the participants thereby enabling the researcher to easily win their trust. This in effect becomes a necessary ingredient for the participants to freely express themselves and also enables both verbal and nonverbal aspects of communication from the participants to be captured (Ndeti, 2013). This in turn makes it possible for holistic capturing of the responses from the sampled participants (King & Horrocks, 2010).

In this study, five key informants were purposively selected and interviewed for about one hour each. These informants include: the Lvct nurses in charge of delivering reproductive health services in the five preventive sites in Nairobi. The researcher started by establishing rapport with each informant. She then provided information on the issues that were to be covered during the interview. These included the youth's knowledge and understanding of contraception, the youth's perceptions of risks of not using contraceptives if they are sexually active and whether the C-Word campaign contraceptive messages contributed to behaviour change. The interviews were recorded to enable the researcher to listen to the flow of discussion and take note of the words that were used by the informants. The researcher asked every informant the same questions, as this enhanced reliability

3.5.2 Focus Group Discussions

Focus group discussions were used primarily to investigate the normative aspects of behaviour. They were used in the study to explore the ways in which the youths interact in their discussions and extent of agreement of opinions, beliefs, attitude and norms (Campbell *et al*, 1999). The advantage of these group discussions is the greater breadth of ideas, opinions and experiences that may be expressed by participants. This study engaged four focus groups of 10 students each in the following age brackets: 15-16, 17-18, 19-21 and 22-24. The participants were sampled purposefully based on their visiting the LVCT preventive site that is promoting the C-Word Campaign. In total, 40 students participated in the focus group discussions.

Purposive sampling was also used to select participants based on certain criteria like visiting the preventive site more than once and other relevant characteristics like familiarity with each other. Familiarity reduced initial tension or embarrassment (Ndeti, 2013). Each discussion took between 45 -60 minutes and was recorded. To direct the discussion, an interview guide was used as a tool of data collection. The researcher was the moderator to ensure that all the students in the group got ample time to contribute and express themselves freely. Issues that were covered in the focus group discussions included meanings and beliefs associated with contraceptives, how discussions with peers, parents and health personnel generated knowledge about the youth's understanding of modern contraceptives, perceived risks if sexually active and not using any contraceptive method and their understanding of the C-Word Campaign and how it contributed to behaviour change among the youths. The researcher only intervened to bring out salient issues, particularly if the participants didn't do so.

3.6 Data Analysis and Presentation

For data analysis, the study used thematic analysis, where related topics were categorized based on the study objectives and various subjects that came up during interview schedules and guides. The researcher developed a coding system based on the data that was collected and grouped the major themes under study and identified their associations. Since the study involved detailed data and in-depth details about knowledge levels,

beliefs, habits, challenges and opinions of the study population the narrative method was employed in data presentation.

3.7 Validity and Reliability

This refers to the accuracy and meaningfulness of inferences, which are based on the research result (Mugenda and Mugenda, 1999). Validity according to Borg and Gall (1989) is the degree to which a test measures what it purports to measure. For validation of the interview schedule, the researcher conducted a mock data collection exercise to five respondents. Upon getting responses, the feedback and process of the mock activity will form the basis for refining the data collection tools. The pilot study helped to improve face validity and content of the instruments. As such, the researcher used member checking by seeking assistance from the supervisor in order to help improve content validity of the instrument.

Mugenda and Mugenda (1999) define reliability as a measure of the degree to which a research instrument yields consistent results or data after repeated tests when administered a number of times. To enhance the reliability of the instrument, a pilot study was conducted in two other universities and contraceptive providers' institutions which shall not be included in the main study. The aim of pre-testing was to gauge the clarity and relevance of the instrument items so that those items found to be inadequate for measuring variables were either discarded or modified to improve the quality of the research instruments.

This ensured that the instrument captured all the required data. The procedure for extracting an estimate of reliability was obtained from the administration of Test-Retest reliability method which involved administering the same instrument twice to the same group of subject with a time lapse between the first and second test. According to Mugenda and Mugenda (1999) a coefficient of 0.80 or more simply shows that there is high reliability of data.

The researcher also examined the content of the interview questions to establish their reliability. This helped exclude irrelevant questions and unnecessary information.

3.8 Ethical Considerations

Research ethics are the moral principles that guide research from its inception through to its completion and publication of results, (Economics and Social Research Council, 2005). Ethics embody individual and communal codes of conduct based upon adherence to a set of principles which may be explicit and codified or implicit and which may be abstract and impersonal or concrete and personal (Zimbardo, 1984).

The respondents were assured that strict confidentiality would be maintained in dealing with the identities and shall take reasonable measures to protect subjects psychologically. The researcher accepted individual responsibility for the conduct of the research and as far as foreseeable, the consequences of the research. Also the researcher fully explained the research in advance and briefed the participants afterwards about the results. All participants were asked to consent to audio recording of their discussions.

CHAPTER FOUR
DATA ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter deals with the findings of the research, the interpretations and discussions in relation to the objectives of the study. Data was obtained through conducting key informant interviews and focus group discussions. The data were analyzed to assess the uptake of modern contraceptives among young women in the research site based on the C-Word campaign.

The data was obtained from conducting a total of five key informant interviews, which comprised nurses in the five preventive sites of LVCT Health. More data was collected from four focus group discussions conducted in Kenyatta University and Kahawa Christian Secondary School.

The findings have been organized thematically into four key areas according to research objectives on knowledge levels of contraceptives among the youth, types of modern contraceptives and providers' knowledge, challenges of accessing contraceptives and knowledge of C-word campaign, its role of communicating and as an intervention on increasing contraceptive prevalence and social behaviour change.

4.1 Knowledge levels of contraceptives among the youth

The first objective of this study was to establish the knowledge levels of contraceptive use among the young women. It was important to understand their common-sense knowledge about contraceptives and there ways of protecting themselves from risks of not using them. This includes the various definitions they give, the meaning and understanding, the types of contraceptive types they know of and ones they are using and the beliefs, myths and norms associated with contraceptives. From the theory of planned behaviour perspective, a behavioural performance is primarily determined by the strength of the youth's intention to know about the different types of contraceptives and choose one that suitably serves their immediate need. Intention to use a certain contraceptive method is a function of attitude toward the behaviour and the influence of the social

environment, which refers to peers, parents, teachers, media and many more. Information from the key informant interviews indicated that most youth are still in school and they don't want to fall pregnant since they are sexually active. Therefore, they visit the Lvct clinic in order to get advice on what method to use. Attitude towards using contraceptives is determined by the youths' belief that contraceptives will protect them against unwanted pregnancies and sexually transmitted diseases.

Information from the focus group discussions indicated that participants had a basic knowledge and understanding of contraceptives. Contraceptives were defined as "medicine taken to prevent unwanted pregnancy and sexually transmitted diseases, ways of preventing early pregnancies and its consequences for instance abortion, products used to prevent unwanted pregnancy and sexually transmitted infections, things that can be used internally or externally to avoid pregnancy and devices used to prevent pregnancies". The link between contraceptives and unwanted pregnancy was common.

This study found that students had heard about contraceptives through various sources. Below are some of the responses from the focus group discussions.

Q: What is the source of your knowledge on contraceptives?

P3: I heard from, guidance and counselling sessions, peers, primary school teaching and social media

P2: I heard from *mabeshte* (friends) and my mum

P1: I read in books, course work, friends *na pia* (and) church

P4: I received information from a hospital, Internet sites and media campaigns like the C-Word.

The participants attributed their source of knowledge to various sources which included friends, guidance and counselling sessions at school, reproductive health topic taught in primary and secondary school, social media, internet sites, religious leaders and hospitals. The friends were mentioned as one of the common sources of information by most of the participants. This is supported by Oriakhi & Okoedo-Okojie (2013) who observed that sources of information that are easily accessible, cheap and user friendly are preferred. Even though they had received information from other sources too but they tended to

believe that which came from their friends and comply with their friends wishes. Social norm is determined by what a person's normative belief about what others think she should do and by individual's motivation to comply with those people's wishes (Glanz *et al*., 1990).

During the focus group discussions the students expressed various myths attributed to contraceptives and how they affected their choice of various methods.

Q: Which myths, beliefs and norms do you associate with contraceptives?

P5: I fear contraceptives…my mother told me they can lead to giving birth to children with abnormalities especially the injections

P3: If you use contraceptives it translates to you will engage in sex anyhow, they make you immoral and to lose control (laughter).

P2: I can't use the coil because I have heard stories that it causes infertility and ectopic pregnancies.

P4: Used to believe that pills cause weight gain after using them but have reading books I changed my perception.

P1: I heard that the coil can burst hence one could get pregnant. So I avoid them just in case there is some truth.

P6: Can you imagine I am using the implant (Norplant), I had it inserted in January this year, since then my life has been hell….I used to weigh 73kg but now am at 56 kg, I have been bleeding for the last 9 months, lost appetite something that has never happened to me since I used to have a great appetite. I started hating men and even broke up with my boyfriend because of low libido. This is a real experience so for me I think implants are terrible methods. As a matter of fact I have come to have it removed. (Sigh).

P9: I heard that the male condom causes cancer on the male organs and reduces pleasure and satisfaction.

P8: The pills cause barrenness and abnormal spotting.

P7: I heard that continuous use of emergency pills causes pregnancy.

From the participants responses it attests that there is still a lot of misconceptions of various methods. This can only be rectified by making information on contraceptives widely accessible, conducting more focus group discussions in schools and universities and educating the students on the characteristics of the various methods to enable them make decisions on the method suitable for them. Studies carried out by PSI Kenya, 2010 indicated that the discussion and dissemination of information about contraceptives remains low in Kenya. As a result the government and contraceptive providers should ensure that information is easily and widely accessible in order to demystify the numerous myths, beliefs and norms surrounding contraceptives.

From the focus group discussions the participants shared that the methods they used mostly were the emergency pills, condoms, daily oral pills and injections. One of the nurses added that some of the myths and beliefs the youth had included worry about infertility, miscarriages, gradual reduction of libido and ectopic pregnancy. He also pointed out the following:

> *"Most of the students want to prevent unwanted pregnancies, so when they come to the site we counsel them on the various methods. Majority use contraceptives secretly. They prefer methods that cannot be noticed by their parents, for example the emergency pills, condoms and injections. However, they mostly ask for the emergency pill because they want to have unprotected sex and at the same time keep safe from pregnancy".*

The nurse expressed that most girls visit the site mostly when they are in trouble, that is maybe they have indulged in unprotected sex so want emergency pills to prevent pregnancy. However, a few visited to get more information on contraceptives.

From the discussions it was noted that students understand that contraceptives prevent pregnancies which was their main concern. The emergency pills (morning after pills)was the most prevalent method because it helped prevent abortion due to unwanted pregnancy, no need to consult a health provider, could be bought at any pharmacy without a prescription and was safe for all women, even those who cannot use regular hormonal methods (www.cword.co.ke).

4.2 Types of Modern Contraceptives and providers knowledge

In Kenya use of modern contraceptive methods among women ages 15–19 is 4.9% and those of age 20 -24 is 23.6%,(PSI Kenya,2010 & KDHS 2008/9).As a result information access on contraceptives by the youth is essential for increasing their knowledge and awareness of the modern methods available. This eventually will affect their perceptions and behaviour and lead to increase in uptake of contraceptives and reduce unwanted pregnancies and transmission of sexually transmitted diseases.

During the focus group discussions participants said they had heard of various types of contraceptives but had limited knowledge on available authorized providers. The places they knew they could buy contraceptives from were limited to chemists, supermarkets, they could pick from their washrooms, condom dispensers in the school compound, Lvct clinic and VCT sites.

Q: What are modern contraceptives?

P6: I think they are better than *miti shamba (herbs)*

P4: Advanced methods, the new ones which are more scientifically proven and tested. They are safer and effective.

P5: Improved ways of preventing pregnancies and sexually transmitted infections.

P2: Methods *za kisasa* (new ones) like femiplan condoms.

P1: They are just contraceptives.

P3: The ones you get from hospitals.

The students had some understanding of what modern contraceptives referred to. The meaning attached was advanced, safer, more effective, good quality and portable. They actually knew of the modern methods, the challenge was in defining the term. As a result there should be easy access to contraceptive literature for in depth knowledge and empowerment. One of the key informants noted that students didn't understand modern methods in details, especially the implants and IUCDs.

Q: What types of contraceptive methods do you know?

P5: I know the injections, coil, condoms and emergency pills.am comfortable using condom. Actually the condom is the best because it prevents against pregnancy and diseases. However, I sometimes use the emergency pills just in case.

P2: I have heard of the condoms, injections and pills. I use the condom I can't afford getting pregnant. My mother always tells me "choose between a degree and a decent burial".

P4: I know of condoms, male pill and everyday pill. I wouldn't use implants because they are complicated. Later in life I may use injections. For now am using the condom because it prevents against pregnancy and infections. Also the condoms are readily available here at school.so no expenses.

P3: I prefer the long term methods for instance the injection and implants. I don't like something that I will have to take every day. However, for maximum protection I pair with a condom.

P1: I would rather abstain. I fear contraceptives. I think traditional methods are better for me. Am not ready to lose my shape.

From the discussion most students were comfortable with the short term methods. Some shared that they feared to use the long term methods for example the implants because their mother would know and that will cause trouble for them. Others argued that for the long term methods two parties should be involved to avoid problems in future when one gets to married and wants children. However, this argument can be resolved if the youth are provided with information about each method including advantages and disadvantages. This will help them make informed decisions based on facts and not myths and fears. It was also observed that the students were well informed about the condom and its advantages. That it serves a dual function of preventing against pregnancy and STIs including HIV/AIDS. Other advantages include no hormonal side effects, easily accessible to students and does not cause delay in getting pregnant in case one wants to. These findings are supported by the KDHS reports of 2008/9, which suggested that the youth aged 15 – 24 years had knowledge about condoms, and that one could use them for protection against pregnancy and sexually transmitted diseases.

Q: Do you know of some of the providers of contraceptive services?

P1: I think its hospitals.

P2: The Vct sites and clinics like this one here.

P3: Ngos, femiplan and shops

P4: Lvct clinic

From the responses the study observed that most students don't know of modern contraceptive providers. Some of them even though they had been visiting Lvct Clinic didn't know its name and that it was one of the major providers of contraceptive services in the country. They thought it was just a clinic. Therefore, there is need to educate the youth on the various authorized providers available in the country for greater access of services. This observation was coupled with one nurse who commented that most students don't know of providers thus buy contraceptives across the counter where they are not given any advice. They also learn about Lvct health by chance.

4.3 Challenges faced in accessing contraceptives

While contraceptive use has grown in Kenya over the years, both unmet need for family planning and unintended pregnancies remain very high suggesting important barriers to effective contraception, (APHRC Policy Brief No.26, 2011). In Kenya the unmet need for FP among youth ages 15–24 is 30 %,(KDHS 2008/9).

Q: What are the challenges you face in accessing contraceptives?

P3: I fear being seen buying a condom or even emergency pills over the counter, chemist or shop. It's so bad and embarrassing (laughter). It's kind of shameful and am scared of what others may think of me (laughter).

P1: I was scared at first about using contraceptives but later got confident after being told that our bodies are different.

P4: There is stigma surrounding the whole idea, I rather go buy it from a far place where no one will see me and know what am doing (laughter). It paints the picture of immorality.

P2: I would rather send a friend to buy for me.

P5: For me it's normal to buy a condom or pills. I don't see any shame in it.

P6: I fear I may become infertile or forget to swallow the pills then fall pregnant.

P7: There is the problem of financial challenges. Emergency pills are very expensive, not many girls can afford them all the time they are need. This contributes to high cases of unwanted pregnancies.

P8: Some staff administering contraceptives are unfriendly thus scare away the youth from going to buy.

P9: Some partners are uncooperative. The boyfriend does not want to use a condom. They say that it denies them pleasure.

P10: The condoms supplied freely along the streets in the university and washrooms are of poor quality. For me anything that is given free is substandard and that's how most girls end up pregnant. I rather go and buy the likes of durex but have my assurance of maximum protection. Also some students have suffered through using counterfeit pills. Most authorized companies where we could buy quality pills are far from school.

From the focus group discussions, it was observed that stigma made many girls shy away from buying contraceptives. Some participants also encountered problems agreeing on the kind of method to use with their boyfriends, who had limited knowledge on the various methods. Socio-cultural beliefs and practices, gender dynamics, poor male engagement, and weak health management system has continued to impede the demand for and utilization of RH/FP services, (KDHS 2008/9).

It was also observed that lack of youth friendly services and most of the facilities being far away from the school posed a barrier to effective communication intervention (MOH 2012). It is therefore necessary for Lvct Health and its partners, government, schools and other contraceptive providers to create more awareness about contraceptives and use more strategies to help remove the fear that surrounds use of contraceptives. Studies have shown that most youth are sexually active from an early age and prone to a lot of challenges and risks, (KDHS Report 2008/9).

One nurse noted that most students are sexually active and could like to prevent unwanted pregnancies but cannot access information. They are also limited by lack of money, cannot make informed choices and fear of parents or guardians knowing that they are using contraceptives.

4.3.1 Perceptions of effects of not using contraceptives among the youth

Perception is a measure of ones willingness to consider behaviour changes (Ndeti, 2013). When one is able to perceive the risks of not using contraceptives and yet they are sexually active it indicates one understands of the consequences of unprotected sex.

During the focus group discussions, participants said that the knowledge they acquired during social interactions with their schoolmates did not change much their perception and understanding of contraceptives.

Q: Do you perceive yourself to be at risk of getting pregnant and contracting sexually transmitted infections?

P2: If my friend tells me they got pregnant after using a certain method, that's bad luck for them, our bodies are different. Though I will be scared for sometime.

P3: God forbid! Such discussions with friends elicit fear, they make me to be careful for sometime but later again I go back to my routine. *Kila mtu ni tofauti* (everyone is different).Also sex is part of life you cannot do away with it (laughter).

P4: That's her, that's her body. For me it might be different. I will do my own investigation and then make a decision.

P6: (Laughter) I will *tulia* for sometime, what if it happened to me.I may change my behaviour for sometime and also change to another method.

P8: If they were using a long time method it will make me change to a different method but if they were using a short term method that's being careless. However, the risks cannot cause me to abstain…what will others think of me.

Tsasis & Nirupama (2008) have argued that it is important to understand how perception of risks is formed among the youth. This will help reduce the rates of teenage pregnancies and infections. The participants reacted to risks of not using contraceptives by simply saying "that was her, our bodies are different, God Forbid!" Some even commented that it was carelessness from the woman's part. One lady aged 20 years in second year summed it as below:

> *"As a woman you are supposed to be smarter than your jamaa (boyfriend), take control of your body, ensure you use maximum protection to avoid pregnancies. We are all having sex here at school and there is no way we can stop. Some friends lie that they used this method and it backfired when in reality they didn't use, they are covering for carelessness."*

4.3.2 Importance of contraceptives to the youth

Promotion of family planning and ensuring access to preferred contraceptive methods for the youth is essential to securing the well-being and autonomy of women, while supporting the health and development of the country. When the youth are empowered with adequate information on types of modern contraceptives available they can make informed choices on what method to use incase they are sexually active. This will help them delay pregnancies and other risks of health problems and death from early childbearing. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion, (WHO, 2013).

During focus group discussions, participants unanimously demonstrated understanding of the importance of contraceptives.

Q: Do you think contraceptive use is important?

P2: Very important. It helps one avoid unwanted pregnancies and STDs.for me am using both the three month injection and the pill for maximum protection.

P3: They are necessary to avoid abortions. A lot of girls are dying while procuring abortions by drinking concentrated juice or jik.Am using condoms to protect myself.

P5: Contraceptives prevent STIs, plan family and prevent pregnancies. It's good to love yourself so you could live longer.

P7: It's a necessity for the youth. Your studies will be affected incase you get pregnant.

One of the nurses added that:

> *"The youth's main worry is to stop or block possibility of getting pregnant. So with contraceptives they will protect them."*

Studies have also indicated that the youth are engaging in premarital sex.This early sexual debut exposed the youth to numerous health risks (KDHS, 2008/9).From the findings it is observed that most youth understand that the condom protects them from pregnancy and sexually transmitted infections. These findings are supported by the KDHS reports of 2008/9, which suggested that the youth aged 15 – 24 years had knowledge about condoms and that one, could use them for protection against pregnancy and sexually transmitted infections. The participants also argued that the condom was the only option of self-protection since they find it difficult to abstain (Ndeti, 2013).

4.4 Role of C – Word Campaign towards increasing contraceptive uptake

The C-Word (C for Contraceptives) BCC (Behaviour Change Communication) campaign was developed in order to address the low awareness and uptake of contraception among sexually active women aged 15-24 years. The campaign's objectives are to demystify the topic of contraceptives among young women and men aged 15-24 years as well as educate young women on the modern contraceptive choices available to them. Evidence showed that among all sexually active women of reproductive age, the unmet need and non-use of family planning (FP) is highest among women aged 15-24 years. Furthermore in the last 20 years, active and consistent national communications to create awareness and demand for family planning, (FP) has been insufficient; therefore there is a large cohort of young women who have never been exposed to FP messaging. (PSI Kenya, 2010). Therefore, this campaign hopes to reach out to the youth and impact on them by creating long term perceptions about risks of not using contraceptives. During the focus

group discussions participants said they were aware of the C-word campaign but had limited knowledge on previous campaigns on contraceptives for example the "*jipangie maisha poa*" and "*panga uzazi*".

Q: Have you heard about the C-word campaign?

P2: Yes this is the only campaign have heard about on contraceptives. I heard it in media advertisements, radio and at KU clinic.

P3: It's an awareness campaign for contraceptives among young people. I heard it from my friends and here at the clinic. I don't bother watching on TV since I already know about contraceptives and it's just any other campaign.

P5: I heard through various television channels. This campaign empowers the youth with information to help them take charge of their sexuality. This will help them prevent pregnancies and consequences. A parent can only support you and not the second mouth.

P6: Its creating awareness to the youth on contraceptives. *Tujichunge, Tujijue, wameetilia maanani (taken into consideration*)…youths are all over the place. I heard about this campaign on television, radio, newspaper and on whatsapp. It educate the youth on contraceptives and confiscate any myths.

During the focus group discussions, some participants said that they only knew about the campaign in a general way without mentioning much detail about it. They argued that the campaign was not very informative. They observed that the C-word messages were making very little impact, if any. According to them, young people continued to involve themselves in sex indiscriminately, in spite of information being passed across through the campaign. These findings were supported by the work of Ndeti (2013) who observed that the lack of in-depth knowledge and understanding of mass media campaigns may be based on limited memory of preventive initiatives and thus of the campaigns' low efficacy in changing the youth's attitudes and behaviour towards contraceptives.

LVCT Health receives feedback on the C-Word Campaign through the hotline 1190 which is free and also the youth can call it for more information. The hotline 1190 is advertised below contraceptives messages that are aired on Citizen Television, Nation Television, Kiss Television, Q television and Radio Jambo before and after prime time news. It is also advertised once monthly in the Insyder Magazine. Communication should be in such a way that it will give opportunity for the respondent or receiver to make a decision with regard to the message and to also seek clarification (Master, 2008).

Q: Have you called the hotline 1190?

P2: Am hearing about it now (laughter) maybe I will call when am in need.

P3: I didn't know about it. I only listen to the voices and not the text.

P5: It's in a small font size hence not visible. Have never called.

From the discussions from the participants it was observed that most students were not familiar with the hotline. This suggests lack of adequate publicity of the number and that students only use it when in need.

This observation was summed up by one of the nurses who commented that:

> *"Students only call the hotline when they have messed up and so need advice on what to do to prevent getting pregnant and getting STIs. They only call when in need".*

Not all contraceptive methods are appropriate for all situations and the most appropriate method of birth control depends on a woman's overall health, age, frequency of sexual activity, number of sexual partners, desire to have children in the future and family history of certain diseases. Individuals should consult their health care providers to determine which method of birth control is best for them. Some types carry serious risks, although those risks are elevated with pregnancy and may be higher than the risks associated with the various methods, (KDHS 2008/9).

The C –word campaigns targets to create awareness on short term methods which are more suitable for the youth. These methods include emergency contraceptive pills, everyday pills, 3 month injections and condoms.

Q: Do you know the type of contraceptive methods targeted by the campaign?

P1: I think they are targeting the condom because it's mostly available, cheapest and so most youth can afford it.Most of them cost kshs.20.00.

P2: I think it's the condom mostly because it's the easiest and cheapest method. It also protects against pregnancy and diseases.

P5: They target all types of contraceptives like the pills, injections, condoms and implants.

P8: They target a long term method because they say "mjipange".

The participants demonstrated understanding of some of the key methods the campaign was targeting. It came out that students had knowledge that the condom is a dual purpose method. However, some expressed challenges with their boyfriends who complained that it reduced sexual pleasure thus sometimes it was difficult to negotiate with them. This observation of uncooperative partners is supported by Ndeti (2013) who from his research found out that most youth who were in long term relationships did not see the need to tell a partner to wear a condom as this would imply not trusting his or her commitment to the relationship and fidelity. Further, he found out that girls were shy in negotiating condom use and their concern about meanings implied by this request. Condom is considered as the only option of self-protection since abstinence is difficult for the youth. However, they were uncomfortable with condoms since they reduced sexual pleasure.

These findings were affirmed by the nurses from the clinic who said:

> *"The C-word campaign is targeting the barrier methods which consist of the condoms and diaphragm. It has no side effect and is safe for everybody. Hormonal based contraceptives are not safe for young people because of the side effects. When students visit our site we counsel them and do a baseline screening in order to advise them on the suitable method for their bodies. The campaign is also targeting the emergency pills, everyday pill and 3 month injections."*

Ndeti (2013) suggested that much of the research had shown that the youth had high levels of knowledge about the transmission of HIV virus and were fully cognizant of the value of barrier contraception, such as condoms in preventing HIV transmission.

Participants in the focus group discussions observed that the C-word contraceptive campaign messages were making very little impact, if any. They argued that they were shallow in content and so need to be improved to clearly explain how to use the different methods, their advantages and disadvantages and emphasise on where to obtain more information.

Q: Do the C-word campaign messages have any impact in you?

P2: I learn from them but they don't change my behaviour. The messages of course show risks. I have a problem with the timing of the adverts because most of the time we are at school and only see them at night when at home with parents…this is even more uncomfortable (laughter).

P3: I think my behaviour is ok.It does not need to be changed. From the campaign messages I gain knowledge and am reminded of my responsibility to take control of my life. I wish they could mostly run this campaigns during weekends and holidays when we have time to pay more attention.

P1: The messages keep you on the know because they are repeated several times. You feel motivated to participate in the campaign through using contraceptives. Also they reach out to those who didn't know.

P5: The messages make me curious…what are they about. Will they affect me, keen on sexual life and change of sexual patterns. Though I change for a short time then go back to previous (laughter).

P6: From some of the characters in the advertisement you can relate it to the real life. For example the advert whereby partners are seated, then one lady says," let's go for family planning counselling" and one man declines by saying "contraceptives *ni story ya wanawake* (women issue)"then the lady tells him, "Jacky akishika ball(gets pregnant) you will also be affected" then he consents and they go.

The participants expressed dissatisfaction with the timing of the campaign adverts. A number of the advertisements were aired at a time when the students were in class.

One of the nurses pointed out that the c-word messages were simple in nature and could be easily understood by both literate and illiterate youth. They also address the behaviour of some but not all and only those with special interest are positively affected. Most youth receive the message, will not take it seriously, listen and then go on with their life. They do not appear inquisitive since they are always in a rush. Ndeti (2013) observed that contraceptive campaign messages can only have an impact if the youth are actively involved in the preparation process of the campaign. This would make them own the campaigns and also identify with them.

During focus group discussions participants expressed the need for the campaign to offer more comprehensive information about different contraceptive methods and demystifying of myths surrounding them. They also argued that the campaign should use more participatory approaches to address the youth for example face to face discussions. This finding was supported by Govender (2010) who suggested that instead of top down behaviour change communication, more participatory approaches were needed.

Q: What do you think should be changed about the C-word campaign to make it more effective?

P2: I find the messages so shallow. They talk about basic things when they should be giving us information on the different methods and bring out the risks, although the messages are simple and easy to understand. Therefore they should design detailed messages.

P3: They should use a language that attracts the youth's attention, for example sheng'. Give facts to clear misconceptions about emergency pills, implants and coils.

P4: They should use other platforms apart from the media to reach out to the youth. For example booklets with information on contraceptives, road shows, activations, focus group discussions, seminars, conferences ,talk shows in primary and secondary schools, colleges, universities, bashes, cultural days, visit youth in churches and talk to them. Also motivate youths to come for the talks by giving them tokens and snacks.

P6: Increase the font size of the hotline 1190.Also have the 1190 mentioned by the characters in the advertisement. The advertisements should emphasise on where to get more information.

Graffigna & Olson, (2009) observed that effective campaigns must speak the language of young people and be perceived to be "close" to their experiences, clearly reflecting young adults' daily problems. The youth like sheng' so campaigns should employ this language in order to reach out to the youth. One of the key informants commented as below:

> "*The campaign does not go further to demystify some myths and beliefs that the youth hold about some contraceptive methods. It should try to give facts concerning the various methods. The youth who are the target audience for this campaign are too busy and not giving us feedback to help us know what to improve. The campaigns so far is picking at a slow pace. Plans of reviewing it are in progress to ensure it creates a meaningful impact on the youth."*

From this discussion it is evident that for communication to be effective, right messages must be passed through the right channels, to the right audience and at an appropriate time. These observations are supported by Ndeti (2013) who posits that for behaviour change to occur, dissemination of right information through the right media is vital. He says that for a health message to be effective in changing behaviour, it should be targeted to a specific group rather than a general audience. The youth are still facing challenges towards access of family planning services or lack information or motivation to use services as observed by a study carried by PSI Kenya, 2010.This clearly indicates the need for making contraceptive literature widely and easily accessible especially using modes of communication that most people can afford, understand and relate to. Since still many youth fear talking about their sexuality, modes of communication that offer confidentiality and participation should be employed.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter contains a summary of key findings and conclusions with respect to the objectives of the study and gives recommendations for further research.

5.1 Summary

5.1.1 Knowledge levels of contraceptives among the youth

It is evident from this research that majority of the youth have a basic knowledge and understanding of contraceptives. This knowledge was about the meaning of contraceptives, definitions and types they know about. Contraceptives were defined as "medicine taken to prevent unwanted pregnancy and sexually transmitted diseases, ways of preventing early pregnancies and its consequences for instance abortion, products used to prevent unwanted pregnancy and sexually transmitted infections, things that can be used internally or externally to avoid pregnancy and devices used to prevent pregnancies". The link between contraceptives and unwanted pregnancy was common. Many issues continue to be a challenge to the youth who are the future leaders of the country especially teenage pregnancies and sexually transmitted diseases, (Kenya Demographic Health Survey, 2008/9).

This study found that students had heard about contraceptives through various sources which included books, friends, primary school and high school teachers, guidance and counselling sessions, lecturers, course work, mothers, social media, internet sites, Lvct clinic,C- word campaign, hospitals and religious leaders. The friends were mentioned as one of the common sources of information by most of the participants. Even though they had received information from other sources too but they tended to believe that which came from their friends and comply with their friends' wishes. Social norm is determined

by what a person's normative belief about what others think she should do and by individual's motivation to comply with those people's wishes (Glanz et al., 1990).

The study found that there are still a lot of misconceptions on various methods. Some of the myths included giving birth to children with abnormalities especially if using injections, contraceptives make one immoral and to lose control, the coil causes infertility and ectopic pregnancies, the pill causes weight gain, the coil can burst hence one can get pregnant, the implant causing loss of appetite, weight loss and low libido, the male condom causing cancer on male organs and reduces sexual pleasure and satisfaction, pills causing barrenness and abnormal spotting and continuous use of emergency pills causing pregnancy. Therefore, adequate information about the various contraceptives methods will help overcome the myths surrounding them. This will also enable them to develop a rational approach to protecting themselves from unwanted pregnancies and sexually transmitted diseases (STDS).In turn this will reduce the high percentage of teenage pregnancies which is at 18% and the unmet need for family planning among youth which stands at 30% (KDHS 2008/9).

The study also found out that the methods mostly used by the students were the emergency pills, condoms, daily oral pills and injections. During the focus group discussions it was noted that students understood that contraceptives prevent pregnancies which was their main concern. The emergency pills (morning after pills) was the most prevalent method.

5.1.2 Types of Modern Contraceptives and providers knowledge

The study found out that the students had heard of various types of contraceptives but had limited access and knowledge on available authorized providers. The places they knew they could buy contraceptives from were limited to chemists, supermarkets, retail shops, they could pick from their washrooms, condom dispensers in the school compound, Lvct clinic and VCT sites.

The students had some understanding of what modern contraceptives referred to. The meanings attached were advanced, safer, more effective, good quality and portable. They

actually knew of the modern methods but not in detail, however, the challenge was in defining the term. The study established that students knew of the following methods: injections, coil, condoms, emergency pills, male pill, everyday pills and implants. Some of the methods where students had limited knowledge were the implants, male pills and IUCDs.

From the focus group discussions it was observed that most students were comfortable with the short term methods. However, they also preferred the injections. It was also observed that the students were well informed about the condom and its advantages. That it serves a dual function of preventing against pregnancy and STIs including HIV/AIDS. Other advantages include: it can be stopped at any time, does not delay one from getting pregnant and it has no hormonal side effects (www.cword.co.ke).

An important finding shared by key informants and participants in focus group discussions was that most students had limited knowledge of modern contraceptive providers. That's why they result to buying contraceptives across the counter where they are not given any advice. They also learn about Lvct health by chance.

5.1.3 Challenges faced in accessing contraceptives

The study found out that most girls faced stigma that led them to shy away from buying contraceptives. Discussions on contraceptives were considered taboo because of the conservative society. Others encountered problems agreeing on the kind of method to use with their boyfriends who had limited knowledge on the various methods. It was also observed that lack of youth friendly services and most of the facilities being far away from the school posed a barrier to effective communication intervention (MOH 2012).

Another important finding was that most students are sexually active and could like to prevent unwanted pregnancies but cannot access information. They are also limited by lack of money, cannot make informed choices and fear of parents or guardians knowing that they are using contraceptives.

The study found out that the knowledge participants acquired during social interactions with their schoolmates did not change much their perception and understanding of contraceptives. The participants reacted to risks of not using contraceptives by simply saying" that was her, our bodies are different, God Forbid!" Some even commented that it was carelessness on the woman's part

From the focus group discussions participants unanimously demonstrated understanding of the importance of contraceptives. The study found out that most youth understand that the condom protects them from pregnancy and sexually transmitted infections.

5.1.4 Role of C – Word Campaign towards increasing contraceptive uptake

The study found out that students were aware of the C-word campaign but had limited knowledge on previous campaigns on contraceptives for example the "jipangie maisha poa" and "panga uzazi". They also knew about the campaign in a general way without mentioning much detail about it.

The study found out that most students were not familiar with the hotline 1190 which is toll free. The study also found out that the students demonstrated understanding of some of the key methods the campaign was targeting. It came out that students had knowledge that the condom is a dual purpose method. This was common with the key informants.

The study also found out that according to the students, C-word contraceptive campaign messages were making very little impact, if any. Participants argued that contraceptive campaign messages can only have an impact if the youth are actively involved in the preparation process of the campaign. This would make them own the campaigns and also identify with them.

The study found that students wished there was in-depth information about different contraceptive methods and demystifying of myths surrounding them. They also suggested that the campaigns should focus more on participatory approaches which involved face to face interaction and forums.

Effective campaigns must speak the language of young people and be perceived to be "close" to their experiences, clearly reflecting young adults' daily problems. The youth like sheng' so campaigns should employ this language in order to reach out to the youth.

This study found out that for communication to be effective, right messages must be passed through the right channels, to the right audience and at an appropriate time.

5.2 Conclusions

Contraception did not appear to be a new term to the participants. Participants from the focus group discussions acknowledged they had basic knowledge and understanding of them. They were defined as "medicine taken to prevent unwanted pregnancy and sexually transmitted diseases, ways of preventing early pregnancies and its consequences for instance abortion, products used to prevent unwanted pregnancy and sexually transmitted infections, things that can be used internally or externally to avoid pregnancy and devices used to prevent pregnancies". This indicated that they also understood the benefits of using contraceptives. For instance, the link between contraceptives and unwanted pregnancy was common and some of the negative consequences included dropping out of school, emotional and financial strain, abortion and maternal deaths. However, the challenge remains in helping the youth translate the knowledge they have about contraceptives into action. This involves having them increase their demand and utilization of them.

There were a lot of myths and beliefs surrounding various contraceptive methods. Most revolved around fear of being discovered by parents and peers that you are using them, stigma attached to contraceptives, that their use leads to immorality, side effects for example weight gain and loss, causing cancer, low libido and reduced sexual pleasure. The myths contributed greatly to the low demands and uptake. However, discussions from the focus groups revealed that religion did not affect the use of contraceptives. Campaigns should design contraceptive messages that demystify these myths and dispatch adequate information to empower the youth to make rational decisions on which method best suits them. Modern contraceptive providers should also create awareness to the youth through vising their schools, doing road shows, holding talk shows, using

favourite youth celebrities and focus group discussions. This will enable the youth to know about them and so can easily access their services which are more standard in comparison to going to buy contraceptives from over the counter and in shops where some products are counterfeit and they are not given any advice. The youth also are more responsive and active to forums where they can talk freely and are given small token for appreciation.

The findings also indicate that most youth use the emergency pills and the condom. However, there is need to educate them that the emergency pill should be taken within 72 hours after indulging in unprotected sex. Also it is just for emergency purposes and should not be taken more than twice in a month because of some of side effects. This will help the youth pursue other methods which have less side effects considering the emergency pill is expensive and not all students can afford it all the time. It costs between kshs.100 - 150.Some also use the injections which is a long term method. Findings from the 2008/9 KDHS also suggest that the injection is one of the most popular modern methods among the youth.

The findings of this study also suggest that students face a lot of challenges towards accessing contraceptives and this has greatly contributed to high cases of pregnancies and sexually transmitted infections. Some of the challenges like fear of using a certain method, unfriendly shop or chemist attendants, fear of being seen buying a condom or a pill, uncooperative boyfriend, scarce places where one can buy from in the school and outside the school and counterfeit products. These are challenges that can be overcome through the c-word campaign and other contraceptive campaigns giving information on the different methods, demystifying the facts by visiting schools and talking to the youth, holding demonstrations on how to use each method, making information about their services easily available and bringing their services near learning institutions. Further, enlightening the public about the importance of contraceptives to the young people in order to overcome use of disapproval and harsh language to the youth when they are buying the products.

The perception of the participants was that contraceptive use was linked to pregnancy and so each one looked for ways of protecting themselves**.** The knowledge they acquired during social interactions with their schoolmates did not change much their perception and understanding of contraceptives. The participants argued that if one fell pregnant that was because they were careless and that their bodies were different. This shows that most young people do not consider themselves at risk because they believe they are smart enough and most feel their behaviour is good and don't need to change. Therefore, there is need to help them understand on the importance of learning from each other's experiences and mistakes in order to avoid falling into the same.

Participants demonstrated a general understanding of the c-word campaign. Most of them didn't know of any other previous campaign on contraceptives. However, they expressed discontent with its lack of demystifying most myths on the various methods, the content was not exhaustive, the media that was used, the toll free number 1190 was not visible, the timing and the language used. For the campaign to be effective in reaching out to the youth sheng' language should be employed because it's the one the youth like using and identify with. The adverts should give more information in their websites and booklets on the advantages and disadvantages of each modern method. The campaign should also be broadcasted through other platforms which are more appealing to the youth like road shows all over the country, actual visits to schools especially during cultural days, sports days or when there is an activity at school, celebrity advertisements and focus group discussions. Also the adverts should be aired on weekends and holidays when most youth are at home and not busy. More channels should be embraced to ensure wide publicity of the content so as to reach youth in rural areas whom some don't have televisions or radios, for example posters, billboards, the church, focus group discussions and road shows.

Contraceptive campaign messages can only have an impact if the youth are actively involved in the preparation process of the campaign. This would make them own the campaigns and also identify with them. The youths tend to listen more to information from their peers. When the youth are involved in forums like focus group discussions and seminars it will be easier for them to change their behaviour rather than when they listen

to information from mass media. Through the numerous views of the focus group participants and key informants, this study has given voice to the growing youth in this country that have the potential to engage in Kenya's development challenges. This is a group of young people who have expressed boldness and willingness to speak about a subject that is considered taboo in order to contribute to social change.

The study has contributed to literature that emphasizes the role of the C-word campaign towards increasing contraceptive uptake among young women. The findings indicate the need to empower young women with adequate information and overcoming the challenges they encounter to enable them be in a position to use that knowledge for a behavioural response. For effective behaviour change communication (BCC), tailored messages should be developed and approaches to develop promote and sustain individual, community and societal behaviour change. Messages that appeal to the youth should be employed.

5.3 Recommendations

Based on the findings of this study, the following recommendations were made. First, it is important for the planners of the C- word campaign to understand the myths, belief and norms that the youth associate with contraceptives then be able to design contraceptive messages that talk about them and clearly demystify any false communication that has been existing. Most students fear using contraceptives because of the negative stories they have heard from friends, parents and literature. In a setting beset with numerous challenges ranging from social and cultural factors to system and implementation challenges, effective communication is critical to facilitate shifts in attitudes, beliefs, perceptions and behaviour which ultimately bring about social change. Also communication initiatives will only have a chance of succeeding only when situated within the cultural context of the target audience (UNAIDS, 1999).Kunda and Tomaselli, 2009 reiterate that "Effective health communication interventions depend on understanding the knowledge, attitudes and practices of people from given cultural vistas". Therefore, any intervention focusing on behaviour change has to design

communication messages that can easily be understood and that are not biased. It is important to understand the target audience's characteristics.

Second, Lvct health and its partners should ensure that they give enough information about the types of contraceptives they offer and even give out booklets to help the youth make rational decisions on their contraceptive choice. There should also be information on the location of their premises so the students can visit them for quality services. This will reduce cases of students having to buy counterfeit contraceptives from shops or unregistered dealers and shortages. The youth should also be educated on the various major contraceptive providers in the country and the services they offer. This will overcome the challenge of poor access to the services.

Third, in order to overcome the challenges the youths face like fear, stigma, lack of friendly youth services and uncooperative boyfriends it is important for the Ministry of Education to introduce more compulsory topics, subjects and courses in contraceptives and reproductive health in primary, secondary ,colleges and universities. The subjects should also be examinable to make the students take them seriously. Most youth argue that the campaign does not involve them adequately in planning, design, implementation and evaluation. This leads to the youth disliking the messages. Therefore, there is need to listen to what the youth think, say and believe in order to come up with appropriate interventions.

Fourth, involving them in road shows, talk shows, activation campaigns, focus group discussions, seminars and conferences can ensure the participation of the youth in contraceptive campaigns. Here they may have the opportunity to reveal their own feelings and as a result own the development of contraceptive messages for the c-word campaign.

Finally, the c-word campaign should be reviewed by Lvct Health and its partners so as to ensure it achieves positive impact on the youth. Most youth expressed a lot of discontent with its shallowness of content, lack of demystifying of beliefs, language choice and timing.

5.3.1 Recommendations for further research

This study had a limited scope. More research needs to be done to enlighten people on some outstanding concerns and address new beliefs. Some of the possibilities for future research are as follows:

(i) There is need to carry out further research to establish how psychosocial factors seem to contribute to the efficacy of contraceptive knowledge and information and how they lead to demand for contraceptives.

(ii) It is worth noting that this study was limited to students from Kenyatta University and Kahawa Christian Secondary School which are both located in Nairobi region. There is room to study other students in rural areas.

(iii)This study focused on only one intervention that is the C-Word Campaign. Future studies could be conducted on other campaigns.

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APPENDICES

Appendix 1: Introduction Letter

Edith Mecha,

P.O Box 10069 - 00100,

Nairobi, Kenya.

Re: Participation in Research

Dear Sir/Madam,

I am a student pursuing a Master of Arts in Communication Studies at the University of Nairobi. I am conducting a research on an Assessment of the Uptake of Modern Contraceptives among Women in Nairobi County: A study of the C-Word Campaign. It should take 30-45 minutes. Your participation is of utmost importance to me.

Should you have any queries or comments regarding this research, please contact me via 0701539324 or email edithkwmbk@gmail.com.

Yours sincerely,

Edith Mecha

University of Nairobi

Appendix 2: Focus Group Discussion Guide

Note: For each group, the age and educational level (i.e., which class and year they are in) of the participants will be written down.

Knowledge of Contraceptives among the youth

1. What are contraceptives? (*Probe for the various definitions they give for contraceptives? What is the meaning and understanding of what contraceptives is? What is the source of their knowledge? What are some of the contraceptive types you know of? Which one do you use?*)

2. Which beliefs, norms and meaning do you associate with contraceptives? *(Probe for specific discussions that generate knowledge about contraceptives. Who brings up these discussions and who controls them?)*

Modern Contraceptive providers' knowledge

3. What are modern contraceptives? (*Probe for what they understand by this term, what meaning do they attach to them?)*

4. Do you know some of the providers of modern contraceptive services? (*Probe for information on their knowledge of the various modern contraceptive providers, Have you heard of LVCT Health? what type of contraceptives do they offer? what are the challenges faced in accessing them?*)

5. What type of contraceptive methods do you know? (*Probe information on their knowledge of types of contraceptives, which methods are they comfortable with? Short term and long term methods? Which methods prevent transmission of sexually transmitted diseases?*)

Perception of effects of not using contraceptives among the youth

6. How does the knowledge and understanding you acquire during interactions with your friends affect your perception of effects of not using contraceptives? (*Probe for their access to modern methods of contraceptives, challenges they face in accessing modern contraceptives, delay in sexual debut, support for safe sex to prevent unwanted pregnancies, abstinence*)

7. Do you think contraceptive use is important? (*Probe for information they have received that can guide them to take precautions against unwanted pregnancies and sexually transmitted diseases?)*

The role of C-Word campaign in increasing contraceptive uptake among the youth

8. Awareness and knowledge of contraceptive campaigns (*Probe about their content, what messages and meaning they pass across, reaction to campaigns, how campaigns have affected or changed their behaviour on contraceptive use (if at all)*

9. Have you heard about the C-Word campaign? (*Probe for their knowledge and understanding of the C-Word Campaign, What is their source of knowledge about the C-Word campaign, Have they called the hotline 1190 to get more information on contraceptives? How campaigns have affected or changed their behaviour on contraceptive use (if at all*)

10. Do you know the type of contraceptive methods being targeted by the C-Word Campaign? (*Probe for information about their knowledge of modern contraceptive methods being targeted by LVCT Health for the C-Word Campaign*.)

11. Do contraceptive messages used on the C-Word Campaign conform to the understanding and knowledge you have of the risks of not using contraceptives in case you are sexually active? (*Do contraceptive messages address their behaviours? What are their beliefs, norms, habits, language? Probe for information on how they view contraceptive messages*.)

12. Are contraceptive messages on the C-Word Campaign packaged and communicated in an easily understood manner? (*Probe for information about language used in the C-Word Campaign, the behaviour and lifestyles of young people and how these influence acceptance and rejection of the messages,how can they be improved to reach the youth more effectively*?

Thank you very much for your participation.

Appendix 3: Interview Schedule for Key Informants

Note: For each interview, the preventive site location and designation of the interviewee will be written down.

Knowledge of Contraceptives among the youth

1. Do the students that visit the preventive site have knowledge about contraceptives? (*Probe: What type of knowledge and understanding about contraceptives do they have? What is the source of their knowledge? What are some of the contraceptive types they know of? Which one do you use?*)

2. Which beliefs, norms and meaning do the students associate with contraceptives? *(Probe for specific discussions among the youth about the risks of not using contraceptives, the myths and beliefs that students associate with contraceptives. What is there understanding about contraceptives?)*

Modern Contraceptive providers' knowledge

3. Do the students understand the term modern contraceptives? (*Probe for what they understand by this term, what meaning do they attach to them?)*

4. Do the students know some of the providers of modern contraceptive services? (*Probe for information on their knowledge of the various modern contraceptive providers available, have they heard of LVCT Health? Do they know the type of contraceptives they offer? Do you face any challenges towards accessing them?*)

5. What type of contraceptive methods do the students know? (*Probe information on the students knowledge of types of contraceptives, which methods are they comfortable with? Short term and long term methods? Which methods prevent transmission of sexually transmitted diseases?*)

Perception of effects of not using contraceptives among the youth

6. How does the knowledge and understanding the students acquire during interactions with their friends affect their perception of effects of not using contraceptives? (*Probe for their access to modern methods of contraceptives, challenges they face in accessing modern contraceptives, delay in sexual debut, support for safe sex to prevent unwanted*

pregnancies, abstinence. Have they received information that can guide them to take precautions against unwanted pregnancies and sexually transmitted diseases?)

7. Do the students think contraceptive use is important? (*Probe for information they have received that can guide them to take precautions against unwanted pregnancies and sexually transmitted diseases?)*

The role of C-Word campaign in increasing contraceptive uptake among the youth

8. Awareness and knowledge of contraceptive campaigns (*Probe about their content, what messages and meaning they pass across, reaction to campaigns, how campaigns have affected or changed students behaviour on contraceptive use (if at all)*

9. Have the students heard about the C-Word campaign? (*Probe for the students' knowledge and understanding of the C-Word Campaign, What is their source of knowledge about the C-Word campaign, Do students call the hotline 1190 to get more information on contraceptives? How has the C-Word Campaign affected or changed students behaviour on contraceptive use (if at all*)

10. What type of contraceptive methods are being targeted by the C-Word Campaign? (*Probe for information about the modern contraceptive methods being targeted by LVCT Health for the C-Word Campaign*.)

11. Do contraceptive messages used on the C-Word Campaign conform to the understanding and knowledge the students have of the risks of not using contraceptives in case they are sexually active? (*Do contraceptive messages address their behaviours? What are their beliefs, norms, habits, language? Probe for information on how the students view contraceptive messages*.)

12. How are contraceptive messages packaged and communicated? Do you think the students understand the messages on the C-Word Campaign? (*Probe for information about language used in the C-Word Campaigns, the behaviour and lifestyles of young people and how these influence acceptance and rejection of the messages, How can they be improved to reach the youth more effectively*?)

Thank you very much for your participation.